Report compiled by The National Collaborating Centre for Mental Health (NCCMH) and Royal College of Psychiatrists in Scotland (RCPsychIS)

Standards for Adult Secondary Mental Health Services in Scotland

Consensus Conference Summary

A summary of outputs from the consensus conference held on 23 June 2022

Contents

1. Introduction

1.1. Background

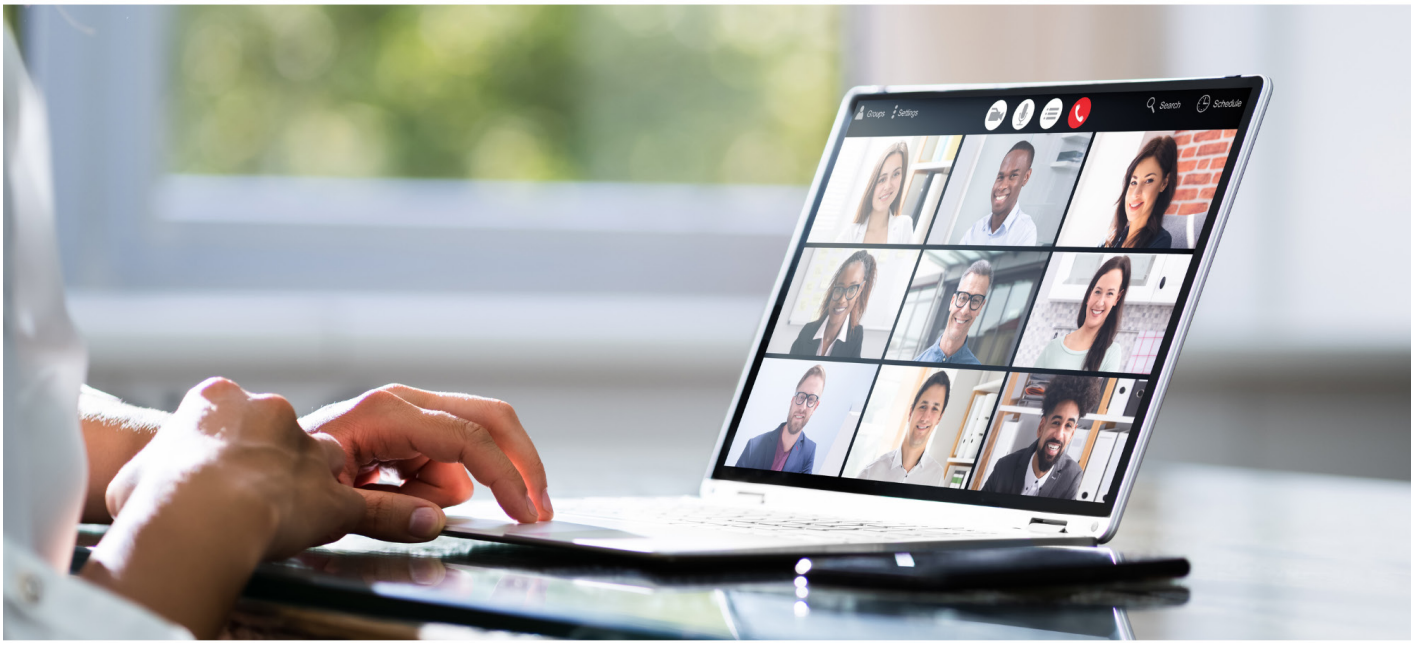
In 2021–22, the Scottish Government commissioned several organisations to carry out engagement work and evidence reviews to inform the development of quality standards for secondary mental health care across Scotland:

- **Healthcare Improvement Scotland (HIS)** were tasked with conducting an evidence review of existing standards for secondary mental health care developed by other countries (in English).
- The **National Collaborating Centre for Mental Health (NCCMH)** and the **Royal College of Psychiatrists in Scotland (RCPsychIS)** were asked to run engagement events with organisations that provide and secondary mental health care in Scotland, as well as leading organisations involved in providing that care. These events were held to find out which areas were priorities for the development of quality standards. In addition:
  - a survey was developed and completed by members of the workforce and leadership
  - the NCCMH carried out an evidence review of relevant position statements, to inform the standards.
- **Voices of Experience (VOX) Scotland** and **Health and Social Care Alliance Scotland** (the ALLIANCE) were commissioned to hold focus groups and carry out a survey of people with lived experience to find out their priorities for quality standards.
  - They also carried out a literature review, collating findings from previous VOX and the ALLIANCE engagement on mental health.

As part of their proposal, the NCCMH suggested a consensus conference as a way of synthesising the three different strands of work, which this report summarises.

1.2. Aim

The aim of the consensus conference was to bring together the feedback from the three areas of engagement work (workforce, lived experience and evidence review) with participants from all three areas, and to reach a consensus on the key priority areas for the quality standards.



1.3. Organisers

The content and structure of the consensus conference (see **"Section 3"** and the **"Appendix"**) was planned by Scottish Government, the NCCMH/RCPsychIS, VOX/the ALLIANCE and HIS.

The consensus conference was chaired by Gordon Johnston, Director of VOX and Chair of the Scottish Government's Standards Working Group, and Catherine Totten, Allied Health Professional Advisor on Mental Health to the Scottish Government.

The NCCMH provided facilitators for each of the breakout groups and researchers to act as scribes during each discussion. The facilitators and researchers used a form to structure and record the discussions (see **"Appendix"**).

The NCCMH and RCPsychIS compiled this report.

1.4. Delegates

Seventy-seven delegates registered to attend the consensus conference on 23 June 2022. It was a virtual conference, taking place on Microsoft Teams video conferencing.

Eleven attendees were from the NCCMH (including two based at University College London) and RCPsychIS, 13 were lived experience collaborators, 14 were from the Scottish Government, five were from NHS trusts in Scotland, two from VOX, two from the ALLIANCE, two from the Scottish Government Care Inspectorate, and 28 other leaders and mental health and social care staff.

The invitation was forwarded by some delegates, so there were more participants than expected at the conference.

2. Summary of priority areas for quality standards

The areas that were ranked by conference delegates as priorities for the development of quality standards in secondary mental health services in Scotland are as follows.

2.1. Access to secondary mental health services

Delegates were in strong agreement about the priority area for access to secondary mental health services being **clear pathways into care**, which also received the greatest proportion (**78%**) of votes in the poll.

2.2. Assessment and care planning

Delegates agreed that two areas of assessment and care planning were of high priority.

- **Comprehensive assessment based on an understanding of service users' psychological, social and physical needs and goals** was rated in the discussions as being most important for the development of standards and received the greatest proportion (**44.7%**) of votes in the poll.
- **Co-production of care plan with service user and, where appropriate, a carer** was also judged to be high priority, with the co-production of care plans receiving the second greatest proportion (**26.3%**) of votes in the poll.

2.3. Support, care and treatment

Consensus on support, care and treatment was less clear cut than for assessment and care planning, but having a **personalised care plan that takes into account choice, holistic needs (that is, including social care) and range of treatment and support (for example community provision, social prescribing)** was discussed as being a high priority for standard development, receiving the greatest proportion (**59.0%**) of delegate votes.

In the breakout group discussions, **routine outcome measurement that addresses experience of care, quality of life and symptom improvement** emerged as a priority area, but received only **12.8%** of the delegate vote.

Access to appropriate evidence-based treatments received **23.1%** of delegate votes. While this was judged as important in the breakout group discussions, concerns were raised about referring solely to evidence-based treatments.

2.4. **Transitions and continuity of care**

In both the breakout groups and polls, there was broad consensus about the priorities for standard development in this area.

In the discussions, **effective systems in place to support navigating transitions between services, including primary and secondary care, age-specific services such as child and adolescent mental health services [CAMHS], and adult and older adult services, inpatient and community care**, was seen as a clear priority, receiving nearly half (**47.4%**) of votes in the poll.

Delegates agreed in the breakout group discussions that **effective systems to support discharge from services** (in particular inpatient care) was a priority, receiving over one-third (**34.2%**) of votes in the poll.

2.5. **Workforce**

In the breakout groups, the delegates said they found it difficult to rank the workforce themes because they felt they were interlinked. However, **service staffing levels are sufficient to provide a safe and effective service** emerged as a priority area for standard development, and there was a clear preference for this in the poll with **51.2%** judging this to be a priority.

Skills of staff in services that are appropriate to **meet the needs of people supported by the service** received the next highest proportion (**27.9%**) of votes in the poll.

3. Content and structure of the consensus conference

3.1. Areas of focus for discussion

When planning the consensus conference, the organisers (see **"Section 1.3."**) identified five areas of focus for the standards from the engagement work and evidence review. These are listed below.

Each area of focus was broken down into several sub-areas or themes to guide discussions and allow for deeper and more nuanced conversations between delegates about which areas to prioritise:

1) Access to secondary mental health services

- Clear pathways into care
- Excellent information about what services provide and are good at
- 'Step-up, step-down' access (which enables prompt access back into the system or reaching a crisis)
- Waiting time target
- Communication and support while waiting

2) Assessment and care planning

- Comprehensive biopsychosocial assessment based on an understanding of service users needs and goals
- Person completing initial assessment has appropriate skills/training
- Multidisciplinary assessments should include an assessment of social care needs
- Co-production of care plan with service user and, where appropriate, a carer
- Signposting and assistance to access other services (also Transitions)

3) Support, care and treatment

- Access to appropriate evidence-based treatments
- Personalised care plan that takes into account choice, holistic needs (that is, including social care) and range of treatment and support (for example community provision, social prescribing)
- Physical health needs should be reviewed and care integrated with that of the mental health needs
- Routine outcome measurement that addresses:
  - experience of care
  - quality of life
  - symptom improvement

4) Transitions and continuity of care

- Effective systems in place to support navigating transitions between services including:
  - primary and secondary care
  - age-specific services (CAMHS, adult, older adult)
  - inpatient and community care
- Support navigating transitions between teams involved in care
- Effective systems in place to support information sharing across care settings
- Effective systems to support discharge from services, in particular inpatient care

5) Workforce

- The skills of staff in services are appropriate to meet the needs of people supported by the service
- Service staffing levels are sufficient to provide a safe and effective service
- Peer support workers and other non-clinical staff are involved in the provision of care
- Effective systems in place to support staff development, training and supervision to ensure staff wellbeing and effectiveness
- People with lived experience are involved in the recruitment and training of the workforce

Cross-cutting themes

In addition to the areas of focus and related themes outlined above, the following themes were considered 'cross-cutting' and relevant to discuss alongside each focus area:

Communication and information:

- About services (what they provide)
- Between services
- Between patients and services

Inclusion and equality:

- Addressing inequalities
- Challenging discrimination
- Standards must reflect the importance of ensuring equality

Person-centred care, for example:

- Empathy
- Respect
- Rights-based
- Choice
- Co-production

Environment:

- Safe
- Appropriate
- Therapeutic

Measurement:

- Reliable
- Valid
- Understandable
- Available

3.2. Breakout groups

Following an introduction to the session and a high-level outline of the work to date, delegates were put into breakout groups to discuss each area of focus. Each breakout group discussed one or two of the focus areas, led by a facilitator from the NCCMH/RCPsychIS.

3.3. Polling

In addition to discussions about prioritising areas of focus in breakout groups, polling was used to gain a better understanding of which areas delegates viewed as most important in terms of standard development.

The details of the polls undertaken and the results obtained are provided in **"Section 4.2."**.

4. Outputs

4.1. Breakout group consensus about priority areas and other areas of high importance

Each breakout group discussed one or two of the focus areas and themes. They were each asked to reach consensus over the areas to prioritise. Across the breakout groups, it was consistently expressed that all of the themes were important, making priority-setting challenging.

In addition, there was a strong feeling that the need for an adequately staffed and resourced workforce to implement the standards was as important as the standards themselves.

In the summaries below, we highlight the following, as agreed by the delegates:

- the priority for each area of focus
- other areas of high importance.

4.1.1. Access to secondary mental health services

Priority area under access to secondary mental health services:

- **Clear pathways into care**

Other areas of high importance:

- **Communication and support while waiting**
- **Step-up, step-down access**
- **Wait time targets**

Priority area: Clear pathways into care

This was identified as a key priority area within the breakout group and within the poll (see "Section 4.2.1."). A consistent theme emerged around a need for clear, integrated pathways into and out of secondary care services, and between services. Themes linked to this included:

- The importance of information about pathways into care being accessible and outlining what the person may expect from the service (and what they may not)
- The need for pathways to have a person-centred approach and incorporate input from people with lived experience
- Pathways need to ensure equity of access and actively address barriers to access.

> ***I think that's really, really important - you know that kind of "no wrong door" approach that ... you go and you make a reach out for help, and you get some kind of personalised face-to-face communication really early on.***

Area of high importance: Communication and support while waiting

There was broad acknowledgement about pressures within services and that some people might need to wait to access appropriate care. However, there was a strong theme around communication and support available to people while waiting to access services. There was consensus on the need for ongoing communication about the progress of the referral and about what services can offer. There was also agreement about the benefit of providing information about other, alternative supports and an emphasis on ensuring that any information provided is accessible and up to date.

To inform people while waiting, you know, inform people and maybe attach other things that people could be doing in the interim to support them so it becomes a reciprocal arrangement rather than a one-sided response.

Area of high importance: Step-up, step-down access

This was seen as being of benefit and a potential priority area. It partly linked to the theme around pathways into care and about information around accessing services. It was seen as being of value in supporting people to avoid a potential crisis. There was some lack of consensus on this theme due to concerns about its impact on existing service capacity.

Just on the experience that I've heard from other people (who have access to mental health services), that step-up, step-down access for people who are known to the service is really valuable.

Area of high importance: Wait time target

There was consensus that some wait time targets could be included and considered as part of the pathway. Some felt that wait time targets would help to demonstrate that services are working efficiently. It was acknowledged that wait time targets can put pressure on systems, but that they can drive improvement. The challenge is the number of standards and pressures services are facing. There are already waiting time standards, and if more are added there needs to be careful thought about how these standards will work with existing ones in a constructive way, without adding pressure on services.

It's not just about setting targets, if we're setting this as our standard, there needs to be resource to back that up.

4.1.2. Assessment and care planning

Priority areas under assessment and care planning:

- Comprehensive biopsychosocial assessment based on an understanding of service users' needs and goals
- Co-production of care plan with service user and where appropriate a carer

Other areas of high importance:

- Signposting and assistance to access other services (also seen as a 'transitions' issue)
- Person completing initial assessment has appropriate skills/ training (also seen as a 'workforce' issue)

Priority area: Comprehensive assessment based on an understanding of service users' psychological, social and physical needs and goals

A comprehensive assessment of an individual's psychological, social and physical health needs, which is rights-based in its approach, was seen as being a key priority area both within the breakout group discussions and also within the poll (see "Section 4.2.2."). There was consensus that it was an area that would benefit from quality standards given the variation across services. A linked theme was around ensuring that staff have the necessary skills and supervision to undertake such an assessment and that assessment tools used are fit for purpose. There was also an emphasis on a collaborative approach to the process and ensuring that it isn't a one-off event but an ongoing process.

[This needs] consideration of the core skills needed for somebody who's undertaken the assessment, and having supervision in place to make sure that the assessments happen and appropriately.

Priority area: The professional and the person using services will work together to create a care plan

Co-production of care plans was seen as another priority area that would benefit greatly from standards. There was a recognition of the significant variation in the quality of care plans and the individual's involvement in their development currently. There was a strong theme around the need to ensure that care planning is an ongoing process and one that incorporates the views of the individual and their carers and significant others where appropriate.

That part about the professional and the person using services will work together to create a care plan, I feel that that's an area that there would be a lot of value in setting standards around.

Area of high importance: Signposting and assistance to access other services (also Transitions)

This was seen as potentially an area of high importance, but one that was linked to other focus areas.

To identify what they [patients] need and possibly signpost them to other places... to me that would seem to be a description of the very least that a person who wants services has a right to expect.

Area of high importance: Person completing initial assessment has appropriate skills/training

This area was also noted to be important but linked to broader standards on training within the workforce section (**"Section 4.1.5."**).

The theme about the person completing initial assessment has appropriate skills and training... is absolutely valuable and it needs to be there.

4.1.3. Support, care and treatment

Priority areas under support, care and treatment:

- Routine outcome measurement that addresses experience of care, quality of life and symptom improvement
- Personalised care plan that takes into account choice, holistic needs (i.e., including social care) and range of treatment and support (e.g., community provision, social prescribing)

Other areas of high importance:

- Access to appropriate evidence-based treatments

Priority area: Routine outcome measurement which addresses experience, quality of life and symptom improvement

There was consensus on routine outcome measurement being one of the priority areas within 'Support, care and treatment'. Ensuring that outcomes are multidimensional and including what matters to the individual were seen as important. However, there was some lack of agreement on the details associated with the process of measuring outcomes and the focus of such measures, especially in relation to measuring the therapeutic relationship and empathy (seen as very important by patients and carers).

We really over complicate things by what we are trying to measure and it can be something really simple....[such as] asking people ....'did you feel a sense of empathy, did you feel somebody cared?'.

Priority area: Personalised care plan that takes into account choice, holistic needs (that is, including social care) and range of treatment and support (for example community provision, social prescribing)

There was also consensus on service users having a personalised care plan as another priority for standard development in this area. Some felt that such a standard could combine elements from other themes, such as access to appropriate evidence-based treatments and meeting physical health needs. But others thought this would be challenging (see 'Access to appropriate evidence-based treatments' below).

A personalised care plan...makes all sorts of things easier and better, if we have good and consistent care plans.

Area of high importance: Access to appropriate evidence-based treatments

This area was deemed to be of high importance, but there was some interesting discussion about the term 'evidence-based'. Some felt that there are not the necessary resources in place to stipulate provision of evidence-based treatment, while others noted that some newer approaches do not yet have a solid evidential foundation but may be beneficial to offer to service users. There were suggestions to refer to the Matrix and to build flexibility into the standards to allow clinicians to offer treatments with a limited evidence base where appropriate. Patient choice and readiness to engage in certain therapies are also factors that need to be considered.

The word 'evidence-based' is really important to have there because it helps us to develop our services knowing what does work...but hope that there will some flexibility around the standards to allow us to use what we think is the best [therapy] for the individual in front of us.

4.1.4. Transitions and continuity of care

Priority areas under transitions and continuity of care:

- Effective systems to support discharge from services (in particular inpatient care)
- Effective systems in place to support navigating transitions between services, including primary and secondary care, age-specific services (CAMHS, adult, older adult), inpatient and community care

Other areas of high importance:

- Support navigating transitions between teams involved in your care
- Effective systems in place to support Information sharing across care settings

Priority area: Effective systems to support discharge from services, in particular inpatient care

Systems to support discharge from services, especially inpatient care, was seen a key priority area for quality standards, especially due to the risks to the patient associated with this process. There was consensus about the need for improved communication channels

and flow of information to ensure that people feel supported in this process, even though achieving this within current systems was seen as challenging.

Standards won't resolve the issues around discharge and the issues that social care have around people coming out of hospital.... that's a major resourcing challenge.

Priority area: Effective systems in place to support navigating transitions between services, including primary and secondary care, age-specific services (CAMHS, adult, older adult), inpatient and community care

This was seen as another priority area and one highlighted as being a high priority within the poll (see "Section 4.2.4."). A consistent theme within the discussions was in relation to information sharing and the need for record sharing systems that would support this. There was also consensus around the need to expand information sharing to include social care and primary care systems to support transitions across all these domains, while taking confidentiality into account.

There are disparities amongst social work in terms of age group. Age, I think, finishes at 16 for social work and health it stays at 18, so it's different services involved and I think one needs to be tightened up a little bit.

Area of high importance: Support navigating transitions between teams involved in your care

Although not seen as high priority, this area was deemed to be of high importance, with the fact that people may use multiple mental health and social care services needing to be acknowledged. As in the priority areas discussed above, the need for improved communication and information flow was highlighted.

One of the things that is perhaps needed is a key contact for the patient because at the moment the patient is responsible for if they see a social worker, or if they see the GP, if they see a peer support worker, a psychiatrist and an occupational therapist, for example, they are responsible for keeping their own diaries and making all the connections and making sure that people are aware.

Area of high importance: Effective systems in place to support information sharing across care settings

This area is linked and is fundamental to the priority areas already discussed, with delegates emphasising the importance of a joined-up information system that can be accessed by all organisations and services involved in a person's care. There was a suggestion that patients should be allocated a single person as a primary contact or key coordinator to help them navigate the system.

One of the most important things is that data can be shared between practitioners, with the patient's agreement, or made available so that if they are admitted to a hospital unconscious, for example, that they put a note on their data [so that] the information about their mental health, in particular, can be shared and that they're not having to tell the same story over and over and over again to different people within the system. It's exhausting.

4.1.5. **Workforce**

Priority areas under workforce:

- Service staffing levels are sufficient to provide a safe and effective service

Other areas of high importance:

- The skills of staff in services are appropriate to meet the needs of people supported by the service.
- Effective systems in place to support staff development, training and supervision to ensure staff wellbeing and effectiveness

Some delegates commented on how the themes under workforce were intertwined and therefore difficult to rank, with some suggesting an overarching standard about having a skilled, support workforce with people with lived experience involved.

Priority area: Service staffing levels are sufficient to provide a safe and effective service

This area was seen as crucial for quality standard development, which is supported by the poll (see **"Section 4.2.5."**). Delegates emphasised the importance of improving staff retention to provide better continuity of care. Some saw retention as being affected by several factors, including having a challenging workplace culture (such as bullying) in some areas.

The one that jumps out and that kind of sits above all the others is whether service staffing levels are sufficient to provide a safe and effective service, and ... over recent years we've seen a kind of diminishment of the kind of staffing levels across most of the professions and disciplines that make up mental health services to the point where, you know, things do feel a bit unsafe at times.

Area of high importance: The skills of staff in services are appropriate to meet the needs of people supported by the service

This was judged to be of high importance, but linked to other themes under the area of workforce. It was about more than just meeting the needs of people, being also about ensuring that they are fully involved in their care.

A person with experience of mental health [problems] is obviously going to build up a relationship and that's important for a person's recovery, especially with things like bipolar and schizophrenia and things like that...I think the skills is the most important part.

Area of high importance: Effective systems in place to support staff development, training and supervision to ensure staff wellbeing and effectiveness

This area was also seen by delegates as linking to the priority area. Having access to training and supervision and to development opportunities allows staff to acquire the right skills needed to meet the needs of people supported by services and provide continuity of care.

I would be really keen that there is a focus and an emphasis on ongoing training and development as well, and that that being seen as a priority, because I think that's something that certainly in my experience has got increasingly difficult to access.

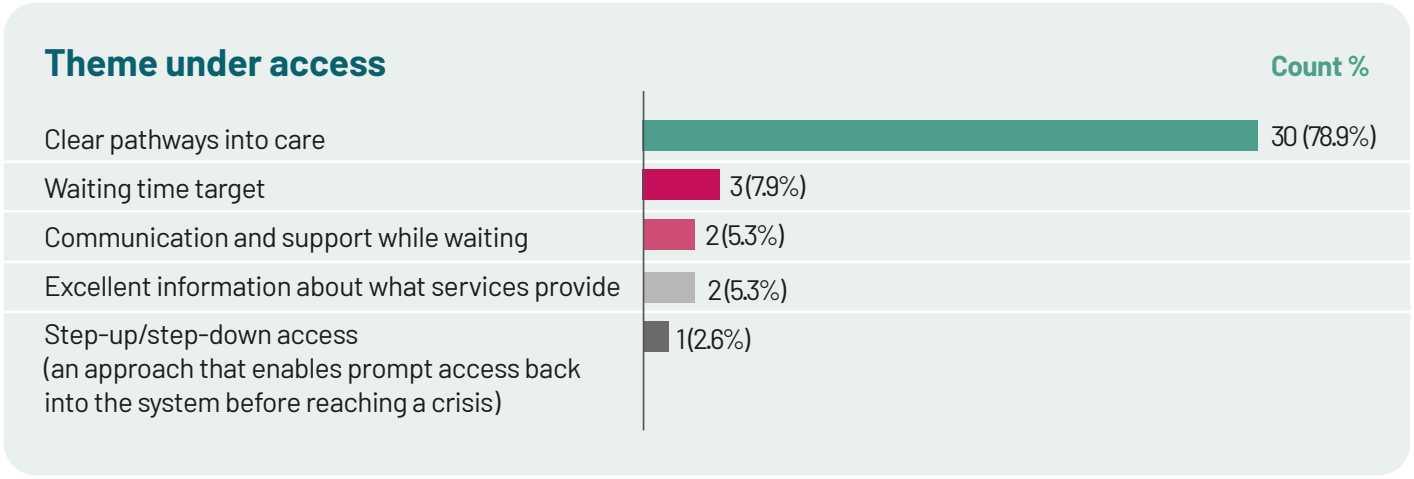
4.2. Results of the polls

Delegates were asked to complete a number of polls asking them to prioritise the themes for each of the focus areas.

While the polls give an indication of what delegates felt about priorities, they should not be read as definitive statements on the priorities. Instead, they should be read alongside the other information that was gathered throughout the engagement process.

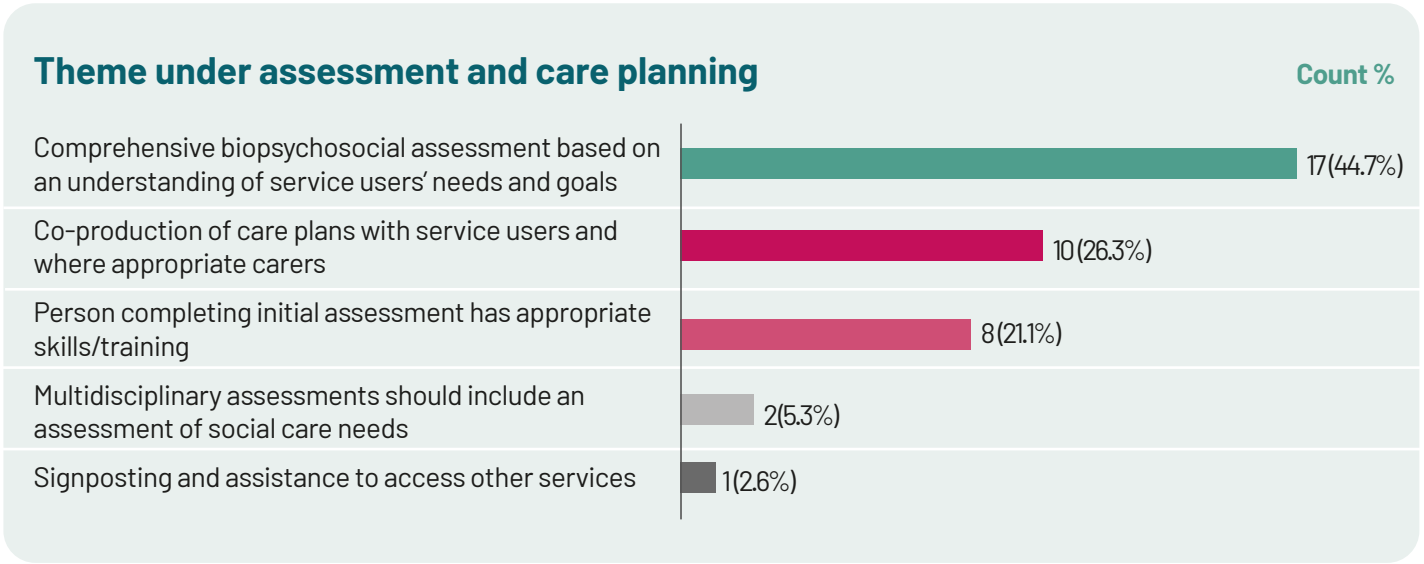
4.2.1. Access to secondary mental health services

Theme being prioritised for quality standards under the area of access to secondary mental health services (n=38)



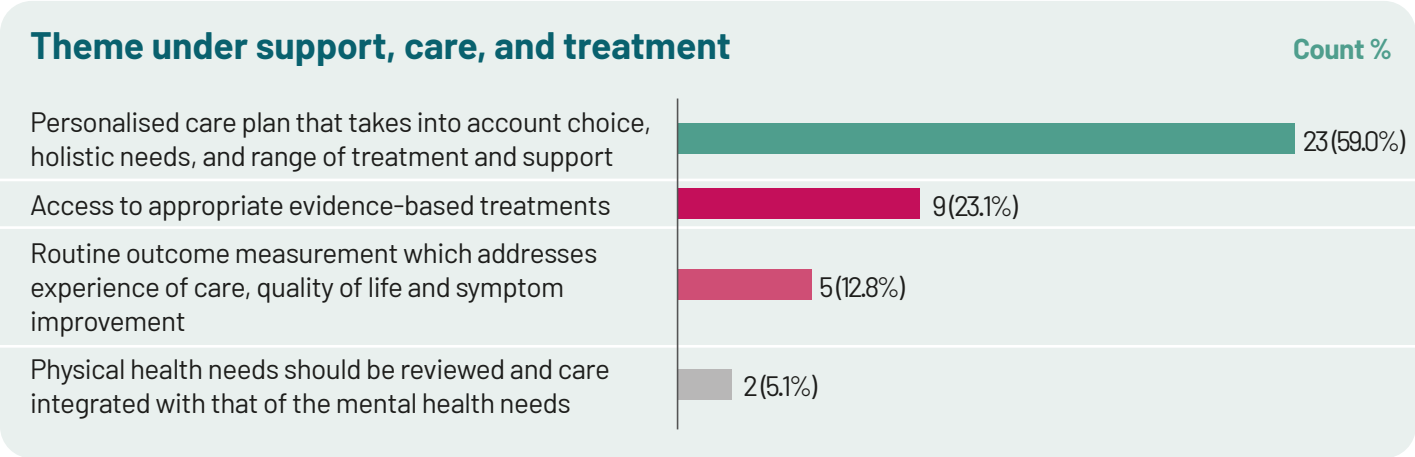
4.2.2. Assessment and care planning

Theme being prioritised for quality standards under the area of assessment and care planning (n=38)



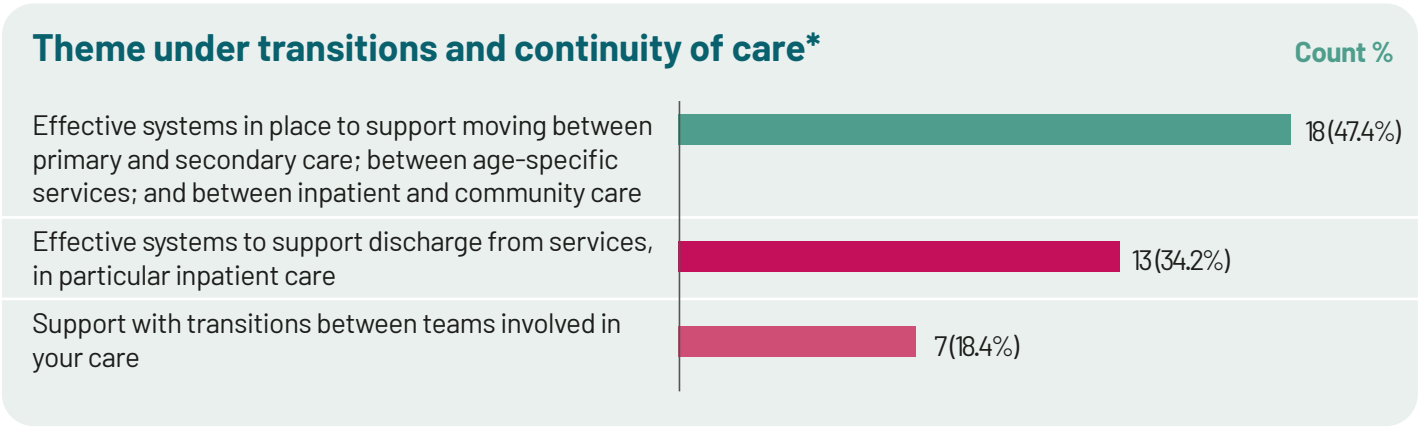
4.2.3. **Support, care and treatment**

Theme being prioritised for quality standards under the area of support, care and treatment (n=39)



4.2.4. **Transitions and continuity of care**

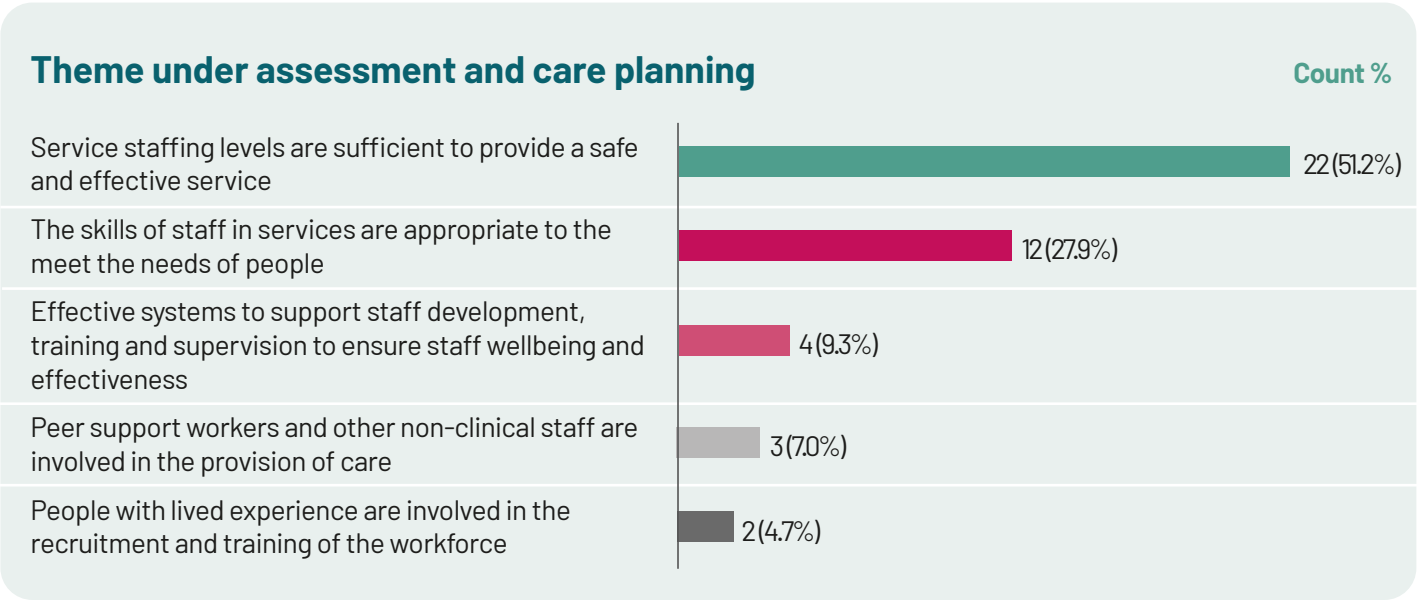
Theme being prioritised for quality standards under the area of transitions and continuity of care (n=38)



*Note: The theme 'Effective systems in place to support information sharing across care settings' was missing in the poll

4.2.5. **Workforce**

Theme being prioritised for quality standards under the area of workforce (n=43)



4.3 Implementation considerations

The following themes were discussed consistently at the consensus conference and throughout the engagement process. We consider them to be 'cross-cutting' – that is, they apply to all of the priority areas discussed – and should be considered in a national level implementation plan.

Measurement

- Measurement and improvement for compassion is important and there is a tool to measure it developed by General Healthcare
- There are real obstacles to services gathering information, and this needs to be considered as part of an implementation plan.
- There was a general consensus that measurement, and an information system that supports it, is vital to the delivery of the standards, along with a concern that this would present a high degree of burden on clinical staff, and that this needs to be fully considered and costed into the standards.

Co-production

- It is essential that all implementation and service improvement activity resulting from the standards is co-produced with frontline staff, service users and their carers.
- Co-production should happen at every level – on local and national boards and committees, at team level, and at the individual level of clinician and patient.

Systems level

- While the focus of the quality standards will be secondary mental health care, this is a systems leadership issue - many of the elements of a high-quality mental health system exist but they could be better joined up.
- While seeking to improve secondary care mental health services, the quality standards should also be careful not to perversely impact on the relationship with primary care services (including mental health) and wider social care and voluntary sector provision.

4.4 Equality

Although equality was identified as a cross-cutting theme for the quality standards ahead of the consensus conference, there were no specific considerations around making care more equitable put forward.

Given that is it well established that access to, experience of and outcomes from mental health care are often poorer according to a number of personal characteristics, such as race, being from the LGBTQ+ community, age, socio-economic status or physical disability (for example, see the **Advancing Mental Health Equality Toolkit**), it is imperative that the quality standards seek to address this.

We recommend that consideration is given to a specific standard to address equality, as well as an equality impact assessment undertaken on all of the standards.

5. Conclusion

It was possible to reach consensus on the priority areas for quality standards for secondary mental health services in Scotland, based on the breakout room discussions and the polls during the conference.

A summary of these priority areas can be found in **"Section 2"**.

For most of the areas there was strong consensus, though a significant number of delegates did comment that they found it hard to rank the sub-areas as they felt that all were important, and that some were interlinked.

We are grateful to all who took part in the consensus conference, and all of the events leading up to it, for their time, thought and energy.

Appendix

Notes taken from priority-setting discussions

The following are rough notes taken by scribes during the consensus conference, containing some direct quotes and some synthesis of discussions during the conference.

Access to secondary mental health services

Priority area: Clear pathways into care

- The priority should be clear pathways into care. The other points draw from this one and should be included in the pathways into care (for example, pathways should be informative and include information about what the service provides).

- Importance of integrating secondary care pathways with other services (for example acute care, primary care, community and so on). The pathways should not be established in isolation.
- Need of having closer links with the third sector.
- A clear pathway will be beneficial for everyone (that is, staff, service users and so on). Clear pathways inform both service users and the workforce expected to deliver services.
- The pathway should include the different stages involved.
- Need of defining an entry to the pathway and the exit as well.
- Pathway as a partnership – This will be related to communication and support while waiting.
- The need to make sure that clear pathways represent people's views.
- Pathways between pathways across services.
- Equitable access to services across the pathways and having the option of accessing psychological services.
- Need for communication across services and across the different stages along the pathway (for example, to avoid repeating work).
- Service users' experience along the pathway should be considered.
- Harm can start in the way that people access mental health services (for example traumatic experiences, or being confused, excluded or unable to access services).
- Need to build on information systems and have the option for people to use technology to access services (that is, include virtual consultations).
- Patients may think the antidote to their problems is secondary care, but this might not always be the case.

Area of high importance: Communication and support while waiting

Communication

- Parity with communications in physical health is very important and what these standards need to achieve.

- Important to communicate to the patient to say that services have received the referral and inform them of when people can expect a response or appointment.
- The way we communicate could be different. People could get video clips on what to expect, what to wear, who is in the team and so on.

- Because we are hospital based there is community based collective advocacy in crisis services and there are gaps e.g. for people with personality disorder and complex needs.
- For patients with autism and/or attention deficit hyperactivity disorder, the short time frame to get back to the service to book an appointment (within 5 days) is a limitation that we need to be mindful of.
- Patients with a neurodevelopment diagnosis experience difficulties accessing services and the structure of services that cause this.

Information

- Up-to-date information telling patients what services providers can offer, and other sources of support and (importantly) being supported to get to there.

- Someone recounted an experience that the GP service they accessed did not know what to do as the hospital hadn't told them. Getting someone at the hospital to give the GP information was difficult, never mind the patient.
- The constant updating of materials and the variety of materials needed.
- Regarding constant change – it will be difficult to come up with standard rules for places with different environments that is rural, city and so on.
- Patients have a strong need for a diagnosis because with one, they can feel understood and accepted, and reasonable adjustments can be made at work. They can fit in, and be able to work or not work.
- Important to have resources that make people accountable for what's going wrong. People need to see a form of accountability more explicitly and transparently rather than a just a complaints page on a website.

Area of high importance: Step-up, step-down access

- Step-up, step-down access for people who are known to the service is very valuable. The two go hand in hand, clear pathways into secondary care initially and then a clear understanding of how to come back into secondary care quickly to avoid a potential crisis. The two pathways are very variable.

- A barrier is patients who become unwell again having to going back to GP and wait for GP appointment and then wait to be seen by community mental health team.
- Step-up, step-down access is a deep source of frustration. Quick access for first episode – then, when they had another episode, they had to go back onto the waiting list, which seems counter intuitive. It would be beneficial if there was a way to step back to where you were. Patients are usually discharged when they have had to leave the area for some reason, not because they are well enough.
- Patients experience difficulty finding a patient pathway to care. Recommend a single page on website with a diagram for patients on the pathway into the care they need. Existence of this data or information would be the first measurable thing and then we can look into issues of quality. Currently, the data and information don't exist comprehensively across health, social care partnerships in Scotland in an easily accessible way.
- I would really like to see better step-up, step-down access in our services, but all of these things place additional pressures on the existing workforce. If you're trying to do that plus maintain progress with delivery of evidence-based ecological therapies, for example, there are a lot of tensions in the system. So how we would do that becomes challenging, but I would really like to see something in the standards because we have to keep driving that down.

- There is now a trend of more people demanding a neurodevelopmental or personality disorder diagnosis; however, there is no pathway to secondary care for patients with that diagnosis.
- Step-up, step-down access – if services are pulled into diagnosis-specific answers it just increases pressure. It's more and more difficult to deal with it. If you can think about what the patients' needs are, and often if there are things that are causing people to be in crisis, then you open up other options than secondary care.

Q: Regarding the suggestion that there should be a separate pathway for people coming through the early intervention for psychosis services and secondary mental health services, should there be an accelerated pathway?

- It would be better if we had a system that allowed people to discuss what was going on and having referrals those specific needs rather than a sequence, for example a no wrong door space.
- Advocate for a social-based alternative. It doesn't have to be a care pathway. Could be an open dialogue pathway or esteemed team approach – so, less clinical.
- One service is trying to move more to a needs-based approach, but that causes a tension.
- Important to have balance and equality of engagement is important.

Area of high importance: Waiting time target

- Should be included and considered as part of the pathway.

- Currently there's no indication of how long people have to wait.
- Considerations about what would help people to quickly access the services they need.
- Demonstrate that services are working at a level of efficiency.
- Patients need to get personalised communication early on to let people know what kind of help they need and where they can receive it – this may not always be secondary service.
- The challenge is the number of standards and challenges services are facing. They already have waiting time standards. We need to think how these standards will work with those in a constructive way. Don't want these to add pressure on services but want them to work in a way that drives improvement.

Q: What does waiting well look like?

- Being informed on how long you're likely wait and what to expect
- Signpost to other things that would help while they wait
- Signpost to other community resources

Assessment and care planning

Priority area: Comprehensive assessment based on an understanding of service users' psychological, social and physical needs and goals

- There was consensus that comprehensive assessment is the most important theme, and picks up on most of the others such as social care needs, physical health and co-production of care plans, and so on.

- The initial theme around assessment of psychological, social and physical health needs having human rights that rights-based approach front and centre was seen as something very important.
- Comprehensive assessment might include an understanding of comorbidity such as drug and alcohol problems alongside mental health issues.
- It is important that various professionals are working together to come up with the assessment, and to translate the results to services provided to clients.
- Might be worth adding the word 'dynamic' – implying that assessment and care is not a one-off event but an ongoing process.
- Some suggested a guideline about the differentiation between crisis and routine assessment, which can be seen as more task-focused and holistic respectively, while some recommended that routine assessment can follow crisis if needed.
    - Person completing initial assessment has appropriate skills/training
    - Multidisciplinary assessments should include an assessment of social care needs
- Do not miss out access to supervision. In addition, encourage clinicians to reflect on both positive and negative cases.
- This is huge – physical health needs are not consistently addressed for people across the country. There isn't a tool that is consistently used, so that still is an issue particularly where medication is concerned. There are huge psychological, social and physical health needs and maybe they need more focus individually and separately.
    - The [House of] Lords review of mental health [unclear which review this refers to; possibly the House of Lords Economic Affairs Committee's report 'Social care funding: time to end a national scandal'] will have a huge impact on social health
- The standards will date if we do not drench them in human rights. If they're not in these standards, patients won't engage with them. This is how you are going to be held accountable from an advocacy point of view.
    - Number one of Health and Social Care standards is, 'My human rights protected and promoted and I experienced no discrimination.' We need to write acute care standards that don't repeat what is already there but add value to what is already there for all services.
- Health and Social Care standards have been around since 2017. In some situations they may be aspirational, but it is still important that they are there. It would be useful to link the standards to those, and to other existing documents.
- Communication is a difficult one with personal planning to make sure that the person is fully involved in that and fully in agreement with the decisions that have been made, but there's been lots of work done on that as well. And I think, again, it would build a link from your document to work that already exists in terms of personal planning.
- Assessment is variable. Assessment documentation doesn't cover everything it

needs to cover. Although there's core training in place the repeated themes continue to happen. The five themes are all important. Audits of care plans show that the same themes come up again. Having consideration of the person carrying out the assessment has core skills is important and making sure assessment happens appropriately and that informs care going forward. All areas are very important.

Priority area: The professional and the person using services will work together to create a care plan

- Following the first theme about comprehensive assessment, co-production of care plans is another essential theme.

- Patient's voice should be incorporated in the care plan.
- It is important to include the roles of significant others such as families and carers. It is a bit alarming that families can hardly be seen across various themes.
- Area that is very much value setting standard around. What do you mean by 'person-centred'?
- We see a lot of variation from bad care plans to where person hasn't seen it – to where person has full autonomy.
- Care planning is the area that there's probably the most value in having a setting the standards. Care planning is an ongoing process.
- Language – recommendation to talk about personal planning rather than care planning and changing service users to something more appropriate. We should be aspiring to co-production so reflect this in the document.

Area of high importance: Signposting and assistance to access other services (also Transitions)

- Apart from comprehensive assessment and co-production of care, this is another important theme but it can go to another focus area.

- It is important to clarify the roles of the clinician making first contact – not just referring the patient out, but having a responsibility to ensure the next stage of care happens – that is, no wrong door.
- A need for care management
- It would be useful to get consistent information from GP regularly, so not letting patients to tell their stories repeatedly, which can be harmful.
- Understaffing/under-resourcing needs to be addressed for the proposed standards to be implemented well.

Area of high importance: Person completing initial assessment has appropriate skills/training

- One person noted that this theme is repeated in workforce section.
- Another commented that this can be a good thing in reality/in practice because it helps focus people on the importance of a worker having training, and in terms of personal planning.

Support, care and treatment

Priority area: Routine outcome measurement which addresses experience, quality of life and symptom improvement

- Simplified outcome measures to measure patient experiences of care.

- There are some measures for therapeutic relationship that have been correlated with outcome measures like symptom improvement.
- Should we just simplify outcome measures [to a five-point Likert scale], for example: 'I felt cared for' – measure 1–5, 'How was your experience?' – 1–5, and so on.
- Data collection and reporting – Scottish Government/Public Health Scotland may be asked to report against standards.
- The Mental Health Quality Indictor (MHQI) profile exists to report on data collected – released on a regular basis to report on centrally held data or received from boards and so on.
- A survey scoring 1–7 or Y/N to report against each quality standard.
- Can get a figure (%) from a question on a survey, for example, 'What % of people felt care was compassionate?' – does not need to be overcomplicated.
- Most recent MHQI: **https://publichealthscotland.scot/publications/mental-health-quality-indicator-profile/mental-health-quality-indicator-profile-26-april-2022/**
- Should standards include a minimum completion 'goal' for outcome measures collected? Would there be issues of burden on already over-stretched staff?
- MHQI – need to make judgement about whether it is appropriate to report data, dependent on completion – looking to set criteria for minimum completion.
- Outcome measurement that measures true quality of care from the patient perspective, speaks to the question of ensuring empathic care and the therapeutic relationship – quality standards developed could be measured against using a simple approach of scoring Y/N, scale 1–7 and so on.
- Outcome is an important theme but should be a separate focus area.
- The measurement can be multidimensional but including what matters to the patient (that is, what they value); how the service is doing at meeting those needs; experience of care; quality of life; symptom improvement; and so on.
- Making sure the outcome measurement is not just a tick-box exercise of reporting but bringing real changes.
- We need to make sure the purposes of outcomes are clear (for example, making them publicly available? Improving services?
- Outcomes: if person-centred, the measure should be people's experience to make people at the heart of the standard – that is how you measure success.

Priority area: Personalised care plan that takes into account choice, holistic needs (that is, including social care) and range of treatment and support (for example community provision, social prescribing)

- Consensus by the group that personalised care plan is the most important theme, which identifies most of the others such as evidence-based treatments, physical health needs, etc.

- There is a tension between this and the access to evidence-based care but perhaps they could be merged into one standard about access to the right care that takes into account people's choices and other needs they may have but 'evidence-based' should be included here – need clarity of the model to affect change.
- Empathetic support and care are not necessarily considered as strongly even though that's what service users want.
- How to measure empathic support? Is there a measure for this? Patient experience measure? Can be related to things that should be relatively easily measured.
- Outcome measurement and output measurement can be related to this [discussed more below].
- Compassion fatigue is a challenge for the workforce.
- Community Chaplaincy Listening Service was highlighted in line with joining up support with community organisations.
- Please also involve the significant others such as families and carers.

Area of high importance: Access to appropriate evidence-based treatments

- There is not the resource in place to provide proper evidence-based treatment that meets the needs of the people accessing secondary care – usually complex needs, trauma and maltreatment etc.

- Often the treatments offered are lacking evidence in psychological therapies, newer approaches do not necessarily have the evidence base – use the Matrix to determine what to use
- Flexibility around the standards to allow clinicians to use treatments available even if the evidence base is premature
- We also need to consider the availability of a range of treatments and the readiness of patients to engage in a particular therapy model.
- Apart from evidence-based treatments, we need to ask what the patients want and value – for example, some might be too distressed to engage in evidence-based treatments but value someone spending time with them which can already be helpful enough.

Transitions and continuity of care

Priority area: Effective systems to support discharge from services, in particular inpatient care

- Effective systems to support discharge from services, in particular inpatient care, are important due to the risk of getting this wrong and the potential for negative effects on patients.

- People move from high-level support to lower-level support when they go from inpatient to community so continuous governance and monitoring of how people fair in the community.
- Implementation point – system to support transition needs to be in place before standards can be actioned.
- Even with good systems in place, communication can break down so there is the need for workforce capacity to enable this to happen – another implementation point before standards can be actioned
- This theme was seen as a priority because of the risk associated with getting it wrong – if people are not supported on discharge, they are at increased risk.
- Some services have a 'discharge hub' where they follow the patient for 2 weeks up until they are transferred and allocated to community mental health team, ensures person has support and safety net in place – the discharge hub can reduce readmissions, data shows this.
- Discharge hub model is not widely used across services but a model that was taken up in Dundee for example, but not used across Scotland.
- Consider the timing of discharge and educate the patient about their care and process for discharge: what to do if they need further care, medication advice. People should not be discharged too early with no follow-up. Those new to the mental health system don't understand the system. Clear, well-planned discharge.
- Communication when discharged back to the care of GP. Need patient education and follow-up. No information on medication, continued meds, how long for dose etc. Supported and feel supported after discharge.
- Pressures on inpatient services lack of beds leading to discharge that is too early. Contrast with community, done better in a more collaboratively way. If needed to speak to psych again would be fast-tracked not through GP (pilot and consulted on the process). Highlights the different experiences of care for different people and services – standards needed!

Priority area: Effective systems in place to support navigating transitions between services, including primary and secondary care, age-specific services (CAMHS, adult, older adult), inpatient and community care

- What underpins all the themes is a clear formulation and written and shared care plan – avoids repetition.

- A standardised way of formulation to ensure smooth transitions and efficiency.
- The community services might be the continuous support while the person moves through the system, so it is challenging to integrate this.
- Transitions from CAMHS to community mental health teams – care plans often fall down because systems between health and social work do not marry (use different systems), same with GPs and mental health services.
- We need one system that everybody involved in a person's care can access – this will be challenging.
- Confidentiality and data sharing issues between services and systems
- A standard around a system wide, standard record sharing system that takes into account confidentiality and data access concerns.
- Doubt that one system is possible – however, in NHS Greater Glasgow and Clyde the clinical portal provides a repository of information for all: Track care, Emis and Vision feed into the clinical portal (for example, outpatient letters, key events and outcomes are all visible). We should look for opportunities to develop that level of pragmatic web-based system.

- Should also join up social care, as well as physical and mental health – however, clinical portal does not incorporate care plans and risk assessments.
- Could the portal be adapted to include social care? There was general agreement this was a good idea.
- Experience of the patient will not be improved until we change the accessibility of the sessions.

Area of high importance: Support navigating transitions between teams involved in your care

- Patient-held access records should be prioritised.
- May use multiple mental health services, acknowledge that. Transitioning through and between multiple services that they may navigate.

- Transition from CAMHS to adult or adult to older adult services. Better information and communication needed. A lifespan approach is what we should aspire to, needs should be met by the system, person-centred. Easy to say difficult to do – that should be the expectation and then work out how you get there.

Area of high importance: Effective systems in place to support Information sharing across care settings

- Data sharing and collection, sharing between practitioners. Information made available to all, so that it is not required to repeat information to different services. With patient consent. Transfer of data to other services/systems.

- The issue of where standards start and stop – where is the end point? Secondary care, primary care differences – who is held to account for the implementation of these standards where they cross over between different parts of the healthcare system.
- Need sufficient staffing to be able to provide the level of care needed, support through transitions. All organisations involved signed up to the standards.
- Provide a key contact for the patient – a single person who is the key coordinator to ensure the person is kept informed about all areas of their care. 'Pathfinder' what does this mean for a system, so complex that this is needed, do we drive change to make it less complex.
- This is what people should get – local systems to provide.
- Highlands is a bit different, small community. Some are happy for contact details to be given to patients. Local delivery for local needs. How specific should they be?
- No cross platform for NHS and social care – digital platforms are separate and do not communicate. One system for all – just need agreement from all. Not suggest but they must.

Workforce

Priority area: Service staffing levels are sufficient to provide a safe and effective service

- Retention is the most important, how we get continuity – paramount for those who require care.

- Having sufficient staffing levels is crucial. They don't feel safe at the moment.
- Inability to recruit.
- Need to consider the importance of improving retention of staff – Work has increased, and staff are expected to take on more tasks.
- How staff are treated can impact on staff retention, developing staff and treated them well to increase? Current culture of bullying.
- Staff retention and continuity of care.
- Specialists don't like travelling to more remote locations which causes problems for continuity of care – geography creates a workforce issue.
- Geography can impact on staff retention also – requirement of staff remaining in Scotland following training.

Area of high importance: The skills of staff in services are appropriate to meet the needs of people supported by the service

- Overarching statement about skilled, supportive workforce with people with lived experience involved. Capturing the vital elements – hard to rank because they all go together.

- Not just meeting needs but ensuring people are fully involved in their care.
- Not one thing above another, but one thing may be necessary for another.

Area of high importance: Effective systems in place to support staff development, training and supervision to ensure staff wellbeing and effectiveness

- Importance of having access to training and supervision, and development opportunities. This will allow staff to acquire the right skills needed to meet the needs of people supported by the service.

- Need for a national workforce plan.
- There is a current focus on how staff can take care of themselves on an individual basis, but it should also have a broader focus.
- What is the foundational block? Supervision, training, continuity of services.
- Staff training (including peer support).
- Better centralised training, difficult to encourage people into the system (whole of Scotland is one area for medical training).

Peer support workers and other non-clinical staff are involved in the provision of care

- Importance of thinking of the whole staff as a group force.

- Importance of thinking of health and social care together.
- Cuts on admin staff and practitioners had to take on these tasks.
- An error could lead to probs. Test of Care – impact of Peer support workers. Permanent contracts are not common.

Areas of focus, themes and facilitator questions

For each area, facilitators were instructed to ask:

How would you prioritise these areas? Are there any gaps related to access themes that should be covered in the standards?

Table 1: Areas of focus and themes that emerged, to inform standards

Focus area	Specific themes to inform standards in each focus area – prioritise for each theme
1. Access to secondary mental health services	Clear pathways into care
	Excellent information about what services provide and are good at
	'Step-up, step-down' access (which enables prompt access back into the system or reaching a crisis)
	Waiting time target
	Communication and support while waiting
2. Assessment and care planning	Comprehensive biopsychosocial assessment based on an understanding of service users' needs and goals
	Person completing initial assessment has appropriate skills/training
	Multidisciplinary assessments should include an assessment of social care needs
	Co-production of care plan with service user and, where appropriate, a carer
	Signposting and assistance to access other services (also Transitions)
3. Support, care and treatment	Access to appropriate evidence-based treatments
	Personalised care plan that takes into account choice, holistic needs (that is, including social care) and range of treatment and support (for example community provision, social prescribing)
	Physical health needs should be reviewed and care integrated with that of the mental health needs
	Routine outcome measurement that addresses: • experience of care • quality of life • symptom improvement

Focus area	Specific themes to inform standards in each focus area – prioritise for each theme
4. Transitions and continuity of care	Effective systems in place to support navigating transitions between services including: • primary and secondary care • age-specific services (CAMHS, adult, older adult) • inpatient and community care
	Support navigating transitions between teams involved in your care
	Effective systems in place to support Information sharing across care settings
	Effective systems to support discharge from services, in particular inpatient care
5. Workforce	The skills of staff in services are appropriate to the meet the needs of people supported by the service
	Service staffing levels are sufficient to provide a safe and effective service
	Peer support workers and other non-clinical staff are involved in the provision of care
	Effective systems in place to support staff development, training and supervision to ensure staff wellbeing and effectiveness
	People with lived experience are involved in the recruitment and training of the workforce

Email: **nccmh@rcpsych.ac.uk**

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