Consultation of RCPsychiS Members – Views on Quality Standards for Adult Secondary Mental Health Services

Submission date: Friday 17 March

General Standards

This response is informed by the views and experiences of the Royal College of Psychiatrists in Scotland's membership, representing over 1400 Scottish psychiatrists.

We are responding to this consultation both in terms of the implications of the standards for our patients and for the colleagues of all disciplines with whom we work, with particular reference to the implications for psychiatrists, the professionals whom the College represents.

The College in Scotland welcomes the ambition of these standards. They are aspirational, however they will require both time and resources to properly implement. Without additional resources these standards risk raising expectations which will not be achievable for services. As a result, patients and the public could be disillusioned, whilst professionals could find themselves under further pressure to achieve impossible standards, with threats to recruitment as well as retention.

Demand for mental health services continues to increase in Scotland and, as with other medical specialties, there are not enough doctors coming through the system to meet this demand. This presents us with a service supply challenge.

With this in mind, we should be mindful of the impact these standards may have on workforce morale and staff turnover, if staff believe the standards will not be achievable. We are already seeing high rates of trained doctors leaving the profession because of workload and workforce pressures. We believe that there is a very real risk of an exodus of staff which may lead to a worsening of care, rather than the improvement that these standards intend.

Members shared with us that, although it is difficult to disagree with the overarching principles of these standards, they lack detail in their current form. In this respect, feedback from our members has echoed their reaction to the first draft of the Mental Health and Wellbeing Strategy. The document is vague and lacks the level of specificity required in terms of service delivery.

They also highlighted that these standards differ substantially from the format used for other specialist services (such as the existing HIS standards for neurological disorders). This contrast is particularly notable around the lack of detail. For instance, consideration is required in terms of underlying clinical and organisational aspects. More emphasis is also needed on standards for leadership.

More awareness is required of what is needed to deliver a quality secondary care service. As is more understanding of why services are not currently able to meet demand.

More specific detail is also necessary to make it possible to measure progress in delivery and to hold services, and the Scottish Government itself, to account. Such detail would require specifying measurable actions and timescales.

Greater consideration should also be given to the language used in these standards. For example, terms such as 'care' and 'support' should be replaced by 'clinical intervention', 'treatment', and 'evidence-based support,' as appropriate. This would promote a better understanding of what secondary health care services provide and distinguish them more clearly from other support services. As psychiatrists we offer a range of evidence-based bio-psycho-social treatments which can bring about recovery as well as mitigate suffering. At the moment our members are concerned that terms such as 'care,' 'treatment,' and 'support' are being used interchangeably, often with 'treatment' not being used at all. Our members highlighted that they do not reference existing key performance indicators, nor do they make reference to existing evidence based clinical guidelines such as NICE or SIGN guidelines.

To achieve these standards, consideration of the needs of the mental health workforce is also required, so this acknowledgement is welcomed. The need for training, supervision and regulation of staff is of course crucial, but the welfare and environmental comfort of staff of all disciplines should also be acknowledged. The provision of appropriate office and consulting space, 24 hour access to healthy affordable food and rest facilities, and convenient transport options should hardly need to be mentioned, but in fact do need to be included as part of such standards if staff are to be retained to deliver high standards of work for patients.

A key theme from the workforce consultation that preceded the development of the standards was around the need to better define the function and role of adult community mental health teams.

It is not just important to define what services should be providing but also to whom they should be providing services. Consideration should also be given as to who are the appropriately qualified professionals to deliver the services. Defining the thresholds for adult mental health secondary care services and identifying who would benefit most from such services is critical to ensuring equity of access and consistency of care. The standards as they are currently structured do not allow for that. CAMHS services benefitted from a service specification. Our members believe that a similar exercise could be helpful for adult secondary mental health services. This would be a year one priority of both these standards and the new Mental Health and Wellbeing Strategy. This exercise would operationalise the standards as, in their current form, they are not fully measurable.

Ultimately, an overarching concern is that the standards are not SMART (Specific, Measurable, Achievable, Realistic and Time-Limited). It is important that the standards are measurable in ways that would allow for improved quality of service provision.

Access

The College in Scotland broadly agrees with the access standards. However, there are ways in which these access standards could be improved.

As we said previously, more specificity would be welcomed in terms of language and, in particular, what is meant by 'support' in points 1.2, 1.4, 1.6 and 1.11. A clearer definition would be helpful for both those who access and those who deliver services, as the word 'support' can mean many things to many people. Adult secondary mental health services are specialist services whose remit goes well beyond support.

It was suggested that point 1.1 should be amended to read that: 'I will be able to easily access and understand information on who services are for, what is provided, and if it is appropriate for me to be referred to these.'

Point 1.3 should be amended to read that people accessing adult secondary mental health services will be provided with an average waiting time for that service. This should be an expectation of all services in Scotland too, not just mental health services, and should therefore be included only if the directive to do so extends across the whole NHS in Scotland.

The College in Scotland believes that point 1.4 is very important, as many people deteriorate on waiting lists. It was suggested that this point should be edited to state that this support will be provided regularly, rather than as an initial offering only.

With regards to point 1.6, more consideration needs to be given to situations in which an adult secondary mental health team is not the appropriate resource to meet the assessed needs of a person.

Experience of feedback on CAMHS provision already suggests there is much distress arising when referrals are declined because CAMHS is not the appropriate agency to provide a response. It would be beneficial in such situations to specify that alternative resources should then be signposted for government departments to reveal which services are available in which locations so that frontline staff can direct patients appropriately. More detail is also required on how this point will be measured.

It would be useful to consider how adult secondary mental health services can link into other services, including primary care mental health, suicide prevention and distress brief intervention services, for example. There should be no wrong door. People should be given the support to easily access the correct service and, if needed, move between them.

The College in Scotland recommends a more ambitious approach to point 1.12, with a commitment to waiting times being presented nationally on an easy to use dashboard, ensuring that the collection of such information does not place additional asks on an already pressured workforce.

It was also proposed that data should be collected at a national level to monitor the availability and accessibility of adult secondary mental health services. This should include protected characteristics such as ethnicity, gender, disability and SIMD (Scottish Index of Multiple Deprivation). Patient and carer satisfaction scales, such as the Friends and Family Test (FFT) and Referrer Satisfaction Scale, should also be used and incorporated into these standards.

Assessment, Care Planning, Treatment and Support

The College in Scotland broadly agrees with the standards for assessment, care planning, treatment and support, and suggested ways in which these standards could be improved.

Firstly, the College in Scotland would recommend that these standards reference existing resources such as the Triangle of Care or the Mental

Welfare Commission’s guidance around confidentiality and the involvement of family and carers.

Point 2.2 states that ‘if I want them to be, and it is appropriate, my carer and/or family should be involved.’ This point should specify who will decide whether this is appropriate.

With regards to point 2.6, the College in Scotland believes that flexibility is crucial. A choice between engaging digitally or face to face should be offered. However, it should be acknowledged that an initial face to face assessment may be required before this choice can be offered.

It was suggested, too, that point 2.6 should include reassurance that if you are not able to engage digitally then you will not be disadvantaged by this.

However, there will be times when remote attendance will not be clinically appropriate and face to face engagement will be necessary. For example, if a Mental Health Act assessment needs to be undertaken, if a person requires direct observation or examination in a particular setting, or if complex diagnostic or clinical treatment is necessary.

With regards to point 2.8’s statement that ‘I will be able to access information, care and support at a time I need it,’ members of the College in Scotland agreed that, although this is a valid expectation, we are concerned that stating this before we have the available resource to enable it could lead to raised expectations and disappointment.

It was suggested that point 2.10 should be amended to acknowledge that clinical evidence and opinion should be considered alongside the preference of the person accessing adult secondary mental health services. This is not in any way wishing to impose paternalistic attitudes on patients, but with the intention of supplying expert and evidence-based information as well as information about the clinical context, to inform individual decision-making.

Point 2.11 should note that it can be extremely difficult to apply an estimated discharge date immediately at the point of admission, particularly where this could set unhelpful expectations. For example, if the person is being assessed under the Mental Health Act. This could lead to friction between patients, families and clinicians if the estimate is incorrect. Any estimate should be recognised as subject to reassessment, unless of course a time-limited course of treatment is negotiated from the start.

The College in Scotland believes that additional resources may be required to achieve point 2.12, in terms of achieving full allowance for diversity and deprivation. However, we agree that consideration of inequalities is an essential principle.

It was suggested that point 2.13 should be extended to routinely monitor the experiences of staff alongside the experiences of those accessing adult secondary mental health services, to further support the improvement of services.

More specific reference, too, to diagnosed mental illness would be helpful in point 2.14. This would more clearly delineate adult secondary mental health services from the mental health and wellbeing support provided by public health, the third sector and wider society. It would also be an obvious next step in the Scottish Government's commitment to use the WHO's ICD11 diagnostic system for mental disorders.

Moving Between and Out of Services

The College in Scotland's members have campaigned for many years for attention to the risks of transitions between services and within different parts of the service. We broadly agree with the standards for moving between and out of services and have some suggestions for further improvement to these standards.

For point 3.1, our members believe that care plans should be stored in a dedicated part of a patient's electronic record, as these plans are too often lost. It was suggested that these care plans should also be made directly available to people accessing adult secondary mental health services through a password protected patient portal, or provision of paper copies for those who prefer these.

Any care plan should also reflect the clinical treatment interventions and available resources within a specific context, as the type and content of a care plan may differ at the point of transition between different services.

Points 3.1 and 3.2 are slightly contradictory as they stand. It was surprising to see that point 3.2 introduced the idea that further permission from a patient would be needed to share care plans within NHS treatment providers, as it is current practice to share confidential patient information within NHS treatment teams without repeated patient permission. The College in Scotland does not think that permission should be sought for sharing a care plan with other members of the care and treatment team. This may prevent the team from providing a safe or effective service if patients decline permission for relevant care plans and clinical information to move with them to other parts of a service.

Point 3.2 should also acknowledge that there are times when it is essential that a person is asked to share their story again. Whilst the number of times should be reduced, there will still be occasions when this is

necessary. The reasons should be explained to the person by the clinician involved in their care.

For point 3.7, our members agreed that it is a good idea to co-produce these care plans. However, people should be given the option of how they contribute to these plans. If non-digital methods are used (for example, a handwritten care plan) then efforts should be made to digitise these so that they are available out of hours and are not lost.

Workforce

The College in Scotland broadly agrees with the workforce standards. As a College, we feel strongly that the decline in the mental health workforce, and in particular in the number of consultant psychiatrists working in Scotland, poses the highest current threat to the provision of high standards of mental health provision.

However, there are ways in which the workforce standards could be improved.

Firstly, longer term robust workforce planning is required. To enact this, these Quality Standards should be closely linked to the upcoming Workforce Plan. Both documents should complement one another.

For point 4.4, any training requirements for staff should be robustly evidenced in advance.

Point 4.7 recommends that the adult secondary mental health workforce are given 'access to continuous professional developmental.' One of our members recommended that focus is given to providing staff training in digital literacy. This will support staff to manage electronic records.

With regards to point 4.9, our members told us that leadership should provide structures to supportively identify and recognise which staff members and services are under pressure and offer advice on how to manage these pressures, ensuring that mechanisms are available to support them. There was concern raised that staff may be reticent to raise concerns and risk negative consequences.

Governance and Accountability

The College in Scotland broadly agrees with the governance and accountability standards. However, as previously discussed, there are ways in which these standards could be improved.

Firstly, we would like greater detail of how these governance and accountability standards are going to be enacted. As we previously commented, the success of evaluation and tracking of progress depends heavily on the use of specific measurable aims.

Accountability is also important. There should be robust measures to act on feedback with necessary resourcing to allow effective change.

Concern was raised that there may be times when point 5.1 is not possible. For example, if a person does not respond, self-discharges or moves to another area. It is important to record where data is missing, and why this is so, otherwise the data which is collected can be seen as biased.

In response to point 5.6, our members recommended the development of a specific means of speedily escalating concerns to the Scottish Government, in the event that gaps arise and these can't be resolved locally, allowing a feedback loop and pooling of information regarding systems pressures.

We also note that existing standards from HIS for other specialist clinical services make reference to 'governance and **leadership**' rather than 'accountability' and our members expressed concern about the reasons for this difference when it comes to mental health services. The term accountability should only be used if it is applied across health services and not only to mental health services. We also believe that the lack of reference to leadership in mental health is a serious omission.

Implementation and Measurement

Support:

Support will be required to properly implement these standards. The College in Scotland suggests that this should include:

- Financial support – effective resourcing;
- Resolution of workforce and capacity issues;
- IT support and training;
- And forums to discuss processes, with agreed routes for implementation.

Proper resourcing was a common theme throughout our members' feedback. At present, the College in Scotland does not believe that members have the capacity to fulfil all of these standards without additional investment. It was suggested that the Scottish Government might introduce core standards that the majority of services can

realistically meet within a period of 18 to 24 months. These could then be supplemented by more ambitious standards over three to five years when services are not under such extreme pressure. Rushing towards overly ambitious standards that are not achievable could damage the morale of the mental health workforce, resulting in poorer services, and undermine the credibility of Government promises to the public.

Our members currently find it very difficult to engage in any service development work due to the demands of providing clinical care in an environment with increased demand and workforce issues. It will be difficult to realise these standards unless workforce and capacity issues are addressed concurrently. Members of the College in Scotland are currently focused on providing essential emergency care. There is concern that these standards may raise expectations to an unrealistic level that services simply cannot fill.

Effective IT infrastructure would enable services to measure adherence to the standards and monitor local variation. However, members of the College in Scotland stressed that this should not fall to clinical staff to complete. Significant investment is required into both digital solutions and staff training to support the mental health workforce to deliver these standards.

Members of the College in Scotland suggested that forums to discuss processes would also support the delivery of these new standards. Services should be encouraged to share learning and information, to promote a collaborative work culture.

Self Assessment Questions:

There were more mixed levels of support for the standards' self assessment questions, with members of the College in Scotland suggesting areas of improvement.

Firstly, it was proposed that it would be more effective to introduce self assessment questions three to five years after the publication of these new standards.

With regards to access, our members are under the impression that waiting times data is already gathered and monitored. It was suggested that it would be more informative to ask if and how people on waiting lists are being actively managed.

The self assessment questions relating to workforce could also be updated to ask about how often staff are given refresher training on digital systems

and if there is a digital champion in each team to offer local tailored support.

Whilst these questions are adequate to provide a snapshot of services, a more robust audit tool is required to cover all of the individual standards. This would allow services to develop and improve against these standards. We recommend reviewing the Royal College of Psychiatrists' AIMS standards as these provide a good example of how to successfully audit standards.

Possible Indicators:

The College in Scotland agrees with the possible indicators suggested to support the standards' implementation and measurement.

However, it was suggested that, to supplement these, it would be helpful to have indicators relating to staffing levels, including for staff in administrative roles. We wondered if the safe staffing legislation and development of workforce tools for multidisciplinary teams would be helpful in this respect.

It would also be useful to include indicators which measure the nature and severity of mental illness, as well as the impact it has on people and those close to them. This could include ICD diagnosis, Clinical Global Impression and CORE (Clinical Outcomes in Routine Evaluation), or another similar measure of general functioning, problems, risk and wellbeing.

The College in Scotland would also recommend that outcomes of treatment are also measured.

With regards to assessment, care planning, treatment and support, indicator 'e' should account for outpatient clinics and services where appointments can take place many months apart.

As with the suggested self assessment questions, the workforce indicators should also seek to measure the proportion of staff who have received refresher digital training in the last two years.

The College in Scotland believes that, whilst a single waiting times indicator or target for all adult secondary mental health services would be inappropriate, waiting times remain an important measurement. Instead, we suggest that a range of targets could be introduced for different services, to ensure that they are supporting people in a timely fashion.

We encourage caution around how these indicators are interpreted. For example, how long people stay in inpatient settings. Whilst it is often better to access community rather than inpatient services, there are times

when a timely inpatient admission is an important part of treatment. It should also be noted that services that have no inpatient beds and therefore have a higher proportion of community to inpatient patients are not necessarily providing a better service. This is illustrated well within learning disability services, where there has been a recent shortage of beds caused by delayed discharge. This situation is bad for patient care and has led, at times, to high risks (and carer burden) when patients have had to be managed in the community.

These indicators require further nuance to reflect the individual needs of each service, as well the people who access those services.