Prepared by the National Collaborating Centre for Mental Health (NCCMH) and the Royal College of Psychiatrists in Scotland (RCPsychIS)

Standards for Adult Secondary Mental Health Services in Scotland

Workforce and Leadership Engagement Events and Survey Report

A summary of themes and the findings from the workforce and leadership engagement events and survey

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** 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 a way of synthesising those three different strands of work, a consensus conference was held. The conference was planned by the Scottish Government, NCCMH/RCPsychIS, VOX/ALLIANCE and HIS, and brought together the feedback from the engagement work (workforce, lived experience and evidence review) with participants from all three areas. It aimed to reach a consensus on the key priority areas for the quality standards.

1.2. What this report covers

This report presents the work carried out by the NCCMH and RCPsychIS to engage with a diverse range of the workforce and leadership across all regions in Scotland, on areas of focus for standards for secondary mental health care in Scotland.

It includes a summary of themes from the workforce and leadership engagement events and survey (as identified by the NCCMH research team), and the methods used for the engagement events and survey. This is followed by the engagement event findings and survey results.

More detail about the method for the engagement events, demographics of the engagement event participants and survey respondents, the survey form, and graphs showing the survey results can be found in the appendices.

2. Summary of strong themes from the engagement events and survey

2.1. General views about standards

- Most viewed the introduction of standards for adult secondary mental health care in Scotland in a positive light
- There was an acknowledgement that it would be a challenge to ensure that the standards are 'meaningful'
- There was a recognition that current high levels of demand, combined with a shortfall in the workforce, create additional challenges for the development of standards
- There was a strong sense that standards need to be realistic and achievable in terms of clinicians' capacity to deliver and that the workforce needs to be stabilised before standards can be introduced
- Many expressed the opinion that rather than 'reinventing the wheel', existing standards, guidelines and principles could be built upon
- There was a strong feeling that poor staff wellbeing, understaffing and under-resourcing need to be addressed first, before the introduction and implementation of standards

2.2. Strong themes and implications for standards

2.2.1. Access

- Getting patients on the right pathway as soon as possible will improve their experience, contact with services and outcomes; therefore, standards should ensure that patients are able to be directed to what they require, when they require it
- Defining secondary mental health care services, communicating what they can provide, and which doors are open, as well as the relationship between primary and secondary care, should inform standards
- Standards need to be flexible and broad enough to work across the country and take account of geographical variation (rural versus urban) and differing levels of deprivation in Scotland
- Waiting times are associated with under-resourcing, understaffing, and difficulty in recruitment and retention, which may impact on the implementation of standards
- Waiting times targets do not always indicate quality and experience of care, and can sometimes compromise the quality of care provided and result in inappropriate service provision, so should not underpin standards
- There are different ways of accessing services (for example, remotely or via alternative routes), which standards would need to reflect to address inequalities
- Standards should acknowledge that multidisciplinary working among different services and sectors is required to improve referral
- There may be resistance changing who can access services, which may impact on the implementation of standards

2.2.2. **Outcomes**

- Standards present an opportunity to ensure that services have a beneficial impact on patients' quality of life
- There was an expressed need for a standard focusing on patient outcomes and experiences, with patient experience measures and quality of life measures being seen as important
- Using different types of assessments and outcome measures (qualitative and quantitative) that represent different areas of improvement and function was seen as important
- Standards should reflect personalised goals
- Simple and quick questions were largely preferred over lengthy questionnaires
- Coordination of data collection and sharing across different services is needed to support quality standards
- Standards need to address the geographical variation of the range of treatments offered (occurring within urban areas as well as rural) as well as the variation in the quality of care provided across the country
- Standards should address inequalities and the fact that people living in disadvantaged areas experience higher levels of mental illness
- The implementation of standards might be impacted by the wide range of socio-economic factors contributing to disadvantage

2.2.3. **Experience**

- Standards present an opportunity to optimise transitions in/out and between services, improve continuity of care and eliminate perceived discrepancies in the 'cut-off' at transition points
- Standards should be supported by seamless shared-information systems across services (for example, using the same software, procedures and systems), and might include a standard for full information-gathering at initial contact and interoperable record-sharing
- Standards need to balance accommodating the choice and preference of the patient where possible with legal constraints and clinical need
- Independent advocacy, and support for people to access it easily, could be reflected in standards
- Person-centred, rights-based care is fundamental to the provision of care and quality standards
- Standards have the potential to reduce unintentional variation in care

2.2.4. **Workforce**

- Standards need to take account of low morale and current concerns about underfunding, understaffing, retention and recruitment
- Standards should be based on having an adequately staffed service with relevant skills, in which retention of staff is prioritised
- Standards should be underpinned by a clear differentiation between the roles of primary, secondary and specialist services
- Training and career development are needed to ensure standards can be implemented and met
- Standards could articulate the broad expectation that staff are trained and well validated
- Standards could reflect the need for robust, evidence-based supervision
- Significant variability in resources and training received across different disciplines and teams to meet a range of complex needs might impact on the implementation of standards
- A standard on staff wellbeing is essential for the provision of high-quality care

2.3. **Implementation and evaluation of the standards**

- Challenges associated with evaluating the implementation and impact of the standards
- Multiple evaluation mechanisms are needed, with a blend of objective and subjective measures

3. Methods of engagement

We engaged members of the workforce and leadership in secondary mental health care services using a mixed methods approach, consisting of (i) virtual engagement events, and (ii) an online survey. There is further detail about the methods in **"Appendix 1"**.

3.1. Virtual engagement events

The virtual engagement events were designed to reach as many health and social care professionals and leaders in Scotland as possible. We held 23 engagement events between 14 March and 13 May 2022: 17 with the workforce, and six with leaders and managers. There were specific events for each region to ensure that there was representation from every area in Scotland.

In total, 254 people participated in the engagement events (220 workforce and 34 leaders). Further anonymised information about the participants can be found in **"Appendix 2"**.

The following four domains ('areas of focus') and sub-areas were used to structure all of the engagement events:

3.1.1. Access

- Access to services ('no wrong door')
- Waiting time for treatment
- Assessment and care planning
- Flexibility to delivery in different parts of the country

3.1.2. Outcomes

- Evidence-based treatment and care
- Addressing inequality in access and treatment outcomes

3.1.3. Experience

- Person-centred, rights-based care
- Information sharing across the system
- Transitions and continuity of care
- Understanding variation in care

3.1.4. Workforce

- Workforce development
- Staff wellbeing

After each event, the NCCMH research team identified themes from the discussion and synthesised them.

3.2. Survey

A survey was designed based on the four main focus areas and sub-areas and distributed as a Microsoft Form via email. A total of 271 people responded to the survey.

The role of the respondents, their area of work, their employer and the region in which they work are listed in **"Appendix 2"**. A copy of the survey form can be found in **"Appendix 3"**.

4. Findings from the engagement events

4.1. General views about standards

4.1.1. Summary of strong themes about standards

- Most groups viewed the introduction of standards for adult secondary mental health care in Scotland in a positive light
- There was an acknowledgement that it would be a challenge to ensure that the standards are ‘meaningful’
- There was a recognition that current high levels of demand, combined with a shortfall in the workforce, create additional challenges for the development of standards
- There was a strong sense that standards need to be realistic and achievable in terms of clinicians’ capacity to deliver and that the workforce needs to be stabilised before standards can be introduced
- Many expressed the opinion that rather than ‘reinventing the wheel’, existing standards, guidelines and principles could be built upon
- There was a strong feeling that poor staff wellbeing, understaffing, and under-resourcing need to be addressed first, before the introduction and implementation of standards

4.1.2. Positive views

In a general discussion about standards at the start of each engagement event, the majority of workforce and leadership groups viewed the introduction of standards for adult secondary mental health care in Scotland in a positive light:

> “Standards are absolutely necessary: they address safety, reducing harm to patients from the care that is intended to help them.”
> (Member of workforce)

> “Standards will help us to avoid waste and duplication and enable a more equitable service to anyone needing it.”
> (Member of workforce)

However, participants gave a range of different responses when asked about the potential positive impact of standards, which encompassed the effect that standards could have on provision of care, on patients' experience, and on the functioning of teams. There are examples of these views in the box below.

Positive views of standards

Standards...

- provide a 'solid foundation'
- are a 'learning process'
- are 'aspirational'
- can promote and are necessary to ensure high quality care
- set expectations and enable quality to be measured
- allow for consistency of care across services and localities
- can provide a source of pride for teams and ownership if standards are met
- are useful for benchmarking
- can help identify gaps in resource and provision
- are a way of providing transparency for patients and improving equality
- enable patients to have more autonomy, information and choice within secondary mental health services
- are useful for identifying roles in multidisciplinary teams (MDTs)
- help to solidify aims and purpose of secondary mental health services

4.1.3. Challenges and concerns

However, some notes of caution were struck in most groups, and there was broad acknowledgement that there would be challenges in developing standards that would have utility across the whole of the country.

The most commonly and strongly expressed views were that it would be a challenge to ensure that the standards are 'meaningful' and that current high levels of demand, combined with a shortfall in the workforce, created another challenge. Participants across at least six groups were concerned about standards adding to the heavy burden on staff, and urged government to consider the consequences of 'unmeetable standards' due to lack of resources in certain areas.

There were concerns from two groups about standards being 'tick box' and that they would not 'fix problems' with the current service model. Participants in three groups outside of the Central Belt also pointed to the fact that services and the workforce are very different across different regions (particularly rural areas versus the Central Belt) and that it would be challenging to create standards that could apply to all these areas. Some participants from two groups were worried about standards compromising other areas of care, for example, diverting resources to ensure that the standards are met, to the detriment of other aspects of care.

Less frequently expressed views (mainly from the leadership sessions) about the introduction of standards included concerns about:

- which standards will be prioritised
- the validity or evidence base of quality standards
- quality standards not being able to accurately measure the quality of care provided

- standards only being as helpful as they are enforceable
- more being needed to be done in terms of co-production of standards
- there needing to be clarity about what the introduction of standards will achieve
- not making standards too prescriptive (with inbuilt flexibility in the method to meet them).

4.1.4. The purpose and remit of standards

Participants in the majority of workforce and leadership groups expressed some view about what they thought the standards needed to be and do.

To be realistic, achievable and efficient

A strong theme from these discussions (expressed by participants in at least eight groups) was that standards needed to be realistic and achievable in terms of clinicians' capacity to deliver and that the workforce needs to be stabilised before standards can be introduced. Linked to this was a view that standards must ultimately enable efficiency. Almost as strong (expressed by participants in at least seven groups) was the conviction that rather than 'reinventing the wheel', existing standards, guidelines and principles could be built upon. The **Standards for Acute Inpatient Services Working-Age Adults** were frequently mentioned.

Whole-system approach

Some participants in at least two groups felt that a 'whole system' approach was required, with the standards being applicable across the entire MDT, including health and social care professionals. Specifically, it was felt by some participants from at least two groups that standards should value and acknowledge utilising different professional roles within MDTs such as occupational therapists and the third sector. Others thought that the standards that follow the 'cancer model' or the 'frailty model', in which each person's case is discussed by the MDT together to decide upon the specific support required.

Measurable standards

Some participants in at least three groups asserted that standards should be measurable, but there were concerns about the practicalities of doing so and a desire not to increase workload or use measurement as a way to penalise services who could not meet the standards. Participants in at least two groups urged the government to ensure that measurement of the new standards was linked to existing quality indicators and standards.

Other themes

Weaker themes emerging from these discussions in both workforce and leadership groups included:

- Using a trauma-informed approach as starting point for standards development
- Ensuring a balance of lived experience and professional voices in standard development
- Considering standards as a set and not prioritising one standard over another (for example, promoting a waiting time standard at the expense of a training standard)
- Individualised care needs within secondary mental health services need to be balanced against wider structures and frameworks
- Standards should be modified and updated to reflect the changing needs of patients
- Standards should be driven by clinical need rather than a top-down approach
- Standards should promote consistent and proportionate service provision
- Standards should create a common understanding of the function of community mental health teams (CMHTs) and who their client group is
- Standards should be encouraging and look across inpatient and community, bringing services more in line with each other.

4.2. Access findings

4.2.1. Summary of strong access themes and implications for standards

- Defining secondary mental health care services, communicating what they can provide, and which doors are open, as well as the relationship between primary and secondary care, should inform standards
- Standards need to be flexible and broad enough to work across the country and take account of geographical variation (rural versus urban) and differing levels of deprivation in Scotland
- Waiting times targets do not always indicate quality and experience of care and can sometimes compromise the quality of care provided and result in inappropriate service provision and should not underpin standards
- There are different ways of accessing services (for example, remotely or via alternative routes), which standards would need to reflect in order to address inequalities

4.2.2. Access to services ('No wrong door')

Under the focus area of 'No wrong door', the following topics were discussed: (i) the current CMHT model; (ii) access points and routes into services; (iii) information and communication; and (iv) referral.

The current CMHT model

Under this topic area, the stronger themes that emerged were related to:

a) the interface and relationship between primary and secondary care (expressed by participants in at least four groups)

b) the definition of a CMHT (expressed by participants in at least five groups), for example:

> It feels like it falls under a primary care model, when that's not what our secondary care clients need. They need that joined up service provision.
>
> (Member of workforce)

In terms of (a), the relationship between primary and secondary care was seen as a potential barrier to accessing services and participants felt that it needed to be considered and defined.

In terms of (b), participants in several groups felt that the CMHT model is not sufficiently defined and not designed to withstand current delivery levels. Participants stated that there needs to be clarity about what is 'CMHT business' and what is not. Nine workforce groups felt that there should be a standard to define secondary mental health care services, what they can provide and which doors are open, with expectations being managed around the type of support that could be provided (that is, that the core business of CMHTs was not to provide support for mental wellbeing).

Furthermore, some people felt that there was a need to ***"put community back into 'community mental health'"*** and to focus on and support people who have a range of needs, including housing, rather than adhere to the medical model, and to offer patients more choice in the services and interventions they can access. One group felt that services need to adapt for the people who do not 'engage well', rather than being set up in a way that works only for those who engage well.

Both of these themes recurred throughout other areas of discussion, thus emerging as strong overarching themes.

Access points and routes into services

No very strong themes emerged in this area, with participants across the workforce and leadership groups not forming a consensus about preferred access points and routes into services.

While participants used terms such as 'easily understandable', 'streamlined', 'simple' and 'accessible for users' to describe routes into services, across the groups, there were conflicting views about the concept of 'no wrong door', which can be encapsulated by this quotation:

> “What is the front door of mental health services? And who can access the door? Are we truly secondary care?”
>
> (Member of workforce)

See also the box below for a summary of views about the idea of there being 'no wrong door'.

'No wrong door'

- One door for 24/7
- One door for health and social care
- Secondary care currently has a lot of wrong doors – people are at risk of 'falling between' service gaps if they don't 'fit'
- Support for 'no wrong door' rather than one door
- Some resistance to the idea of no wrong door (and terminology)
- 'No wrong door' can lead to services being overwhelmed
- 'No wrong door' responsibility should sit with the system not service users
- 'No wrong door' as a phrase is negative and vague

In general, participants from at least four groups felt that access points and routes to services, pathways and tiers are not currently clearly defined, which can make people feel that there is a 'randomness' to accessing services. This random aspect:

> “can be down to factors that are not clinically relevant that can dictate whether a person ends up in the third sector, because there is nothing else for them. There are lot of reasons for that but they are not necessarily based on clinical need.”
>
> (Member of workforce)

At least three groups saw a single point of access seen a preferable option, as it would help patients reach the right services without having to repeat their story. Another two groups felt that those patients who are already known to services should have 'direct access', while another two groups wished that alternative access routes could be considered, such as access through primary care.

Navigating the system

There was some recognition from participants in at least two groups that referrals through GP services can be difficult to follow and are time-consuming and that the mental health system needs to support GPs more effectively, and be easier for GPs to navigate. For another two groups, being able to navigate the mental health care system could be challenging for staff more broadly, as well as for patients – it was felt that ideally patients should be able to navigate the system independently and have more autonomy while doing so. One group articulated the case for a tiered approach to care, reflected in standards.

Pathways

In terms of pathways, one group discussed the importance of getting on the right pathway, at whatever point of entry, while another emphasised the need to create clear pathways between services; two leadership and one workforce group made the case for pathways to alternative support if clinical interventions are not deemed appropriate. Participants from three groups wanted to see 'a baseline standard for access to services', supporting clear pathways to care and options for treatment, regardless of diagnosis or presence of multiple conditions or dual diagnosis.

Consistency and speed of access

Participants from two groups stressed that the speed of access to services matters in terms of how long people have to wait for treatment. Participants from at least another three groups felt that access to third sector support is not consistent across the country, especially to support people during time on wait lists. Participants from at least another three groups cited the roles of community link workers and wellbeing practitioners as being able to facilitate access to some services, and others suggested building on the development of wellbeing hubs.

The themes of digital access and routes back into community services following discharge from inpatient care emerged more strongly in other focus areas of discussion.

Access to 24/7 support in crisis was raised in at least three groups, with some feeling that CMHTs are not structured or staffed to deal effectively with crises, some feeling that there is need to better understand why 24/7 services are accessed, and others suggesting that there should be a focus on developing core services to relieve requirement for out-of-hours and crisis services.

Information and communication

Information and communication were seen by many groups as being key aspects of improving access to services for people with mental health problems, and this can be considered to be a strong theme from across the workforce and leadership groups. One group explicitly made the case for a standard covering good communication and team working, and communication about what services can offer.

Some participants from at least five groups thought that there needed to be better information about individual services for patients, which set expectations about what the service could provide. (This theme emerged in other areas of the discussions.) The importance of digital information was iterated:

> “The support required may not always be from a physical person. It may be a digital resource that may be sufficient at that time.”
>
> (Member of workforce)

It was, however, recognised that digital access could be a barrier for some patients due to geography or data poverty.

In terms of communication, having different ways of making contact and communicating with patients was seen as vital by one group, while most groups recognised that communication between services could be difficult due to the use of different IT and documentation systems (see **“Section 4.4.3.”** for detailed exploration of this theme).

Referral

A theme that ran like a strong thread through many of the engagement events, and was present in discussions about referral, was the belief that there needed to be some checks on who was referred to CMHTs (because ***“CMHTs can't take everyone”***) or a formalised measure for when people should enter secondary care (depending on need, presentation and risk). Others felt that presentation and risk may be very different from need. The role of primary care in the gatekeeping of assessment referrals is related to this point, with some participants from at least two groups feeling that there was too much reliance on GPs to make referrals.

There was some discussion that there is a lack of clear referral pathways into mental health services and participants from at least four groups thought that a standard on referral was needed. One group highlighted that the system would need to be improved first before introducing such a standard.

The importance of focusing on the patient journey and their experience and the need to empower people rather than merely support them emerged as a weaker theme in discussions about access and referral, but needs to be considered as a strong theme overall (see **"Section 4.4."**).

4.2.3. **Addressing inequality in access**

Under this focus area, the stronger themes that emerged were related to inequalities linked to geography and poverty rather than personal characteristics such as age, race, gender or sexuality, although disability was discussed by some groups.

Differences in access for rural and urban areas

Participants from across at least eight groups felt that standards needed to be flexible and broad enough to work across the country and take account of geographical variation (rural versus urban) and differing levels of deprivation in Scotland, with local areas tailoring the standard to suit their specific populations. Participants cited various ways in which areas differed, including the lack of availability of some types of service in some locations and lack of access to public transport. Participants in one group suggested being able to share staff from different professions across localities to manage caseloads and minimise inequality in access.

Digital access

Digital access emerged as a strong theme across the engagement events. It was discussed in relation to inequality of access to mental health services. While many recognised the potential for care to be delivered remotely through such platforms as 'Near Me', others (from at least four groups) highlighted that Internet access can be patchy in remote areas, and some patients do not possess digital devices, do not have the necessary skills to use them or cannot always afford a data package:

> “The use of Near Me and telephone prior to and over the pandemic has been of much benefit in recent times to provide a service. There are some benefits to virtual work/engagement.”
>
> (Member of workforce)

> “Near Me is amazing, if only we had decent broadband in our rural communities. Sadly some of our rural places are excluded due to lack of decent broadband so we have to see [patients] face to face – double edged sword! We have moved away from the telephone due to challenges of assessing risk.”
>
> (Member of workforce)

Inclusivity of information

One group mentioned the need to ensure that information about services needed to be as inclusive as possible, while others highlighted the need to consider reaching people who do not know about the services available in their local area. Regarding, 'opt-ins', participants in one group felt that these may create barriers to accessing services among those who do not have stable housing or those who have learning disabilities.

4.2.4. **Waiting time targets for treatment**

In discussions about this focus area, while there were some positive comments about introducing waiting times into standards – for example, because they can 'drive positive change' and can increase access to services – the overwhelming response from across at least 11 groups (workforce and leadership) was strongly negative. There are examples of the types of negative comments in the box below.

Reasons for negativity about waiting time standards (stronger themes at the top)

- Waiting times and a focus on 'hitting targets' do not always indicate quality and experience of care and can sometimes compromise the quality of care provided and result in inappropriate service provision
- Waiting time targets can create unrealistic expectations and extra pressures
- Waiting time targets are not always helpful as a standard
- Waiting time targets can put extra pressure on services and variety of services across the country would make targets challenging
- Waiting time targets can result in other areas of patient care being neglected
- Setting standards around waiting times will reinforce conveyer belt mentality rather than focusing on the individual
- Need to prioritise the care of patients over meeting targets
- Waiting times are time consuming: reporting and presenting the targets and data can inappropriately become the focus of services
- Waiting times have become the focus of the managers, which is a barrier to improving quality of care

If waiting time targets were to be introduced as part of the standards for adult secondary mental health care services in Scotland, participants made various suggestions for how this could be done, while making certain caveats and pleas, such as the importance of multi-agency communication.

Participants in one of the leadership events felt that if some areas had waiting times, such as child and adolescent mental health services (CAMHS) and psychological therapies, then all areas should have waiting times. Another leadership group stressed that waiting times should not be the only focus – other measures should be in place too.

Some participants were concerned about 'hidden waits', with people having to wait for treatment following assessment. Indeed one group suggested that a standard for access should incorporate when patients actively receive care rather than having had an assessment.

Participants from at least three groups felt that an important standard around waiting would be managing expectations, keeping people informed about their wait, and offering alternative and parallel support while waiting, for example offering people non-medical support while they are waiting ('waiting well'). Participants in one group thought that services should prioritise greatest need rather than on the basis of how long people have been waiting.

Resource availability

Related to the strong overarching theme of concerns about capacity in the workforce (see **"Section 4.5."**), participants from at least three groups highlighted that any waiting time standard would be dependent on resource availability. Therefore waiting times would need to 'reasonable' and standards that included waiting times should 'not set up services to fail' (see box above), and there would need to be support for services if waiting times were not being met. One group highlighted the regional differences that dictate how quickly people can access treatment.

4.2.5. **Assessment and care planning**

This area was not given as much attention as other areas under 'Access' and participants tended to focus on a range of issues. Therefore, there are few strong themes, but some participants noted that there were few standards in this area, that there is current variation in the ways assessments are carried out, and that standards for assessment are needed, including a standard that defines assessment. This might include an identified set of core principles that can be applied in different settings. While there was some recognition that having a standard for assessment would be challenging given the different levels of assessment required and the range of outcomes of assessment, two groups suggested wording for a standard:

> A person should be offered an assessment with an appropriately trained member of staff followed by an appropriate referral.
>
> (Member of workforce)

> If a person seeks support, they should be offered an appropriate assessment within a specific timeframe that directs them to the right care.
>
> (Member of workforce)

There was a perception in one group that 'log jams' around assessment were leading to increased waiting times and that there had been an increase in requests for neurodevelopmental assessments.

Some participants from at least three groups described what they judged to be important for the operationalising of assessments, including having shared assessments across MDTs and utilising assessment clinics and harnessing the wider workforce.

Related to discussions about referral, one group highlighted the importance of initial contact with services, and not referring or signposting patients ad infinitum.

Formulation as an outcome of assessment

One of the stronger themes that emerged in this focus area was formulation. Some participants from at least three groups felt that ideally there would be a formulation as an outcome of the assessment, and that there was a need for a standard on formulation-driven approaches to care. But this same group felt that a standard should not set an expectation that every service user has a formulation because this was not considered realistic given current resources.

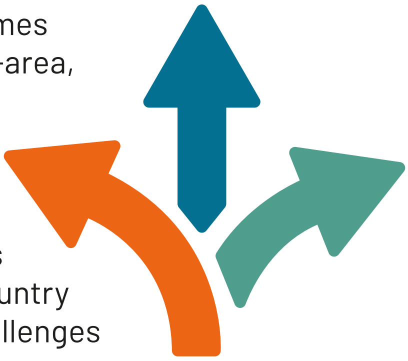
Collaborative care plans

Some participants from at least three groups felt that care plans should be created collaboratively with patients in a way that is meaningful to them and appropriate to their needs. But participants also recognised the importance of care plans as a way of managing patient expectations, given the constraints on choice of treatments, both in terms of their suitability and availability. Others from at least two groups emphasised that care planning should be multidisciplinary (as per the 'cancer model'), and accessible to out-of-hours staff. Participants from one group stated that patients were often responsible for operationalising their own care plans. Some participants from two other groups thought there should be a standard covering care planning and who needs a care plan, and that asking patients if they have a care plan would be a good outcome measure.

Risk assessment

There was little discussion of risk assessment. Participants in one group felt that risk assessments were not 'dynamic' and were not always acted on.

4.2.6. Flexibility to deliver in different parts of the country



While no strong themes emerged in this sub-area, the vast majority of groups recognised the practical challenges that delivering standards across the entire country presents. These challenges were related to:

- the geographical diversity
- the vastly different services and pathways across the country
- the difficulty of accessing services for certain conditions (for example, autism and attention deficit hyperactivity disorder) in some areas due to lack of trained staff and increasing demand
- the lack of choice of treatment in some parts of the country
- access issues related to transport links and Internet connectivity.

Participants across at least five groups (workforce and leadership) were keen to stress the need to carefully balance the drive for national consistency with being flexible across different regions/services and. One leadership group felt that standards should not be too prescriptive so that they could be interpreted and adapted at a local level.

Themes from this focus area (such a digital access and availability and capacity of trained staff) also emerged in discussions about inequality of access (see **"Section 4.5.2."**) and the workforce (see **"Section 4.5."**), and have been combined there.

4.3. Outcomes findings

4.3.1. Summary of strong outcomes themes and implications for standards

- There was an expressed need for a standard focused on people's outcomes and experiences, with patient experience measures and quality of life measures being seen as important
- Using different types of assessments and outcome measures (qualitative and quantitative) that represent different areas of improvement and function was seen as important
- Simple and quick questions were largely preferred over lengthy questionnaires
- Coordination of data collection and sharing across different services is needed to support quality standards
- Standards need to address the geographical variation in terms of the range of treatments offered (occurring within urban areas as well as rural) as well as the variation in the quality of care provided across the country

4.3.2. Evidence-based treatment and care

Most of the discussions in this focus area were about the types of outcomes and outcome measurement. There was broad consensus from at least nine groups that there should be a standard about people's experiences of secondary mental health care and the outcomes.

There was a call for validated outcome measures that are clinically meaningful, and meaningful to patients and services. One group felt that these measures should be standardised. There were conflicting views about routine outcome measurement, with some in favour and others feeling that it could be a box-ticking exercise that lacked meaningful benefit.

A range of views were aired on the types of outcomes that should be measured, with some advocating for multiple mechanisms:

> Outcome from the patient point of view and outcome for the service, how we delivered, did we deliver according to our SOP [standard operating procedures] etc. have we flow through the system, how do we demonstrate ongoing improvements based on our data.
>
> (Member of workforce)

Other views are summarised in the box below.

Views on outcome measurement, with stronger themes at the top

- Patient experience measures are needed
- Quality of life measures or mental health confidence measures should be used
- Multifaceted/multidimensional measures are needed (using different types of assessments and outcome measures [qualitative and quantitative] that represent different areas of improvement and function)
- Functional outcomes and measuring disability scores should be emphasised
- Outcomes need to be symptom- and recovery-focused
- Goal-based measures should be used (discussing the patient's goals and what they want from the service, and whether they are achieved)
- Outcomes should have clinical utility
- A process measure to support effective delivery of care (around admission and discharge) should be in place
- Population-based measures (such as reduction in suicide, access to services and nationwide recovery) should be included
- Adaptable measures that can show staff have still performed their role well even when patients drop out of treatment were called for
- Having a universal outcome for all conditions has difficulties

Participants in at least two groups recognised the challenges in defining outcomes of care, with some seeing particular difficulties with choosing and measuring outcomes:

> We want to help people get better and keep them better. There has been years of discussion already about how we measure outcomes. Measuring disability scores and quality of life measures has been identified as the most meaningful outcome we can measure. We lose ourselves down rabbit holes when we try and agree symptom rating scales. There are too many scales, and too many conditions to measure. No matter who we are seeing, we want to be able to evidence we have helped them become less disabled, and that their quality of life has got better as a result of our care. This applies whether we are helping someone with anorexia, or schizophrenia, or dementia.
>
> (Member of workforce)

Participants in at least one leadership and one workforce group were keen to make the distinction between outcome and process: if data collection focuses on outcome rather than process, services can ensure that every patient gets what they need while allowing for flexibility in how this is achieved in different systems.

Regarding patient experience measures, some leaders observed that patient experience varies and should be measured over time. Others felt that mental health services could learn how to measure patient experience from the third sector.

Outcome measure tools

In terms of the tools used for measurement, simple and quick questions rather than lengthy questionnaires, were favoured by participants from at least four groups, with the option of administering them electronically. There was some support for Clinical Outcomes in Routine Evaluation – 10 items (CORE-10) and the Health of the Nation Outcome Scales (HoNOS):

> [CORE-10 is] quite straightforward and provides an overview of the delivery and effectiveness of care.
>
> (Member of workforce)

> Comparing the CORE-10 with patient rated and clinician rated improvement gives a broad picture along with GAF [Global Assessment of Functioning] to measure functioning.
>
> (Member of workforce)

> I think sometimes there is a misconception that outcome measures need to be lengthy – e.g. HoNOS takes 10 mins when you have the right professionals involved.
>
> (Member of workforce)

Some participants from at least one workforce group felt that there should be consistency in the tools used. Participants from at least one leadership group suggested that feedback could be collected from every patient after each contact with health and social care services.

Collection of outcome data

A strong theme related to IT systems and collection of outcome data emerged. Some participants from at least four groups (workforce and leadership) felt that outcome measurement is not currently systematic or routinely used and is difficult within the current systems. Therefore coordination of data collection and sharing across different services was seen as important, although it was recognised that this could be challenging.

There was a suggestion from participants in one workforce group of a central database of outcome data (profession-specific) so that local areas could benchmark themselves against each other and against national evidence-based guidelines and standards. This was supported by another group, but with the caveat that:

> Benchmarking is great but has to be in context of the fact that no two services across Scotland are set up identically, and [there are] differences in geography and population density.
>
> (Member of workforce)

Other themes around outcome measurement

As in previous discussions, some participants reiterated that the focus should be on the quality of care provided not just on 'hitting targets'. Participants in one of the leadership groups suggested that information should be published about safety of patients in services and the effectiveness of services.

Participants in one workforce group discussed the importance of measuring outcomes for people who are 'largely self-managing', while participants in at least two workforce groups expressed a need to collect data about people who do not attend appointments or drop out of treatment.

One workforce and two leadership groups discussed the collaborative nature of outcome measurement, in which the professional and patient are 'partners'. Despite potential differences of opinion between professionals and patients regarding outcomes, it was felt that the patient's view needed to be considered.

4.3.3. Addressing inequality in treatment outcomes

There was some overlap in discussion of this focus area with other areas, including inequality in access (see **"Section 4.2."**). Inequality in access was mirrored by inequality in treatment outcomes, with some similar factors being cited. These are summarised in the box below.

Factors related to inequalities in treatment outcomes, with stronger themes at the top

- **Geography:**
  - Geographical variation in terms of the range of treatments offered, occurring in urban as well as rural areas
  - Variation in the quality of care provided across the country
  - Poor public transport links in rural areas and insufficient resources to provide home care for those in need
- **Poverty:**
  - the impact of digital inequalities
  - unequal access to housing support nationwide
  - economic disadvantages related to type of care package (self-funded compared with state-funded)
- **Physical health problems**
- **Language barriers and accessibility requirements not being met**

Data collection and inequalities

Collection of data in relation to inequalities was also discussed. Some participants in one leadership group perceived that there was a paucity of data about the protected characteristics of patients and that this was a barrier to addressing inequalities. It was suggested that this data could be gathered through the patient's GP or at first contact with a mental health service (though it would be important to make it clear why information about protected characteristics was being collected, and how it would be shared).

With some protected characteristics changing over time, this data would need to be collected on a repetitive cycle. Participants from one workforce group expressed a need to understand local demographics.

4.4. Experience findings

4.4.1. Summary of strong experience themes and implications for standards

- Standards present an opportunity to optimise transitions in to/out of and between services, improve continuity of care and eliminate perceived discrepancies in the 'cut-off' at transition points
- Standards should be supported by seamless shared information systems across services (for example, the same software, procedures and systems used), and might include a standard for full information-gathering at the initial contact and interoperable record-sharing
- Standards need to balance accommodating the choice and preference of the patient where possible with legal constraints and clinical need
- Independent advocacy and support for people to access it easily could be reflected in standards
- Standards have the potential to reduce unintentional variation in care

4.4.2. Transitions and continuity of care

One of the stronger themes to emerge in this focus area from at least five workforce groups was the recognition that transitions and continuity of care could be improved, and are limited by workforce capacity and funding cuts, and there was appetite for standards in this area:

> “KPIs [key performance indicators] around transfer of care are important as these are definitely hot spots for risk.”
>
> (Member of workforce)

Even stronger was an expressed need by participants from at least seven groups (workforce and leadership) to optimise transitions into and out of services. This was described as being achievable by ensuring that people are discharged only when they are ready, that they are adequately prepared for discharge, with appropriate contact information, and that there is continuity of care on discharge.

Barriers to transitions and continuity of care

Participants from at least six groups (workforce and leadership) highlighted the barriers that impede fluid transitions and continuity of care. The strongest theme related to this topic was perceived discrepancies in the 'cut-off' at transition points (for example, the age at which people move from CAMHS to adult services, or from adult to older adult services). Weaker themes emerging from other groups encompassed a range of barriers:

- Moving between highly resourced services to those that are poorly resourced (some saw certain specialist services as being under-resourced
- Clash of perspectives and models across different systems

- Very high CMHT caseloads
- Staff not being able to help patients manage transitions because they often do not know what referrals to expect or 'where the patient will end up'
- Language used can impact the culture of treatment provision and whether continuity is able to be achieved.

To improve transitions and continuity of care, several groups made suggestions; these weaker themes (from one or two groups) are summarised in the box below.

Suggestions to improve transitions and continuity of care

- Alternative support (i.e., from the third sector) for patients when secondary services are not appropriate
- Collaborative and flexible working across teams, including linking up care between mental health and addictions services
- Needing a cultural change around reading patient notes before appointments
- Joint working with social care
- Flexibility in commissioning
- Need for shift in the structure of care provision
- Make use of existing high-quality models of care in other countries
- Shift public understanding about the range of mental health professionals and that a patient might need to see different professionals for different needs
- Increase people's sense of control, involvement, and ownership in their own journey at all points including transitions
- Consider transitions to and from third sector
- Support from IT systems

Overlap with other areas of discussion

Some of the discussions in this area overlapped with discussions about access, notably the interface between primary and secondary care and referral processes. At least one workforce group felt that there should be a standard for discharge and transfer of care.

4.4.3. Information sharing across the system

Some strong themes emerged in this focus area, pertaining to communication methods and information systems.

Participants from at least eight groups (workforce and leadership) articulated the current challenges in information sharing due to differences in electronic health records systems and no sufficient digital interface between primary care, social care and secondary care. There was a call for a government-led and mandated commissioning structure to address IT issues. A lack of effective communication methods between services and teams could lead to delays in services receiving information.

Equally as strong as a theme was the need for and the benefits of seamless shared information systems across services (for example, the same software, procedures and systems used) including the third sector and other external and partner organisations, such as social care and the police.

Some wanted to see a simplified version of patients' notes, such as a single shared record for health and social care at the national level. This would mean that patients would not have to repeat their story (unless there was benefit in doing so).

Person-centred data and information sharing

The tension between patients' rights and clinicians' data sharing/information access needs was discussed, with the majority view being that information should be shared as appropriate and with consent. Some felt that the amount of information shared should be defined, while others were keen to stress that different professionals might need different information and that information sharing would need to be determined ion an individual basis. Others emphasised that information-sharing processes need to be person-centred and that patients should have ownership over their own data.

Suggestions for standards

Several suggestions were put forward for standards in this area, including a standard for full information-gathering at the initial contact and for interoperable record-sharing, as well as a suggestion that standards should address staff knowledge and understanding of rules relating to data sharing so they can be confident they are doing so appropriately.

4.4.4. **Person-centred, rights-based care**

In this focus area, there were fewer strong themes. One of the strongest was related to the tension between patients' rights and the legal framework (such as the Mental Health Act) and the provision of evidence-based care. The majority view from at least six groups (workforce and leadership) was that it was important for staff to be flexible and accommodate the choice and preference of the patient where possible, but to set realistic expectations given legal constraints, clinical need and the skillset of the MDT:

> Patient choice can only be as wide as the skill set of the staffing.
>
> (Member of workforce)

> Aspects of law like the Mental Health Act may be a conflict to this. Patient capacity and ability to consent may be important also
>
> (Member of workforce)

It was recognised by participants from at least two workforce groups that patients' rights are not always understood by staff or by patients themselves and therefore some perceived a need to ensure that there is clear communication with patients at a clearly defined point on the care pathway about (a) their rights; and (b) any clinical decisions made that might override patient preference.

One of the other stronger themes from at least four groups (workforce and leadership) was around the importance of independent advocacy and support for people to access it easily (with a suggestion of embedding this function in MDTs).

Person-centred care generated weaker and more diffuse themes. These are summarised in the box below.

Views on person-centred care

- Person-centred care should be trauma-informed (but there are challenges in implementing trauma-informed principles due to lack of resources and staffing levels)
- Achieving person-centred care within the current systems is challenging – the barriers to achieving this need to be better understood
- Person-centred care is about patients' views and opinions being heard and considered
- Person-centred care is a 'whole person' approach to health – physical and mental health care being unseparated
- Person-centred care is about focusing on individual needs of trying to make people 'fit' within specialist teams
- Recognise the importance of families and carers in delivery of person-centred care
- There should be co-production at every level of service development
- Training staff and providing time for reflective practice is important for ensuring person-centred care

In terms of standards, there was a suggestion of a standard about patients having an individualised approach (***"was the service right for me and did it meet my expectations?"***) and one that establishes what services should do to improve patient experience across the pathway.

4.4.5. Understanding variation in care

This focus area did not receive as much attention as other areas, and most of the topics that were discussed overlapped greatly with those raised in other areas and have therefore been combined there (see **Sections "4.2.3."**, **"4.2.6."** and **"4.5.2."**).

The need for consistency in quality and provision of care was recognised by at least two workforce groups. The reasons put forward for variation in care from at least six workforce groups included: regional differences across the country, which some articulated as a 'postcode lottery'; resource and capacity issues in the workforce, with not enough staff to ensure consistent care; differences in the level of housing support available; and differences in how well care is integrated between areas.

There were various suggestions about how to reduce unwarranted variation, including at the workforce, commissioning and clinical governance level.

4.5. Workforce findings

4.5.1. Summary of strong workforce themes and implications for standards

- Standards need to take account of low morale and current concerns about understaffing, retention and recruitment
- Standards should be based on having an adequately staffed service with relevant skills, in which retention of staff is prioritised
- Training and career development are needed to ensure standards can be implemented and met
- Standards could articulate the broad expectation that staff are trained and well validated
- Standards could reflect the need for robust, evidence-based supervision
- Staff wellbeing should be reflected in standards

Under this main focus area, several overarching topics were discussed, namely: (i) current concerns about understaffing, retention and recruitment; (ii) workforce development; (iii) staff wellbeing; and (iv) governance, leadership and organisational change.

4.5.2. **Current concerns about understaffing, retention and recruitment**

A significant number of groups (11 workforce, one leadership) expressed concerns about staffing levels, be it understaffing, unsafe staffing levels, lack of experienced staff, non-regular staff, staff having to shift roles, retention of existing staff, recruitment challenges, current capacity of workforce or fixed-term contracts:

> “We cannot recruit on a 23-month fixed-term contract, folk can’t buy a house with a temporary contract, and if there is no ‘new blood’ we’re just rearranging deckchairs.”
>
> (Member of workforce)

Challenges to staffing levels

Some particular challenges to staffing levels were perceived to be related to such factors as an ageing workforce, fewer trainee psychiatrists, making mental health job roles ‘more attractive’ and a lack of desirable career pathways in adult social care. Concerns about the current capacity and staffing of the workforce emerged as one of the strongest themes of the workforce engagement exercise. These concerns were primarily rooted in feelings of not being able to deliver high-quality and safe care, which in turn had an impact on staff morale.

The national workforce strategy

Some participants from at least two workforce groups welcomed the national workforce strategy, which will accompany the introduction of secondary mental health care standards, while others from at least two other workforce groups believed that while an increase in the workforce is needed, the workforce and mental health care system themselves needed to be re-structured.

4.5.3. **Workforce development**

Within this topic, three themes emerged: (i) training and career development; (ii) roles, specialisms and professional standards; and (iii) supervision and support.

Training and career development

The need for training and development emerged as one of the strongest themes of the engagement events, with participants from at least 16 groups (workforce and leadership) expressing this need.

There was a recognition that workforce development was needed to ensure standards can be implemented and met. Specifically, some wanted to see more career development support for staff and better pathways to support staff career journeys, while others focused on the need for more training opportunities to carry out their current more competently, effectively and safely.

However, some participants perceived that there were currently few incentives for staff development and growth, while others thought that there was limited funding for training or that the pandemic was still having a detrimental effect on training commitments.

Some groups articulated what they wanted to see in terms of an improved training offer. These views are summarised in the box below.

Views on training, with the more commonly expressed views at the top

- There is a need for training on trauma-informed care and on specific conditions such as autism spectrum conditions, learning disabilities and emotionally unstable personality disorder
- Training should be applied in practice with supervision and feedback
- Staff need to feel valued and have protected time for training, rather than it being a 'tick-box' mandatory exercise
- Training should be delivered to the workforce and setting where it will be most effective, i.e. where the skills and competence of the workforce match the demands of the population
- Student training placements and opportunities should be increased and cover all geographical areas
- There are inequalities in terms of who has protected time for learning, development and upskilling

There was some appetite from participants from at least four groups (workforce and leadership) for a standard that encompassed workforce development and training. One group of leaders suggested that any standard related to workforce development would need to be 'high level' and non-specific, and focus on the broad expectation that staff are trained and well validated. Another leadership group wanted to see a 'learning health system' in which individual and organisation priorities were more aligned.

Roles, specialisms and professional standards

This was a weaker theme that emerged in discussions about workforce development. Participants from at least two workforce groups saw the benefit of having staff specialisms and 'role definitions' for specialist staff.

The development of new roles, or expanding existing roles into other areas, was also discussed by some groups, with mention of mental health practitioners, peer support workers, allied health professionals, wellbeing practitioners, advanced practitioners and non-consultant medical posts. The peer support worker role was seen by participants from at least two workforce groups as a valuable addition to the workforce, but also as:

> “very underdeveloped and an untapped resource”
>
> (Member of workforce)

One of the leadership groups articulated an ambition to enable to staff to work more flexibly in teams, and an appeal for standards to be compatible with existing professional standards so that staff are available to navigate different sets of standards.

Supervision and support

In what amounted to a stronger theme, participants in at least five groups (workforce and leadership) stressed the importance of embedding a culture of robust, evidence-based clinical supervision. People wanted to see supervision that was 'supportive', 'reflective' and 'time-protected'.

In terms of staff support, participants from at least three groups expressed a need for improved and appropriate support for staff, including for those in third sector who are often in challenging positions. Three of the leadership groups wished to see greater support for staff dealing with traumatic or challenging situations, so that they did not have to manage such events singlehandedly, and a standard that addressed violence and aggression. Two of these groups saw the standards themselves as something that staff would need support with, especially if they were in a service that was failing to meet the standards.

There was also a suggestion from participants in at least two of the workforce groups of a standard or measure about how well staff are supported/supervised.

4.5.4. **Staff wellbeing**

Improving staff wellbeing emerged as a strong theme in the focus area of workforce, with at least seven groups (workforce and leadership) discussing low morale and the reasons for it (see also **"Section 4.5.2."**, 'Current concerns about understaffing, retention and recruitment'). See the box below for a summary of views on the reasons for low morale.

Reasons for low morale

- Increased pressures due to the pandemic
- Increased demand for services
- Understaffing, lack of experienced staff and poor staff retention
- Short-term contracts
- Lack of training and support to provide the right care

Although participants in at least one workforce and one leadership group acknowledged that there had been an increased focus on staff wellbeing in recent years, with accompanying resources, there was a perception that there was little time to use the resources and that wellbeing was not routinely or extensively monitored. Participants in another workforce group felt that staff wellbeing had been less of a priority since the pandemic started.

Factors that were cited as contributing to staff wellbeing included having a healthy work-life balance, having a progressive, flexible and empathetic working culture, being provided with support and supervision (see above) and ensuring that staff feel valued and have adequate time and capacity to carry out their job role.

As mentioned in the section directly above, on 'Supervision and support', some participants from at least one leadership group felt that the standards themselves could have a detrimental impact on staff wellbeing and that they would have to be 'realistic' and achievable.

At least four workforce groups felt that there should be a standard or an indicator for staff wellbeing, but there was uncertainty about how to measure it, while participants from one other workforce group felt that an emphasis on staff resilience was too much to take when staff felt unsupported. Participants in at least one workforce and one leadership group suggested that staff morale could be improved by acknowledging the current difficulties and another urged leaders to 'treat the cause not just the symptoms' by tackling the underlying reasons for work-related stress.

4.5.5. **Governance, leadership and organisational change**

Most of the groups (at least three leadership and one workforce) who spoke at length about workforce development and staff wellbeing, also discussed the importance of leaders and senior managers in effecting change in this area. Of those who spoke about this, the majority view was that workforce development and staff wellbeing needs to be invested in, driven by and taken on board at senior management/health board level to ensure space is created for supervision and training and that this is embedded in organisations.

Regarding the recruitment and capacity challenges within the current mental health care system, participants from at least four groups (workforce and leadership) made suggestions about how these could be tackled. These are summarised in the box below.

Suggestions to stabilise and make best use of the current workforce

- Determine resources and staffing required for service provision according to demand in local population
- Consider the diversity of the workforce currently to be found within MDTs (including peer support workers and mental health practitioners)
- Make better use of skills within the third sector, and linking with community resources where available
- Consider utilising support networks that people already have to fill in the gaps created by workforce shortages
- Clarify the function of CMHTs and the specialists needed to deliver evidence-based care

Participants from at least three groups (workforce and leadership) looked at what could be put in place within the workplace to improve staff retention and wellbeing, including: creating an appealing work environment that helped motivate staff to stay, providing more transparency on decisions made at a managerial level, and monitoring staff wellbeing.

There was a suggestion from at least three workforce groups that there should be a standard based on having an adequately staffed service with relevant skills, in which retention of staff is prioritised. One of the leadership groups asserted that standards should not aim to individualise the requirement to provide a particular service, but should consider workforce development.

4.6. Implementation and evaluation of standards

4.6.1. Summary of strong implementation and evaluation themes and implications for standards

- Challenges associated with evaluating the implementation and impact of the standards
- Multiple evaluation mechanisms are needed, with a blend of objective and subjective measures

In addition to discussing the four focus areas of access, outcomes, experience and workforce, at the end of each engagement session we also asked the participants about how the implementation and impact of the standards could be evaluated.

Participants in at least six groups (workforce and leadership) commented on the challenges associated with evaluating the implementation and impact of the standards. Most of these challenges were linked to themes that had emerged in discussion about the four main focus areas, and are summarised in the box below.

Challenges

- Lack of resources and workforce shortfall will hinder the implementation of standards
- There needs to be 'ownership' of the standards and who takes responsibility for implementing them (this could be reflected in the standards themselves)
- The current CMHT model should be redesigned before introducing standards
- There are inefficient processes within the current health and social care system that will impede standards being met
- The practicalities of implementing standards in different regions will make evaluation difficult
- Other initiatives and reviews may have implications for the implementation of standards, such as the Mental Health Law Review

Roll out of the standards

- Secure local agreement on the wording of the standards
- Have a phased roll-out with testing and adaptation to different services and provide support to services throughout the implementation process
- Develop a clear communication strategy that sets out what the standards aim to achieve and how they can be achieved
- Engage staff from the outset to ensure ownership
- Engaging patients and other stakeholders in the implementation process
- Ensure that the workforce strategy to accompany the standards is robust
- Provide training in standards implementation
- Introduce a national quality improvement programme
- Build a governance framework around the standards, with internal and external monitoring systems
- Utilise integrated care pathways as a way of delivering standards

The majority (14) of the groups also discussed the roll out of the standards, and how this could be best achieved in the current climate to ensure that staff were prepared for and involved in their introduction. Their suggestions are summarised in the box above.

In terms of evaluating the implementation and impact of the standards, the majority of groups who discussed this (five workforce and three leadership) felt that multiple evaluation mechanisms were needed, with a blend of objective and subjective measures. These included peer evaluation, independent and academic evaluation, self-assessment, patient feedback, and an accreditation or reward-based approach.

> Goodness of fit of standards would mean that standards would make meaningful change to services on the ground evidenced by increased access to services (measured), outcomes (patient specific, service and wider system), patient experience (measured) and workforce (satisfaction recruitment)
>
> (Member of workforce)

One workforce group suggested basing the evaluation on the criminal justice system model for measurement of standards.

Participants from at least five groups (workforce and leadership) discussed the outcomes of any evaluation of the standards, which ranged from patient and staff experience outcomes to a reduction in complaints and readmissions. One leadership group emphasised the importance of being able to distinguish anomalies from failures.

More generally, some felt that evaluation should be 'realistic' and 'helpful' rather than a tool to hold services to account:

> We need to practise realistic management and realistic policy development. For every new thing we bring in like quality standards, we need to be clear about what we are asking staff to stop doing so they have time and attention to implement them.
>
> (Member of workforce)

There was a feeling from at least four groups (workforce and leadership) that evaluation should start internally before moving to external evaluation, taking account of local variation and using existing systems where possible.

Finally, it was suggested that:

> People who use our services and their families should be involved in co-producing the standards and what is important to measure.
>
> (Member of workforce)

5. Survey results

This section of the report narratively summarises the findings from the survey. There are graphical presentations of the results in **“Appendix 4”**.

The themes that emerged are defined as strong, moderate or weak, based on the spread of the themes across different regions.

Weak = 1–3 regions; **moderate** = 4–6 regions; **strong** = 6+ regions.

5.1. General views about standards

5.1.1. Summary of strong themes and implications for standards

- Poor staff wellbeing, understaffing, and under-resourcing need to be addressed before the implementation of other standards

From the free-text boxes available, respondents expressed a range of views about standards, which can be grouped under the following themes:

Acknowledge the need for standards

- Standards are needed to benefit the people being served (**weak**)

Prioritise the workforce domain

- Poor staff wellbeing, understaffing and under-resourcing need to be addressed first, before the implementation of other standards (**strong**)

Other standards that might be needed

- Waiting times should not be solely focused on while ignoring other areas such as quality of care, staff wellbeing, and resourcing (**weak**)
- Physical health of mental health patients (**weak**)
- Cultural change in understanding mental health, such as stigma to mental health, social inclusion, and recovery (**weak**)
- Move away from traditional hierarchical model within the multidisciplinary team to better collaboration between different professions (**weak**)
- Redesign composition of workforce, for example staff with lived experience, allied health professionals, and assistant practitioners (**weak**)
- Engage patients in the design of services (**weak**)

Consider wider context

- A Scotland-wide framework for mental health services that includes primary care, secondary care, third sector, and specialist services (**moderate**)
- Address social determinants of mental health, such as poverty (weak)
- Manage public expectations of mental health services (**weak**)

5.2. Access

Respondents were asked, 'In your opinion, how important are standards that relate to access to secondary mental health care and treatment', and the level of importance was rated as 4.61 (where 1 = not very important and 5 = highly important).

Respondents were then asked, 'Which of the following areas do you think could make the most difference/have most impact if translated into an appropriate standard about access'. They could choose one option from: (1) access to services ('no wrong door'); (2) waiting time for treatment; (3) assessment and care planning; and (4) flexibility to deliver in different parts of the country. They were also asked which of those options 'would be the most challenging to implement as a standard'.

5.2.1. Summary of strong access themes and implications for standards

- Getting patients on the right pathway as soon as possible will improve their experience, contact with services, and outcomes, therefore standards should ensure that patients are able to be directed to what they require, when they require it
- Standards should acknowledge that multidisciplinary working amongst different services and sectors is required to improve referral
- Waiting times are associated with under-resourcing, understaffing, and difficulty in recruitment and retention, which may impact on the implementation of standards
- There may be resistance to making changes to who can access services, which may impact on the implementation of standards

5.2.2. Access to services ('no wrong door')

Of the options, 51.3% of respondents rated access to services ('no wrong door') as having the most impact, and 29.5% rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Initial access to services

- A single point of quick access to an initial quality triage, followed by appropriate signposting or referral (**moderate**)
- Triage can be virtual or in person (**weak**)
- Allow self-referral (**weak**)
- Change service focus from keeping people out to meeting their needs (**weak**)

Address inequality in access

- Decrease barriers for patients with complex needs and challenging behaviours (**moderate**)
- Address existing stigma for some groups of patients (**weak**)
- Background such as ethnicity should not stop a person from accessing mental health services (**weak**)

Referral to other services

- Ensure patients are able to be directed to what they require, when they require it (**strong**)
- Sometimes multidisciplinary working among different services and sectors is required (**strong**)
- A wider range of services and treatments is required (**moderate**)
- Clear criteria for services can guide both patients and referrers (**weak**)

Patient experience, care and outcomes

- Getting patients on the right pathway as soon as possible will improve their experience, contact with services, and outcomes (**strong**)
- If access is available at the earliest possible time, it will hopefully reduce demand on inpatient care and crisis interventions (**moderate**)

Most challenging to implement

Limited resources

- 'No wrong door' also implies 'open door' and significantly increases demand (**moderate**)
- Staff shortages should first be addressed (**weak**)

Difficulty in collaboration between services

- There may be resistance to making changes to who can access services (**strong**)
- May involve multiple disciplines and would require improved understanding of various clinical roles (**moderate**)
- Requires good inter-service/inter-agency links (**weak**)

Unclear access routes

- The distinction between primary and secondary care is not clear to professionals and patients (**weak**)
- Patients in rural regions have an unequal opportunity for access to support (**weak**)

5.2.3. Waiting time for treatment

Of the options, 26.6% of respondents rated waiting for treatment as having the most impact, and 41.3% rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Improve patient experience and outcomes

- Being seen sooner would potentially improve patient and outcomes (**strong**)
- Reducing waiting times should be a top priority (**moderate**)
- Being seen sooner would potentially improve patient experience (**weak**)

Improve provision of service

- Having access to early treatment has the potential to prevent difficulties from becoming more severe, which then requires longer treatment times (**weak**)

Clear inclusion criteria and standards

- Services need to have well-defined inclusion criteria so that patients will not be waiting in the wrong queue (weak)
- More training for staff to refer to the appropriate services (**weak**)

Most challenging to implement

Caution about using waiting time as a target

- Using waiting times as a target is not person-centred care (**weak**)

Understaffing and limited resources

- Waiting times are associated with under-resourcing, understaffing and difficulty in recruitment and retention (**strong**)
- The pandemic has worsened the situation and creates a longer waiting list (**moderate**)

5.2.4. Assessment and care planning

Of the options, 17.3% of respondents rated assessment and care planning as having the most impact, and 6.3% rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Importance of assessment and care planning

- Multidisciplinary assessments and ongoing care planning are essential so that people can access the correct service quickly (**moderate**)

Most challenging to implement

Caution about using assessment and care planning as a target

- Any attempt to standardise this would quickly skew the assessment process to meet the standards rather than to best meet the needs of service users (**weak**)

Understaffing and limited resources

- Need to first address the issues of understaffing and limited resources (**weak**)

Limited multidisciplinary collaboration

- Difficulty in different agencies and disciplines working together (**weak**)

5.2.5. Flexibility to deliver in different parts of the country

Of the options, 4.8% of respondents rated assessment and care planning as having the most impact, and 22.9% rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Support needed

- Rural areas have their own challenges and should be better supported (**weak**)
- Smoother transfer of clinical notes between agencies (**weak**)

Most challenging to implement

Limited access to services in remote areas

- Challenging for remote and rural areas as access is geographically impacted and provision of mental health services is limited (**moderate**)

Understaffing and limited resources

- Remote areas are underfunded (moderate)
- Staff retention is challenging in more remote areas (**weak**)

5.2.6. Barriers to improving overall quality of care

When asked about the biggest barrier that needs to be overcome to improve overall quality of care, respondents chose the following, in order of most rated:

- Availability of appropriate services (36.5%)
- Difficulty navigating service structures to get help (22.5%)
- Waiting times (15.9%)
- Awareness of available services (8.5%)
- Geographical variation (rural versus urban, transport issues and so on) (8.5%)
- Other (5.2%)
- Socio-demographic factors (for example ethnicity, sexuality, disability, gender, socio-economic status) (3.0%)

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Overview of access issues

- All of the above access barriers need to be addressed (**strong**)
- All of the above are closely linked (**weak**)

Availability of appropriate services

- Lack of appropriate services and long waiting times (**strong**)
- There are simply not enough staff or resources to manage the demand on services currently (**strong**)

Difficulty navigating service structures

- Pathways to care are not clear to professionals or patients (**strong**)
- Too specific inclusion criteria might limit access (**strong**)
- Clients' presentation can vary and may not meet service criteria (**weak**)
- Mental and physical health services need to work together more effectively (**weak**)

Waiting times

- Long waiting times affects patient's experience and outcomes (**weak**)
- Understaffing leads to longer wait (**weak**)
- Should ensure quality of care while improving waiting times (**weak**)

Awareness of available services

- Awareness of third sector services (**weak**)

Geographical variation (rural versus urban, transport issues and so on)

- Due to staff or funding shortages, services can become 'centralised' (**moderate**)

Socio-demographic factors (for example ethnicity, sexuality, disability, gender, socio-economic status)

- Health inequalities for individuals and their communities (**weak**)

5.3. Outcomes

Respondents were asked, 'In your opinion, how important are standards that relate to people's outcomes of mental health care and treatment', and the level of importance was rated as 4.61 (where 1 = not very important and 5 = highly important).

Respondents were then asked, 'Which of the following areas do you think could make the most difference/have most impact if translated into an appropriate standard about patient outcomes?' They could choose one of the following three options:

1) Ensuring collected outcomes are aligned with evidence-based care.
2) Addressing inequality in treatment outcomes (for example, among the most disadvantaged communities).
3) Ensuring that there are outcomes that reflect person-centred patient experience

They were also asked which of those options 'would be the most challenging to implement as a standard'.

5.3.1. Summary of strong outcomes themes and implications for standards

- Standards present an opportunity to ensure that services have a beneficial impact on patients' quality of life
- Standards should address inequalities and the fact that people living in disadvantaged areas experience higher levels of mental illness
- The implementation of standards might be impacted by the wide range of socioeconomic factors contributing to disadvantage
- Standards should reflect person-centred care and personalised goals

5.3.2. Ensuring collected outcomes are aligned with evidence-based care

Of the options, 21.4% of respondents rated 'ensuring collected outcomes are aligned with evidence-based care' as having the most impact, and 15.5% rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Values of evidence-based care

- Ensure that services have a beneficial impact on patients' quality of life (**strong**)
- Ensure a certain degree of consistency across services (**weak**)

Most challenging to implement

Use appropriate measures

- Outcomes are only of use if they are measuring something valuable and people can use them as an aid to guide care and treatment (**moderate**)
- Outcomes based on interventions and symptoms sometimes do not capture the progress made (**weak**)
- Balance between evidence-based and person-centred care (**weak**)

5.3.3. **Addressing inequalities in treatment outcomes**

Of the options, 34.4% of respondents rated 'addressing inequalities in treatment outcomes' (for example, among the most disadvantaged communities) as having the most impact, and 63.8% rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Strive for equality

- People living in disadvantaged areas experience higher levels of mental illness. It is essential to understand the impacts of social determinants on mental health and direct resources to the right people (**strong**)
- Address issues of stigma among certain groups of people (**weak**)

Most challenging to implement

Require interventions from a higher level

- Disadvantaged communities are disadvantaged because of a whole range of socio-economic factors and cannot be addressed purely by a single service (**strong**)
- Resources need to be allocated to areas of deprivation (**strong**)

Identify the most disadvantaged

- Often services respond more to people who are more proactive about seeking help than those who are disadvantaged (**weak**)
- Need to overcome barriers to access (**weak**)

5.3.4. **Ensuring that there are outcomes that reflect person-centred patient experiences**

Of the options, 44.3% of respondents rated 'Ensuring that there are outcomes that reflect person-centred patient experiences' as having the most impact, and 20.7% rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Importance of personalised goals

- Person-centred care must be supported by personalised goals – we should avoid creating outcomes defined from a pathway or disease specific perspective (**strong**)

Most challenging to implement

Disagreement between services and patients

- There may be disagreement between what services and patients think is the right person-centred experience (**moderate**)
- Validated measures might not capture patients' lived experiences and outcomes can be difficult to be reliably measured in mental health (**moderate**)

5.3.5. **Barriers to improving overall quality of care**

When asked about the biggest barrier that needs to be overcome to improve overall quality of care, respondents chose the following, in order of most rated:

- Inequality in treatment outcomes (recovery, improvement, drop-out) (47.6%)
- Provision of evidence-based care (24.7%)
- Outcomes monitoring (including data collection) (21.0%)
- Other (6.6%)

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Overview of outcomes barriers

- Resources related to equality in treatment outcomes, evidence-based care, and outcomes monitoring should be addressed (**strong**)

Inequality in treatment outcomes (recovery, improvement, drop-out)

- Services need to be less risk adverse and keep individuals open to services longer (**weak**)
- Wider inclusion of allied health professions in services (**weak**)
- Focus on wider issues contributing to mental health, especially for patients who need contextual changes rather than individual treatments (**weak**)
- Collaboration between services, such as mental health and addiction (**weak**)

Provision of evidence-based care

- Importance of evidence-based interventions (**moderate**)
- The evidence base is not based on the populations being served in secondary care (**weak**)
- Evidence-based care should be recognised by executive managers (**weak**)
- Need to develop research posts and practice-based research (**weak**)

Outcomes monitoring (including data collection)

- Importance of monitoring progress and sharing positive outcomes (**moderate**)
- Outcomes monitoring should ensure person-centred care at the same time (**weak**)
- Issues of mental health can be subjective and difficult to quantify (**weak**)

Other

- Agreement among professionals and patients about what is the best outcome (**weak**)
- Meaningful engagement with service users is warranted (**weak**)
- Inequality in treatment access (**weak**)

5.4. **Experience**

Respondents were asked, 'In your opinion, how important are standards that relate to people's experience of secondary mental health services', and the level of importance was rated as 4.59 (where 1 = not very important and 5 = highly important).

Respondents were then asked, 'Which of the following areas do you think could make the most difference/have most impact if translated into an appropriate standard about patient experience?' They could choose one option from: (1) information sharing across the system; (2) person-centred, rights-based care; (3) minimising unwanted variation in care; and (4) transitions and continuity of care. They were also asked which of those options 'would be the most challenging to implement as a standard'.

5.4.1. **Summary of strong experience themes and implications for standards**

- Inconsistent record keeping systems across agencies is a challenge for the implementation of standards
- Person-centred, rights-based care is fundamental to the provision of care and should underpin standards
- Reducing patients' disengagement from services and ensuring that they continue to receive necessary services is a priority for standard development

5.4.2. **Information sharing across the system**

Of the options, 16.2% of respondents rated 'information sharing across the system' as having the most impact, and 26.9% rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Improve patient's experience and care

- Sharing patient information across services can prevent patients from repeating stories over and over again (**moderate**)
- Facilitates multidisciplinary working (**moderate**)

Most challenging to implement

Technological challenges

- Inconsistent record keeping systems across agencies (**strong**)
- Lack of technological support (**moderate**)
- Lack of electronic records of patient information (**weak**)
- Sharing information versus maintaining confidentiality is a challenging issue (**weak**)

5.4.3. **Person-centred, rights-based care**

Of the options, 48.7% of respondents rated 'person-centred, rights-based care' as having the most impact, and 14% rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

As a top priority

- The standard is fundamental to the provision of care (**strong**)
- Person-centred care should encompass all the other standards under the experience domain (**weak**)

Improve patient's experience and care

- Improve patients' outcomes (**strong**)
- Enable patients to be empowered (**moderate**)
- Address the issue of power imbalance between patients and mental health professionals (**moderate**)
- Facilitate transitions of care (**weak**)

Most challenging to implement

Understaffing and under-resourcing

- The issues of not having enough staff and resources must first be addressed (**moderate**)

Different views on the understanding of the terminology

- Various definitions of the meaning of 'rights' (**weak**)
- Difficult to measure outcomes around person-centred and rights-based care (**weak**)
- Various models of care are used across services (**weak**)

Resistance to a cultural change

- Understand that mental health is largely a social issue instead of a medical one (**weak**)
- Professional hierarchies will be challenged (**weak**)

5.4.4. **Minimising unwanted variation in care**

Of the options, 8.1% of respondents rated 'minimising unwanted variation in care as having the most impact', and 36.9 % rated it as likely to be the most challenging to implement.

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Address inequalities and improve patient's care

- Reduce the postcode lottery related to accessing services (**moderate**)
- Reduce confusion and distress among service users (**weak**)
- Ensure implementation of evidence-based care (**weak**)

Most challenging to implement

Variation in practice

- Different professionals will deliver care in a variety of ways, which can create unintentional variation in care (**moderate**)
- Difficult to differentiate between necessary variation and unwanted variation (**moderate**)
- Continuity of care is difficult when there are staffing shortages and difficulties in retaining staff (**moderate**)
- Different localities have different priorities (**weak**)

5.4.5. **Transitions and continuity of care**

Of the options, 26.9% of respondents rated 'transitions and continuity of care' as having the most impact, and 22.1% rated it as likely to be the most challenging to implement.
When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Most impact

Create an integrated care

- Reduce the chance of patients' disengagement and ensure that they continue to receive necessary services (**strong**)
- Reduce the loss of patient's information during transitions (**weak**)

Most challenging to implement

Understaffing and under-resourcing

- Staff shortages create long waiting times, limiting access to required services (**moderate**)

Geographical variation

- Rural areas struggle to provide equitable services (**weak**)

5.4.6. **Barriers to improving overall quality of care**

When asked about the biggest barrier that needs to be overcome to improve overall quality of care, respondents chose the following, in order of most rated:

- Regional variation in quality of care ('postcode lottery') (41.0%)
- Meaningful inclusion of patients (and relatives/carers) in care decisions (29.2%)
- Availability of information sharing across systems (21.8%)
- Other (8.1%)

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Regional variation in quality of care ('postcode lottery')

- Waiting times and staff numbers vary across regions which means that access to the same care varies from region to region (**weak**)
- Working outside the city centre is a barrier, with most recourses being centralised (**weak**)
- Not all services are available in all areas, so people need to travel (**weak**)

Meaningful inclusion of patients (and relatives/carers) in care decisions

- Require a cultural shift to shared decision-making (**strong**)

Availability of information sharing across systems

- Digital recording systems across services are not compatible (**moderate**)

5.5. **Workforce**

For this section of the survey, respondents were given a series of statements about resources, training and development, supervision and management, support provided to deliver services to people with a range of needs, and staff wellbeing, and were asked how much they agreed with the statements.

5.5.1. **Summary of strong workforce themes and implications for standards**

- Standards will be impacted by services being underfunded, understaffed and overstretched and difficulties in recruiting and retaining staff
- Standards should be underpinned by a clear differentiation between the roles of primary, secondary and specialist services
- Significant variability in resources and training received across different disciplines and teams to meet a range of complex needs might impact on the implementation of standards
- A standard on staff wellbeing is essential for the provision of high-quality care

5.5.2. **Resources**

Respondents were asked how much they agreed with the following statement: 'Secondary mental health care services in Scotland are sufficiently resourced to meet local population needs'. The level of agreement was rated as 1.69 (where 1 = strongly disagree and 5 = strongly agree).

When asked to expand on their level of agreement, respondents' answers were focused on some common themes, as follows:

Understaffing

- Services are seriously understaffed and overstretched (**strong**)

Difficulty in recruitment and retention

- Difficulty in recruiting and retaining staff (**strong**)
- Staffing ratios, pay grades, career progression, training opportunities, and staff wellbeing need to be addressed to attract and retain staff (**strong**)

Underfunded services

- Services are underfunded and under-resourced (**strong**)
- A wide variation in how resources are distributed across different locations, but without consideration of population needs (**strong**)

Difficulty in meeting the needs of local population

- Understaffing and lack of resources result in long waiting lists and inappropriate staff/patient ratios (strong), as well as limitations to carry out preventive work (moderate) and inflexibility in meeting changes of population needs (**strong**)
- The pandemic has a significant impact on the delivery of mental health services (**moderate**)

Service redesign is warranted

- Clear differentiation between the roles of primary, secondary and specialist services (**strong**)
- Wider inclusion of allied health professions in services (**moderate**)
- More investment in frontline staff (**weak**)
- More investment in addressing wider issues contributing to mental health (**weak**)
- Expansion of the roles of carer assistants and support workers (**weak**)
- More collaboration between teams and services (**weak**)
- There can be more third sector support, especially in areas outside of the main cities (**weak**)
- Clear definition of the local population who can be mostly benefited from secondary mental health services (**weak**).

5.5.3. **Training and development**

Respondents were asked how much they agreed with the following statement: 'Staff working in secondary mental health care services are provided with good opportunities for training and development.'. The level of agreement was rated as 2.85 (where 1 = strongly disagree and 5 = strongly agree).

When asked to expand on their level of agreement, respondents' answers were focused on some common themes, as follows:

Training is adequate

- Adequate training opportunities are provided (**strong**)

Needs related to training and development

- More training and development opportunities are warranted (**strong**)

- Opportunities for training and development could be impacted by overstretched services and limited funding (**strong**)
- Opportunities for training and development vary across disciplines and services (**strong**)
- Quality and contents of training remain an issue (**weak**)

5.5.4. **Supervision and management**

Respondents were asked how much they agreed with the following statement: 'Staff working in secondary mental health care services are provided with regular supervision and management'. The level of agreement was rated as 3.31 (where 1 = strongly disagree and 5 = strongly agree).

When asked to expand on their level of agreement, respondents' answers were focused on some common themes, as follows:

Supervision is regular

- Supervision is regular and easily accessed (**strong**)

Needs related to supervision

- More supervision and support are warranted (**strong**)
- Quality and effectiveness of supervision remain an issue (**strong**)
- Level of supervision varies across disciplines and services (**strong**)
- Offer of supervision could be impacted by overstretched services (**moderate**)

5.5.5. **Support to provide appropriate and high-quality services to people with a range of differing and complex needs**

Respondents were asked how much they agreed with the following statement: 'Staff working in secondary mental health care services are adequately resourced and trained to provide appropriate, high-quality support to people with a range of differing and complex needs'. The level of agreement was rated as 2.59 (where 1 = strongly disagree and 5 = strongly agree).

When asked to expand on their level of agreement, respondents' answers focused on the following common themes:

More training required

- Training in specialist areas (**strong**)
- Training in evidence-based practices (**moderate**)
- More training opportunities (**weak**)
- Training in person-centred care (**weak**)
- Training to use IT systems in the delivery of care (**weak**)

Understaffing/lack of resources

- Services overstretched with staff shortages, high turnover, and lack of resources such as inadequate spaces for patients and staff and limited funding (**strong**)
- Overstretched services limit staff's capacity to attend training (**strong**)

Access to services

- Services might not be designed to meet the needs of a certain group of patients, hence creating service gap (**weak**)

Wide variation across different professions

- Significant variability in resources and training received across different disciplines and teams to meet a range of complex needs (**strong**)

5.5.6. **Staff wellbeing in the delivery of high-quality care**

Respondents were asked 'How important is staff wellbeing in the delivery of high-quality care?' The level of agreement was rated as 4.82 (where 1 = not very important and 5 = highly important).

When asked to expand on their rating, respondents' answers were focused on some common themes, as follows:

Wellbeing as a top priority

- Staff wellbeing should be considered to be a top priority and an essential standard (strong)
- Staff wellbeing is currently not recognised in the workplace, sometimes it feels like a tick box exercise (**moderate**)

Quality of care

- Staff wellbeing is essential to high-quality care to patients (**strong**)

Staff retention

- Staff are exhausted and burnt out, followed by high sickness levels and low retention, eventually crippling services significantly (**moderate**)

Staff shortages and recruitment challenges

- Currently, extreme staff shortages and challenges in recruiting have caused staff distress (**moderate**)

Service level change that will enhance staff wellbeing

- Focus needs to move from individual wellbeing (for example, information on staff support) to looking at service-level change that will enhance staff wellbeing (**strong**)
- Organisational changes are warranted, such as:
    - overcoming issues of understaffing/lack of resources (**moderate**)
    - addressing heavy caseloads (**moderate**)
    - valuing staff (**moderate**)
    - providing supportive management (**moderate**)
    - reducing burden of bureaucracy (**weak**)
- It is better to ask about how to support staff wellbeing (**weak**)

5.5.7. **Barriers to improving overall quality of care**

Respondents were then asked which workforce issues pose the biggest barriers that needs to be overcome to improve overall quality of care, from five options: (1) understaffing/lack of resource; (2) staff training needs and skills development and opportunities; (3) staff retention and turnover; (4) poor staff morale and wellbeing; and (5) other.

- Understaffing/lack of resources (54.6%)
- Staff retention and turnover (19.9%)
- Poor staff morale and wellbeing (11.4%)
- Other (7.7%)
- Staff training needs and skills development opportunities (6.3%)

When asked to expand on their choices, respondents' answers were focused on some common themes, as follows:

Overview of workforce barriers

- All of the above workforce barriers need to be addressed (**strong**)
- All of the above are closely linked; for example, understaffing leads to low staff morale, which causes poor staff retention and high turnover, providing less time for training and development (**moderate**)

Understaffing/lack of resources

- Understaffing and lack of resources are seen as the root cause of other workforce barriers (**strong**)
- Understaffing and lack of resources are noticeable across various mental health professions (**moderate**)
- Increasing work demand but with the same number of staff (**weak**)
- Recruitment tends to be from existing group of workers, so filling a gap would create another gap – rarely do outside people apply (**weak**)
- The pandemic worsens the situation (**weak**)
- Significant resource investment is warranted to deliver stable high-quality services (**weak**)

Staff retention and turnover

- Ageing workforce with no handover periods – loss of experience and information (**moderate**)
- Long-standing difficulties about recruitment and retention across geographically diverse areas (**weak**)
- More difficult in rural areas to provide career paths for staff (**weak**)
- Staff retention is directly linked to:
  - pay and allowances (**weak**)
  - clear career progression (**weak**)
  - staff wellbeing and satisfaction (**weak**)
  - workload stress (**weak**)
  - management (**weak**)
  - professional status (**weak**)
- Developing new workforce roles to support the work of the traditional workforce is needed (**weak**)

Poor staff morale and wellbeing

- Staff are underfunded, over-worked, and working in a chronically stressful environment with high turnover and at capacity with little support (**moderate**)
- Improving staff morale and wellbeing allows them to deliver compassionate and high-quality care (**weak**)
- Improvement in morale and wellbeing leads to improved retention and less turnover, which leads to more resource use (**weak**)

Other

- Interdisciplinary rivalries (the fragmentation of mental health services) versus multidisciplinary working (**weak**
- Workforce redesign for inclusion of relevant allied health professionals including arts therapists in multidisciplinary mental health teams (**weak**)

Staff training needs and skills development opportunities

- Training based on a medical model (for example, 'treatment' for 'mental illness') is not always helpful (**weak**)
- Training should aim at self-reflection geared toward optimising genuine engagement, and not presuming we know best (**weak**)
- Training related to skills, tools, and supervision to undertake their roles is warranted (**weak**)
- Good training and support lead to feeling valued (**weak**)

6. Conclusion

From March to May 2022, the NCCMH and the RCPsychIS engaged with a significant proportion of the secondary mental health care workforce and leadership on the topic of new quality standards to understand what staff and leaders would want included in standards (and what they would not).

Over 23 engagement events, we spoke to 254 staff and leaders. A total of 271 people responded to our survey.

Through both of these methods of engagement and our analysis of the emerging themes, we have been able to provide the Scottish Government with a clear steer on the priorities for standard development (see **"Section 2"**).

These priorities can be briefly distilled into the following focus areas and corresponding themes to inform standards, with themes that overlapped several focus areas listed at the end:

Focus area	Specific themes to inform standards in each focus area
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 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)

Focus area	Specific themes to inform standards in each focus area
3. Support, care and treatment *(continued)*	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 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 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	**Communication and information**
	Inclusion
	Person-centred care
	Environment
	Rights-based approach

Appendix 1: **Method for engagement events**

Members of the workforce were contacted via email and invited to attend an event for the region in which they worked. There was also the option of attending an open event (for any region) if the participant was unable to attend their region-specific event. Leaders and managers were invited to separate events.

The events were held via Microsoft Teams and lasted for 2 hours. If the groups were large (about 15 or more participants) then the groups were split into breakout groups for 1 hour of the discussion.

Each engagement event was facilitated by a member of the NCCMH and RCPsychIS leadership team (Dr Pavan Srireddy, Professor Steve Pilling or Tom Ayers). Two members of the NCCMH research team took notes of the discussions during the events, using a form template, and the event was supported by a project manager. If breakout groups were used, one of the groups was facilitated by another NCCMH staff member (a quality improvement coach). The events were recorded for internal use only (the recordings will be deleted on completion of the project).

After each event, the NCCMH research team identified themes from the discussion and extracted them into a matrix in Excel. This matrix was used to analyse the themes from across all of the engagement events, and these themes are synthesised in this report. Each theme was tagged with a code so that it could be linked to the engagement event from which it emerged.

Appendix 2: **Participants and survey respondents by role**

Workforce and leadership engagement participants by role[a]

Table 1: **Role of participants in workforce engagement session (n=162)**

Role	Number (%)
Manager (e.g. Service Manager, Team Leader, Clinical Director)	**54 (33.3%)**
Psychologist (e.g. Clinical Psychologist, Counselling Psychologist)	**28 (17.3%)**
Nurse (e.g. Community Mental Health Nurse, Liaison Nurse)	**24 (14.8%)**
Medical Doctor (e.g. Consultant Psychiatrist, Specialty Doctor)	**15 (9.3%)**
Social Worker (e.g. Mental Health Officer)	**14 (8.6%)**
Occupational Therapist (e.g. Specialist Occupational Therapist)	**9 (5.6%)**
Therapist (e.g. Arts Therapist, CBT Therapist)	**7 (4.3%)**
Researcher (e.g. Data Analyst, MH Planning)	**4 (2.5%)**
Support Worker (e.g. Peer Support Worker, Healthcare Assistant)	**3 (1.9%)**
Physiotherapist	**3 (1.9%)**
Chaplain	**1 (0.6%)**

Table 2: **Role of participants in leadership engagement session (n=26)**

Role	Number (%)
Manager (e.g. Service Manager, Team Leader, Clinical Director)	**14 (53.8%)**
Nurse (e.g. Mental Health Nurse)	**4 (15.4%)**
Medical Doctor (e.g. Consultant Psychiatrist, Specialty Doctor)	**3 (11.5%)**
Researcher (e.g. Policy Advisor, Mental Health Planning)	**3 (11.5%)**
Occupational Therapist (e.g. Specialist Occupational Therapist)	**1 (3.8%)**
Therapist (e.g. Arts Therapist)	**1 (3.8%)**

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[a] Please note that registration forms were not completed by everyone for some sessions, so these tables contain role information for up to 188 participants.

Table 3: **Role of participants across both workforce and leadership engagement sessions (n=188)**

Role	Number (%)
Manager (e.g. Service Manager, Team Leader, Clinical Director)	68 (36.2%)
Psychologist (e.g. Clinical Psychologist, Counselling Psychologist)	28 (14.9%)
Nurse (e.g. Community Mental Health Nurse, Liaison Nurse)	28 (14.9%)
Medical Doctor (e.g. Consultant Psychiatrist, Specialty Doctor)	18 (9.6%)
Social Worker (e.g. Mental Health Officer)	14 (7.4%)
Occupational Therapist (e.g. Specialist Occupational Therapist)	10 (5.3%)
Therapist (e.g. Arts Therapist, CBT Therapist)	8 (4.3%)
Researcher (e.g. Data Analyst, Mental Health Planning)	7 (3.7%)
Support Worker (e.g. Peer Support Worker, Healthcare Assistant)	3 (1.6%)
Physiotherapist	3 (1.6%)
Chaplain	1 (0.5%)

Survey respondents by role and geography

Table 4: **Role of respondent**

Role	Number (%)
Nurse (e.g. Community Mental Health Nurse, Staff Nurse)	60 (22.1%)
Manager (e.g. Team Leader, Clinical Director)	44 (16.2%)
Medical Doctor (e.g. Consultant Psychiatrist, Specialty Doctor)	36 (13.3%)
Social Worker (e.g. Mental Health Officer)	35 (12.9%)
Psychologist (e.g. Clinical Psychologist, Counselling Psychologist)	31 (11.4%)
Occupational Therapist (e.g. Specialist Occupational Therapist)	30 (11.1%)
Support Worker (e.g. Peer Support Worker, Healthcare Assistant)	10 (3.7%)
Therapist (e.g. Arts Therapist, CBT Therapist)	9 (3.3%)
Physiotherapist	4 (1.5%)
Administration (e.g. Clinical Support Secretary, Medical Records Clerical Officer)	4 (1.5%)
Dietitian	3 (1.1%)
Pharmacist	2 (0.7%)
Speech and Language Therapist	2 (0.7%)
Chaplain	1 (0.4%)

Table 5: **Area of work**

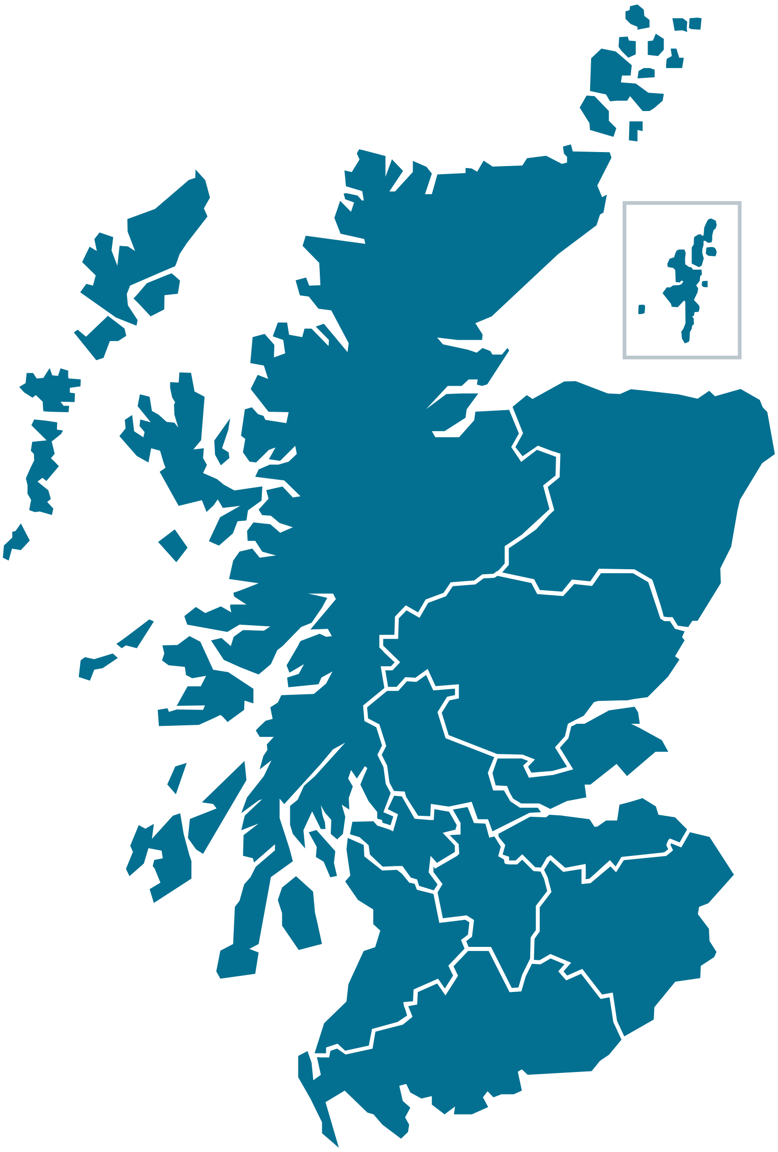
Area of work	Number (%)
Community mental health services	158 (43.5%)
Inpatient mental health services	69 (19.0%)
Management and leadership	37 (10.2%)
Social work and social care	31 (8.5%)
Crisis/urgent and emergency care	26 (7.2%)
Other (e.g. drug and alcohol, forensic, intellectual disability)	26 (7.2%)
Primary care	16 (4.4%)

Table 6: **Employer of respondent**

Employer	Number (%)
NHS	200 (71.4%)
Health and social care partnership	49 (17.5%)
Local authority	22 (7.9%)
Voluntary and community social enterprise ('third sector') organisation	5 (1.8%)
Other (e.g. membership organisation)	4 (1.4%)

Table 7: **Region of Scotland in which the respondent is based**

Region of Scotland	Number (%)
Highland	43 (15.9%)
Glasgow	41 (15.1%)
Borders	21 (7.7%)
Greater Glasgow & Clyde	20 (7.4%)
Grampian	17 (6.3%)
Lothian	17 (6.3%)
Fife	16 (5.9%)
Lanarkshire	16 (5.9%)
Edinburgh	13 (4.8%)
Argyll and Bute	12 (4.4%)
Aberdeenshire	9 (3.3%)
Renfrewshire	7 (2.6%)
Ayrshire	7 (2.6%)
Tayside	6 (2.2%)
Dumfries and Galloway	5 (1.8%)
Forth Valley	5 (1.8%)
Central Scotland	3 (1.1%)
Nationally (no single region)	3 (1.1%)
Falkirk	2 (0.7%)
Inverclyde	2 (0.7%)
Dunbartonshire	2 (0.7%)
Angus	1 (0.4%)
Orkney	1 (0.4%)
Shetland	1 (0.4%)
Western Isles	1 (0.4%)



Appendix 3: **Survey form**

Standards for secondary mental health services in Scotland - workforce engagement

This form has been put together as part of the work to develop a set of standards for secondary mental health services in Scotland. The Royal College of Psychiatrists' National Collaborating Centre for Mental Health (NCCMH) is undertaking a series of engagement activities with the workforce and leadership of mental health services in Scotland, on behalf of the Scottish Government

This form has been developed to allow members of the workforce and leadership to contribute to the discourse even if they are unable to attend scheduled engagement events The form provides here follows a similar structure to that of the engagement meetings and will provide an opportunity for contributions to specific topic areas regarding setting standards for the provision of secondary mental health care in Scotland.

This survey contains a mixture of questions including multiple choice, Likert scales and free-text boxes.

Please contribute your thoughts and opinions. **This form should take no longer than 10 minutes to complete.**

All responses are anonymous ad will be stored in line with the Data Protection Policy at the Royal College of Psychiatrists. This survey does not require you to submit any personal or identifiable information.

General information

Please enter the information requested in the boxes provided

1. Please enter your role * ☐

2. What is the main area in which you work? *

- ☐ Crisis/urgent and emergency care
- ☐ Community mental health services
- ☐ Inpatient mental health services
- ☐ Management and leadership
- ☐ Primary care
- ☐ Other

3. Who is your employer? *

- ☐ Health and social care partnership
- ☐ NHS
- ☐ Local Authority
- ☐ National Organisation
- ☐ Voluntary & Community Social Enterprise ('third sector') organisation
- ☐ Other

4. What area of Scotland do you work in * ☐

Access

Questions in this section are about standards relating to ACCESS to care and treatment.

5. In your opinion, how important are standards that relate to ACCESS to secondary mental health care and treatment? *

	1	2	3	4	5
1 = not very important, 5 = highly important	○	○	○	○	○

6. Which of the following areas do you think could make the **most difference/have most impact** if translated into an appropriate standard about ACCESS? *

Please select ONE option

○ Access to services ('no wrong door')
○ Waiting time for treatment
○ Assessment and care planning
○ Flexibility to deliver in different parts of the country

7. Would you like to add anything to expand on your selection about the area you think would have the most impact as a standard?

(Optional) ☐

8. Which of the following would be the **most challenging** to implement as a standard? *

Please select ONE option

○ Access to services ('no wrong door')
○ Waiting time for treatment
○ Assessment and care planning
○ Flexibility to deliver in different parts of the country

9. Would you like to add anything to expand on your selection about which area would be the most challenging to implement as a standard?

(Optional) ☐

Experience

Questions in this section are about standards relating to people's EXPERIENCE of secondary mental

10. In your opinion, how important are standards that relate to people's EXPERIENCE of secondary mental health services? *

	1	2	3	4	5
1 = not very important, 5 = highly important	○	○	○	○	○

11. Which of the following areas do you think could make the **most difference/have most impact** if translated into an appropriate standard about patient EXPERIENCE? *

Please select ONE option

○ Information-sharing across the system
○ Person-centred, rights-based care
○ Minimising unwanted variation in care
○ Transitions and continuity of care

12. Would you like to add anything to expand on your selection about the area you think would have the most impact as a standard?

(Optional)

13. Which of the following would be the **most challenging** to implement as a standard? *

Please select ONE option

○ Information-sharing across the system
○ Person-centred, rights-based care
○ Minimising unwanted variation in care
○ Transitions and continuity of care

14. Would you like to add anything to expand on your selection about which area would be the most challenging to implement as a standard?

(Optional)

Outcomes

Questions in this section are about standards relating to treatment OUTCOMES.

15. In your opinion, how important are standards that relate to people's OUTCOMES of mental health care and treatment? *

	1	2	3	4	5
1 = not very important, 5 = highly important	○	○	○	○	○

16. Which of the following areas do you think could make the **most difference/have most impact** if translated into an appropriate standard about patient OUTCOMES? *

Please select ONE option

○ Ensuring collected outcomes are aligned with evidence-based care

○ Address inequality in treatment outcomes (e.g., among the most disadvantaged communities)

○ Ensuring that there are outcomes that reflect person-centred patient experiences

17. Would you like to add anything to expand on your selection about the area you think would have the most impact as a standard?

(Optional) ☐

18. Which of the following would be the **most challenging** to implement as a standard? *

Please select ONE option

○ Ensuring collected outcomes are aligned with evidence-based care

○ Address inequality in treatment outcomes (e.g., among the most disadvantaged communities)

○ Ensuring that there are outcomes that reflect person-centred patient experiences

19. Would you like to add anything to expand on your selection about which area would be the most challenging to implement as a standard?

(Optional) ☐

Workforce

Questions in this section are about the WORKFORCE and include questions regarding both resource

20. How much do you agree with the following statement: *'Secondary mental health care services in Scotland are sufficiently resourced to meet local population needs'* *

1 = not very important
2 = disagree
3 = neither agree or disagree
4 = agree
5 = strongly agree

1	2	3	4	5
○	○	○	○	○

21. Would you like to add anything to expand on your selection above?

(Optional)

22. How much do you agree with the following statement: *'Staff working in secondary mental health care services are provided with good opportunities for training and development'* *

1 = strongly disagree
2 = disagree
3 = neither agree or disagree
4 = agree
5 = strongly agree

1	2	3	4	5
○	○	○	○	○

23. Would you like to add anything to expand on your selection above?

(Optional)

24. How much do you agree with the following statement: *'Staff working in secondary mental health care services are provided with regular supervision and management'* *

1 = strongly disagree
2 = disagree
3 = neither agree or disagree
4 = agree
5 = strongly agree

1	2	3	4	5
○	○	○	○	○

25. Would you like to add anything to expand on your selection above?

(Optional)

26. How much do you agree with the following statement: *'Staff working in secondary mental health care services are adequately resourced and trained to provide appropriate, high quality support to people with a range of differing and complex needs'* *

1 = strongly disagree
2 = disagree
3 = neither agree or disagree
4 = agree
5 = strongly agree

1	2	3	4	5
○	○	○	○	○

27. Would you like to add anything to expand on your selection above?

(Optional)

28. How important is staff wellbeing in the delivery of high quality care? *

	1	2	3	4	5
1 = not very important, 5 = highly important	○	○	○	○	○

29. Would you like to add anything to expand on your selection above?

(Optional)

Barriers and challenges

Questions in this section are about the perceived barriers and challenges associated with the provision of high-quality secondary mental health care in Scotland.

30. In your opinion, which of the following ACCESS issues poses the **biggest barrier/challenge** that needs to be overcome to improve the overall quality of mental health care? *

Please select ONE option

○ Awareness of available services
○ Geographical variation (rural vs urban, transport issues etc.)
○ Difficulty navigating service structures to get help
○ Availability of appropriate services
○ Waiting times
○ Socio-demographic factors (e.g., ethnicity, sexuality, disability, gender, socioeconomic status)
○ Other

31. Would you like to add anything to expand on your selection above?

(Optional)

32. In your opinion, which of the following EXPERIENCE issues poses the **biggest barrier/challenge** that needs to be overcome to improve the overall quality of mental health care? *

Please select ONE option

○ Regional variation in quality of care ('postcode lottery')
○ Meaningful inclusion of patients (and relatives/carers) in care decisions
○ Availability of information sharing across systems
○ Other

33. Would you like to add anything to expand on your selection above?

(Optional) ______________________________

34. In your opinion, which of the following OUTCOMES issues poses the **biggest barrier/challenge** that needs to be overcome to improve the overall quality of mental health care? *

Please select ONE option

○ Inequality in treatment outcomes (recovery, improvement, drop-out)
○ Provision of evidence-based care
○ Outcomes monitoring (including data collection)
○ Other

35. Would you like to add anything to expand on your selection above?

(Optional) ______________________________

36. In your opinion, which of the following WORKFORCE issues poses the **biggest barrier/challenge** that needs to be overcome to improve the overall quality of mental health care? *

Please select ONE option

○ Understaffing/lack of resource
○ Staff training needs and skills development opportunities
○ Staff retention and turnover
○ Poor staff morale and wellbeing
○ Other

37. Would you like to add anything to expand on your selection above?

(Optional)

38. Are there any other relevant or important issues that have not been captured above that you would like to raise?

(Optional)

Appendix 4: Graphical presentation of the survey results

Participant background

Figure 1: Role of participant (count)

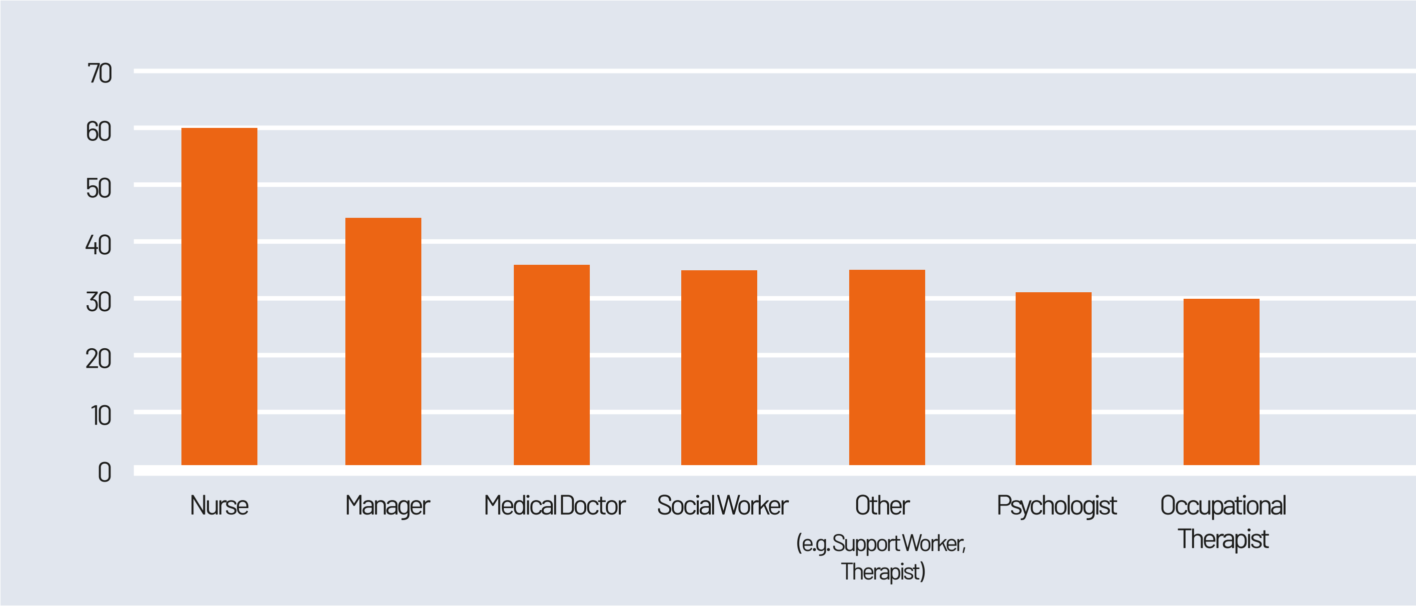


Figure 2: Area of work (count)

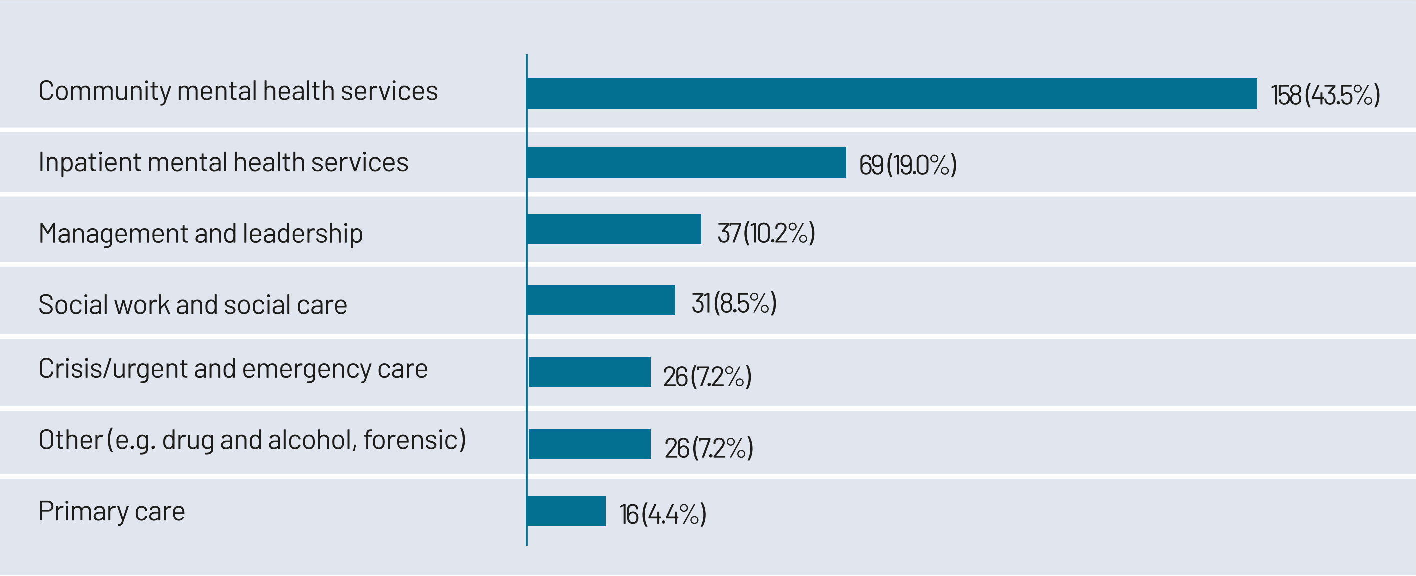
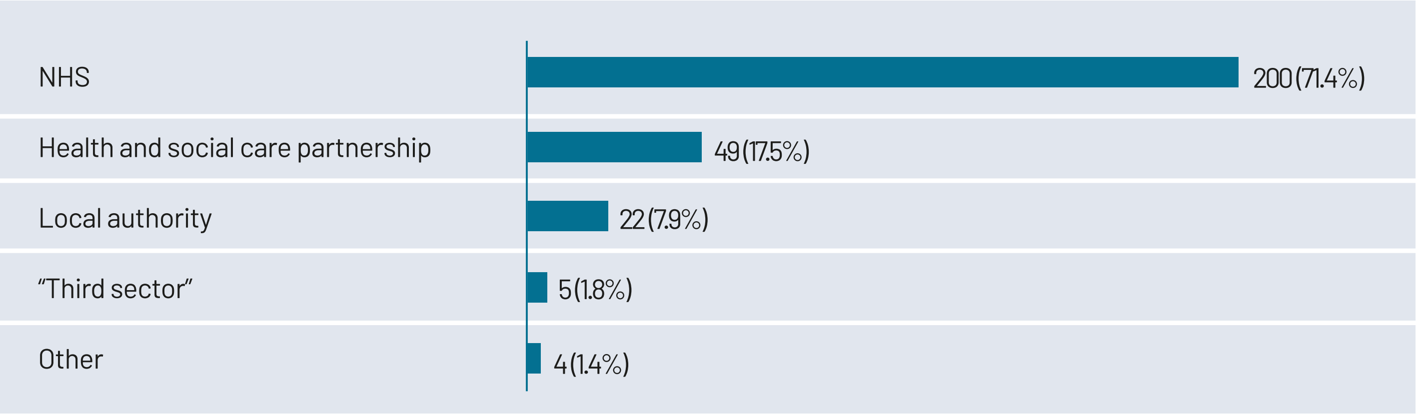
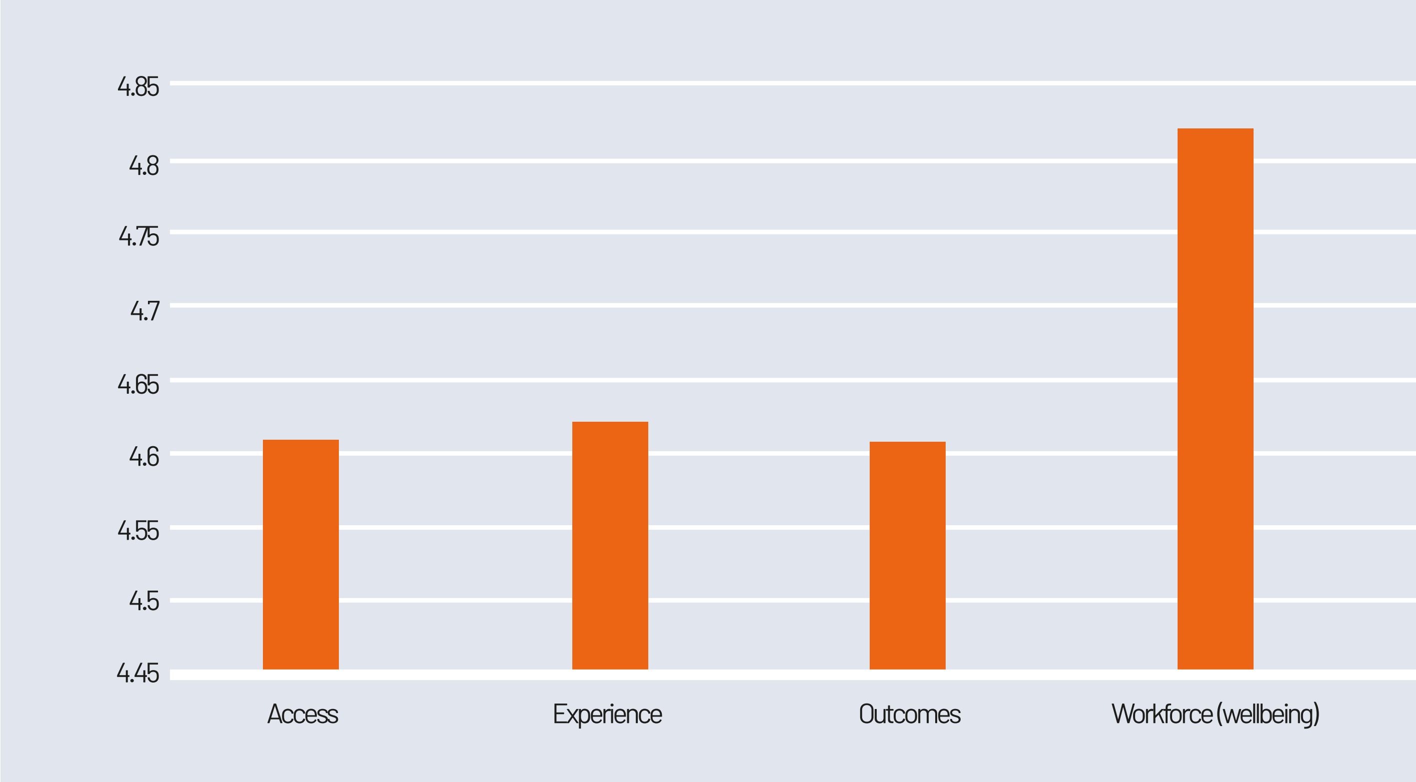


Figure 3: **Employer of participant (count)**



Focus domains

Figure 4: **Rated level of importance of standards under the four focus domains (1 = not very important, 5 = highly important)** [b]



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[b] Under 'Workforce (wellbeing)' in Figure 4, only data of the specific staff wellbeing, but not the broad workforce domain, were collected.

Access

Figure 5: **Standards under 'access' rated as likely to be having the most impact (%)**

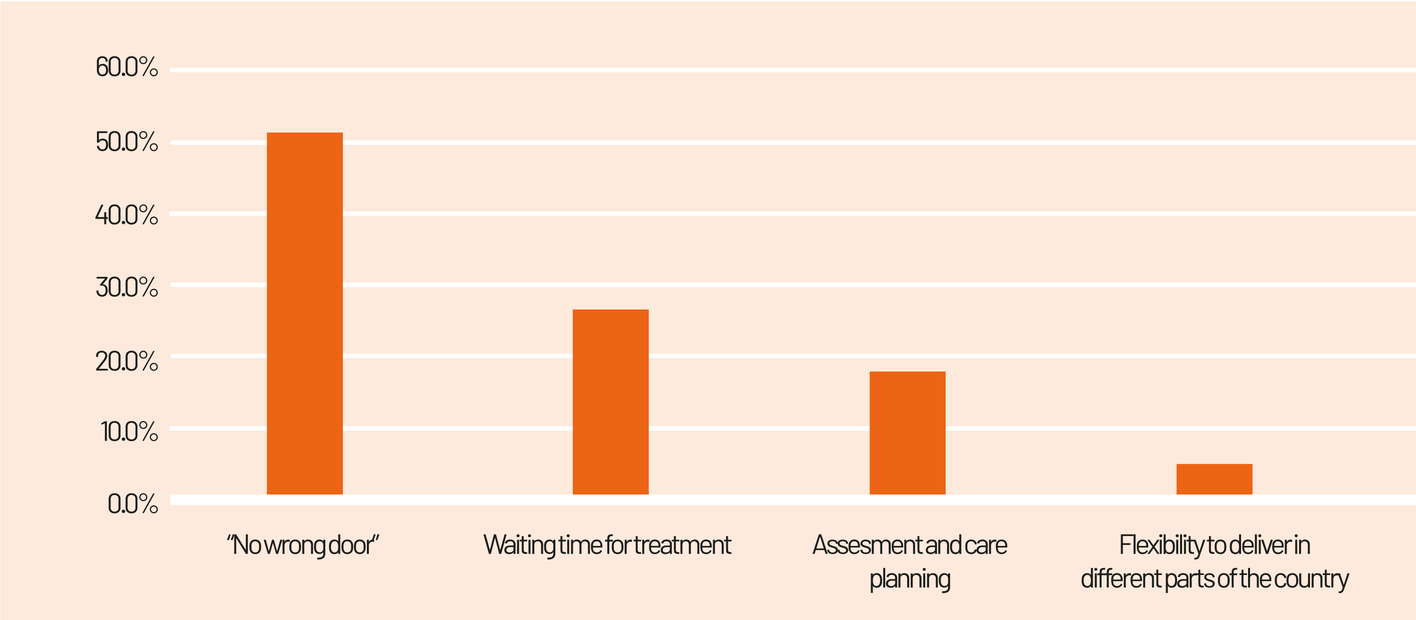


Figure 6: **Standards under 'access' rated as likely to be the most challenging to implement (%)**

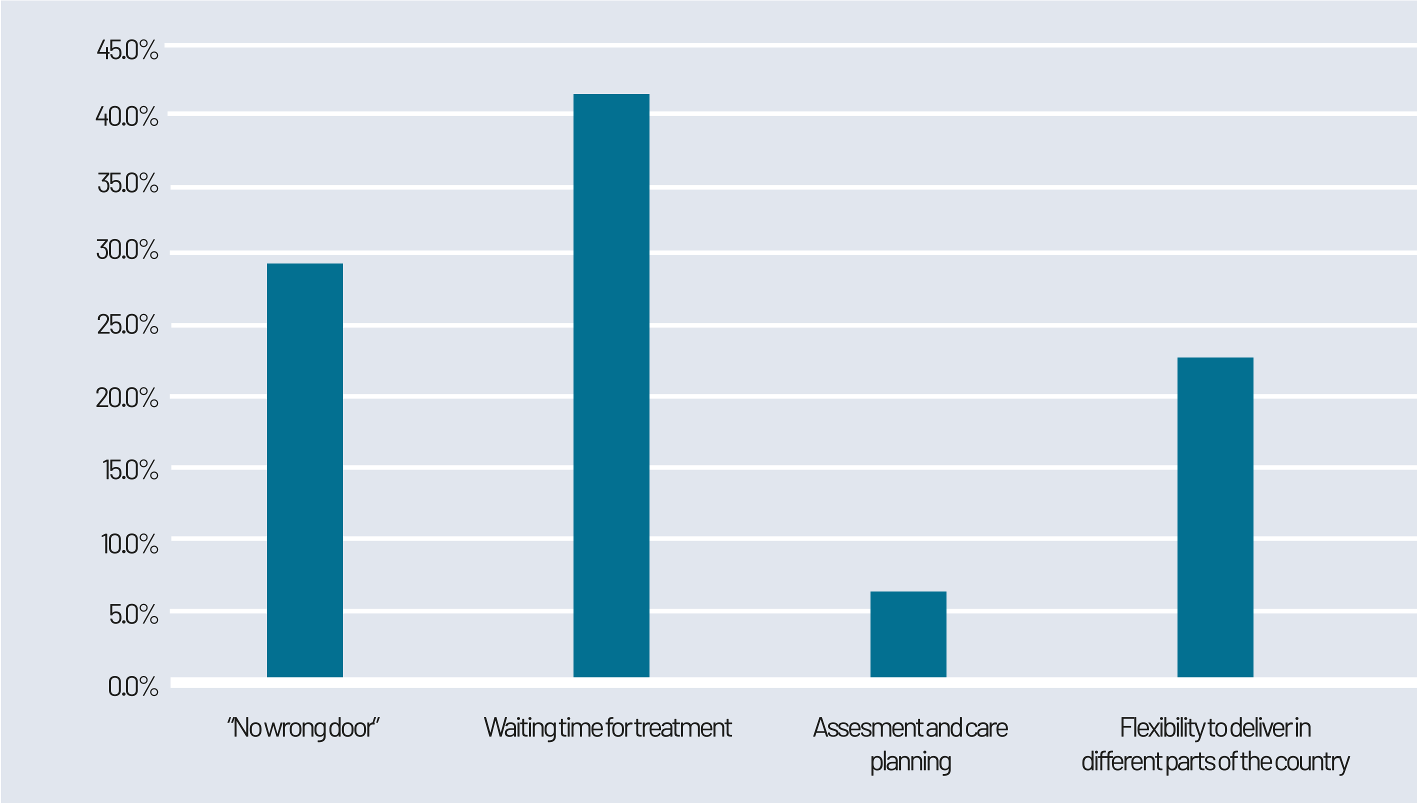
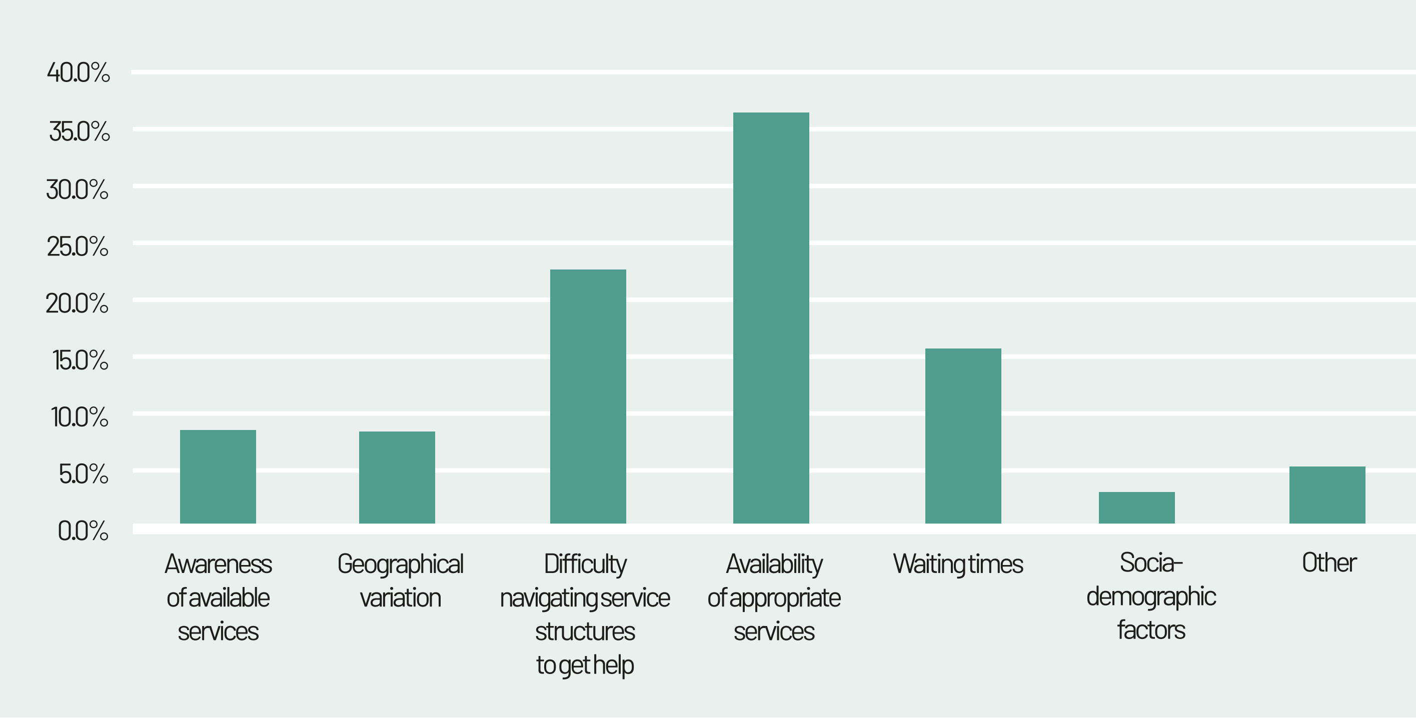


Figure 7: **Biggest access barrier that needs to be overcome to improve overall quality of care (%)**



Outcomes

Figure 8: **Standards under 'outcomes' rated as likely to be having the most impact (%)**

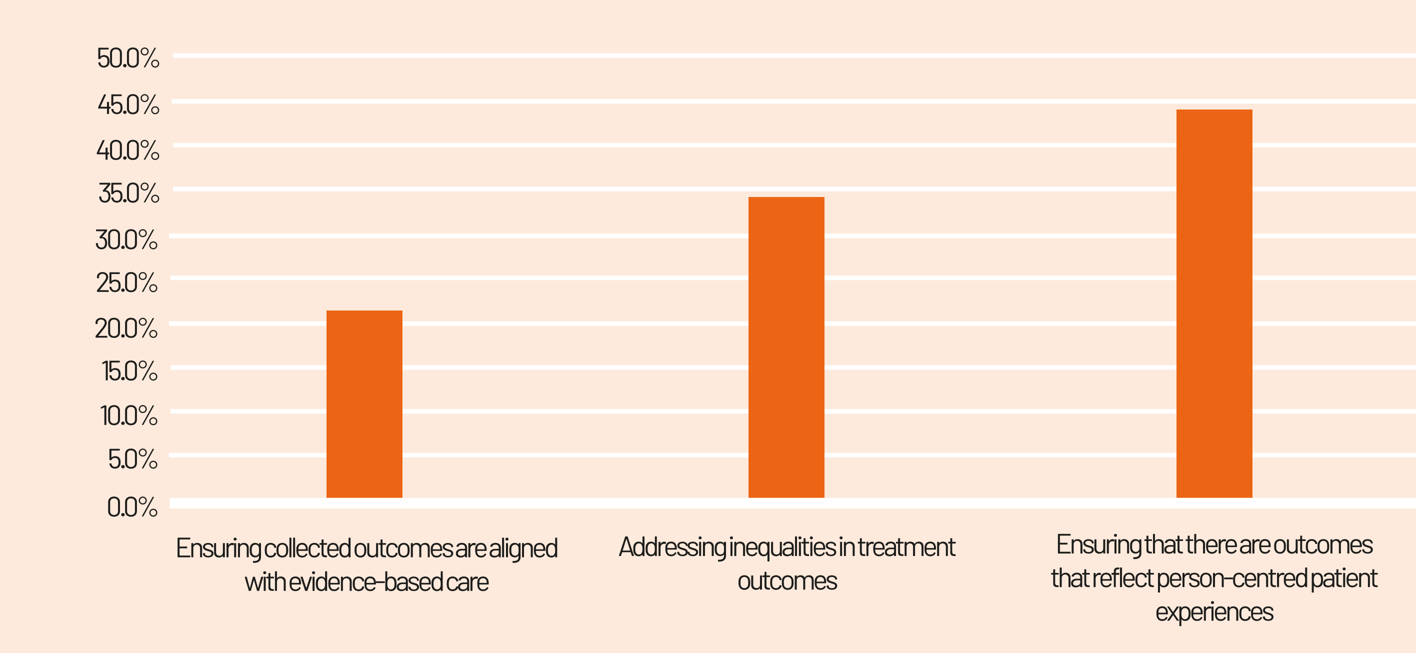


Figure 9: **Standards under 'outcomes' rated as likely to be the most challenging to implement (%)**

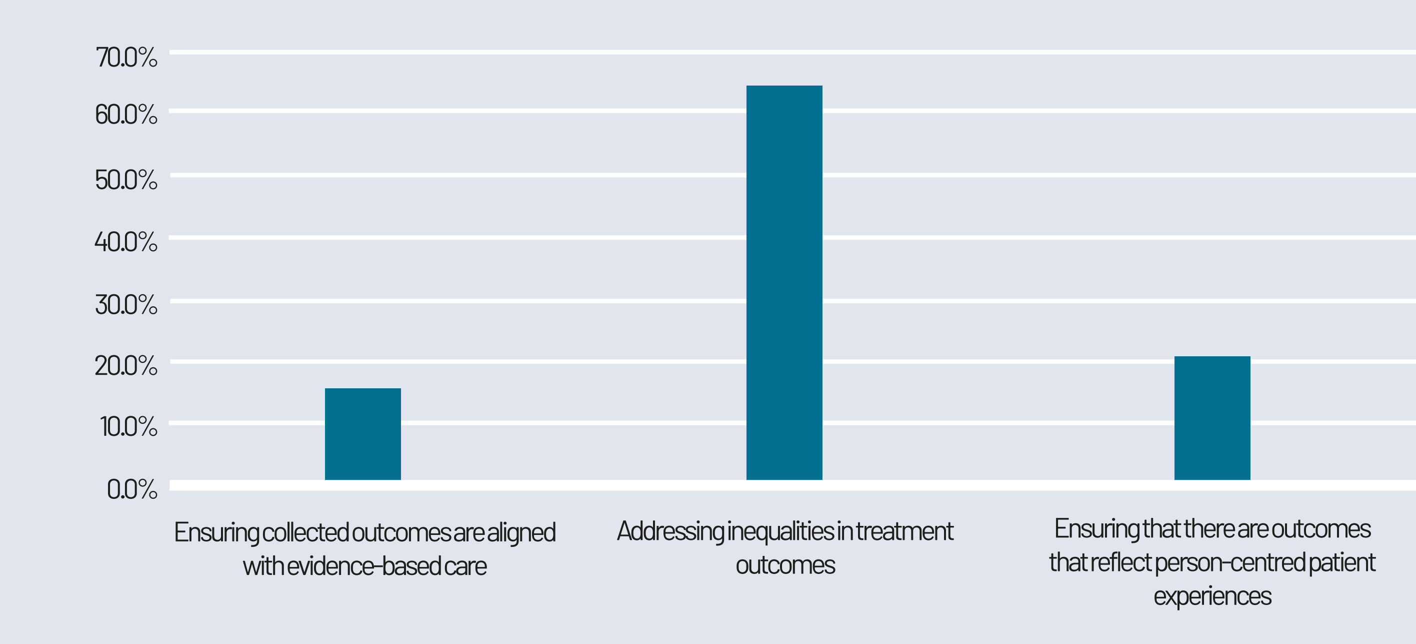
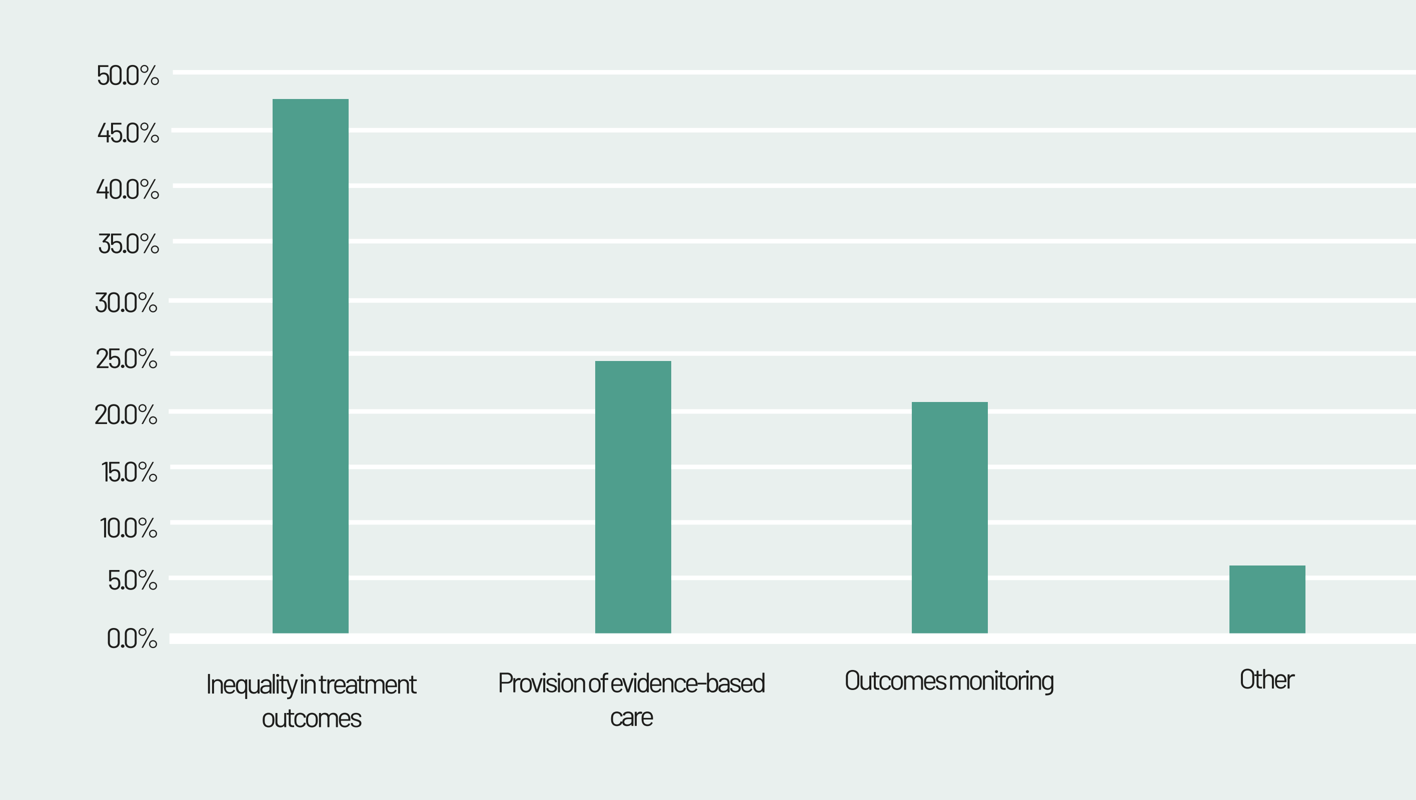


Figure 10: **Standards under 'outcomes' rated as likely to be having the most impact (%)**



Experience

Figure 11: **Standards under 'experience' rated as likely to be having the most impact (%)**

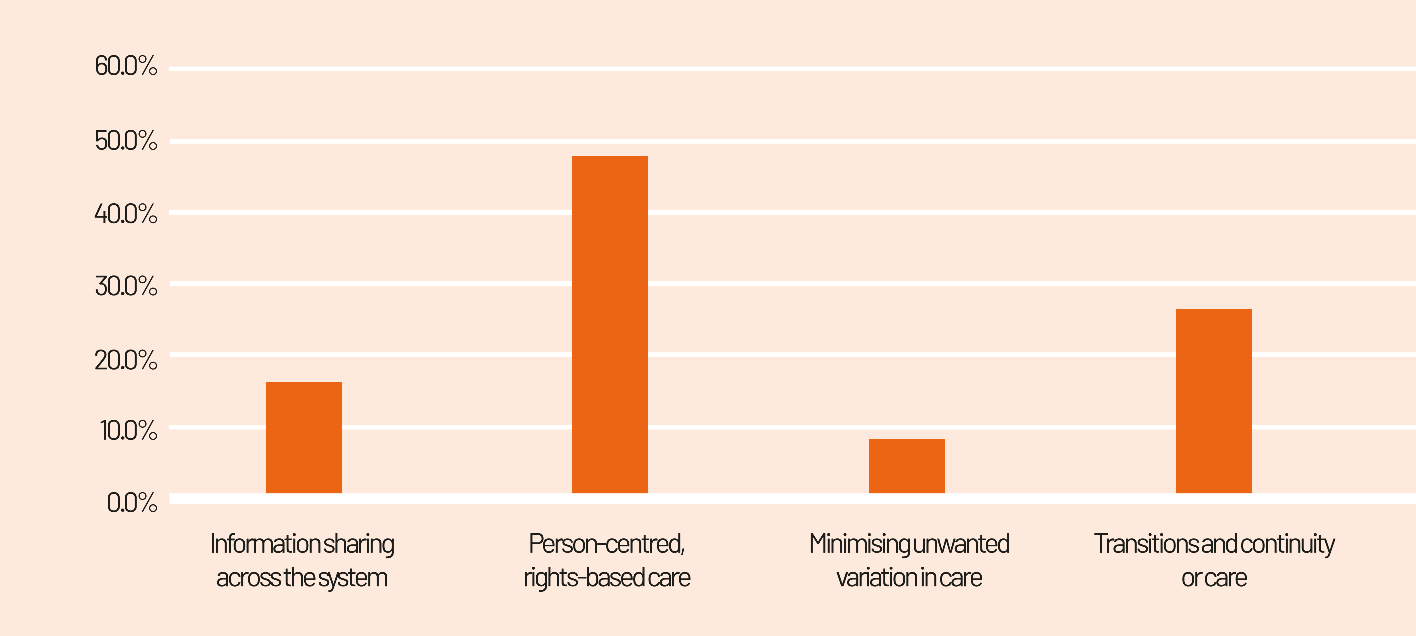


Figure 12: **Standards under 'experience' rated as likely to be the most challenging to implement (%)**

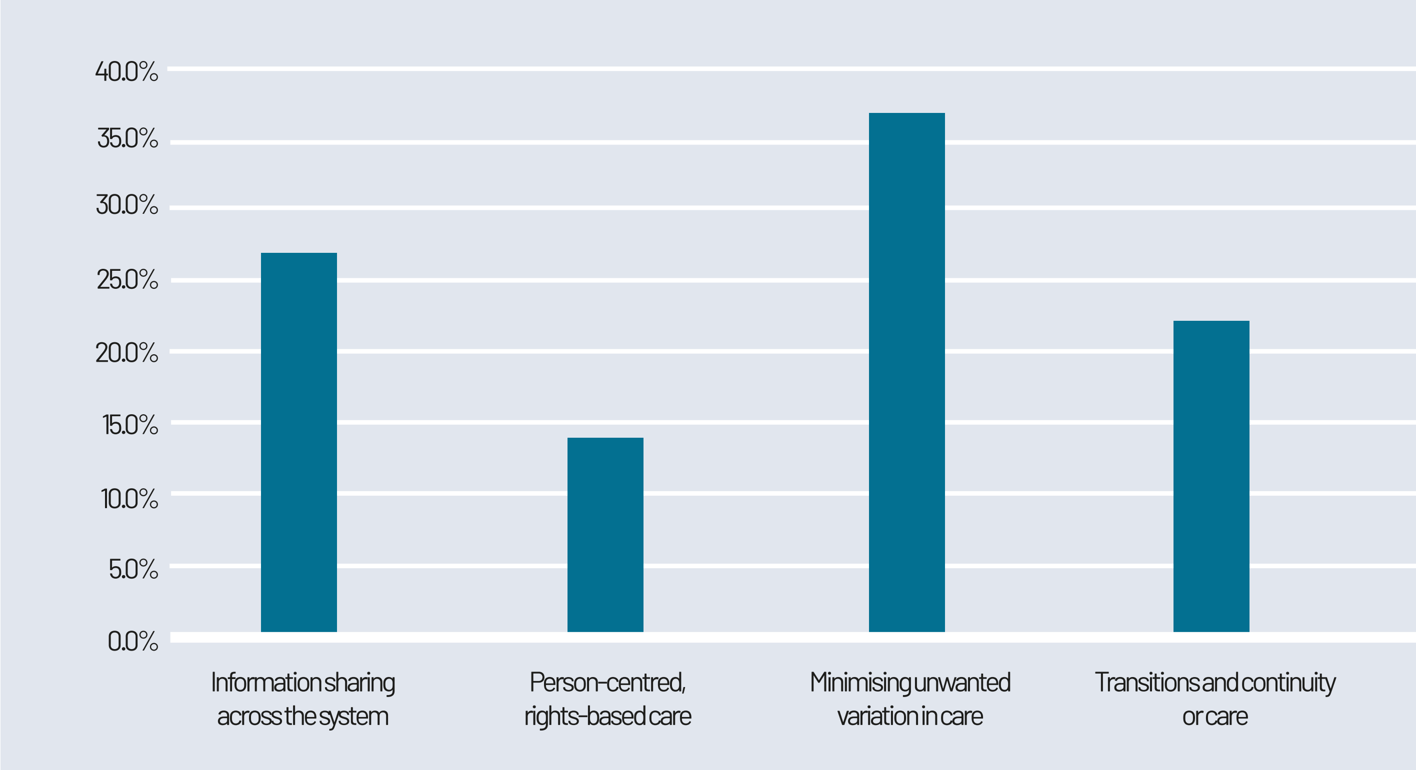
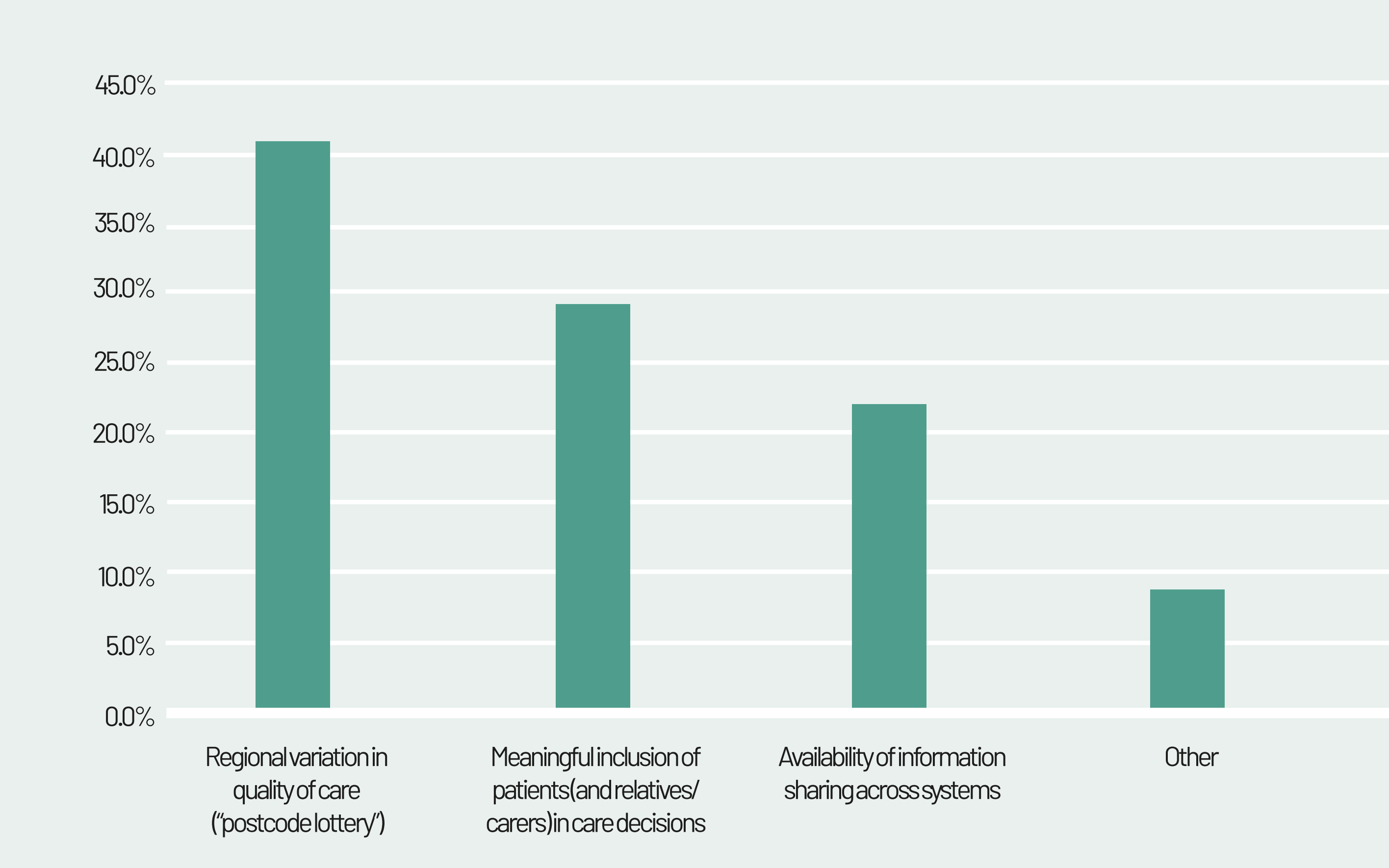


Figure 13: **Biggest 'experience' barrier that needs to be overcome to improve overall quality of care (%)**



Workforce

Figure 14: **Rated attitudes towards current workforce issues (1 = strongly disagree, 5 = strongly agree)**

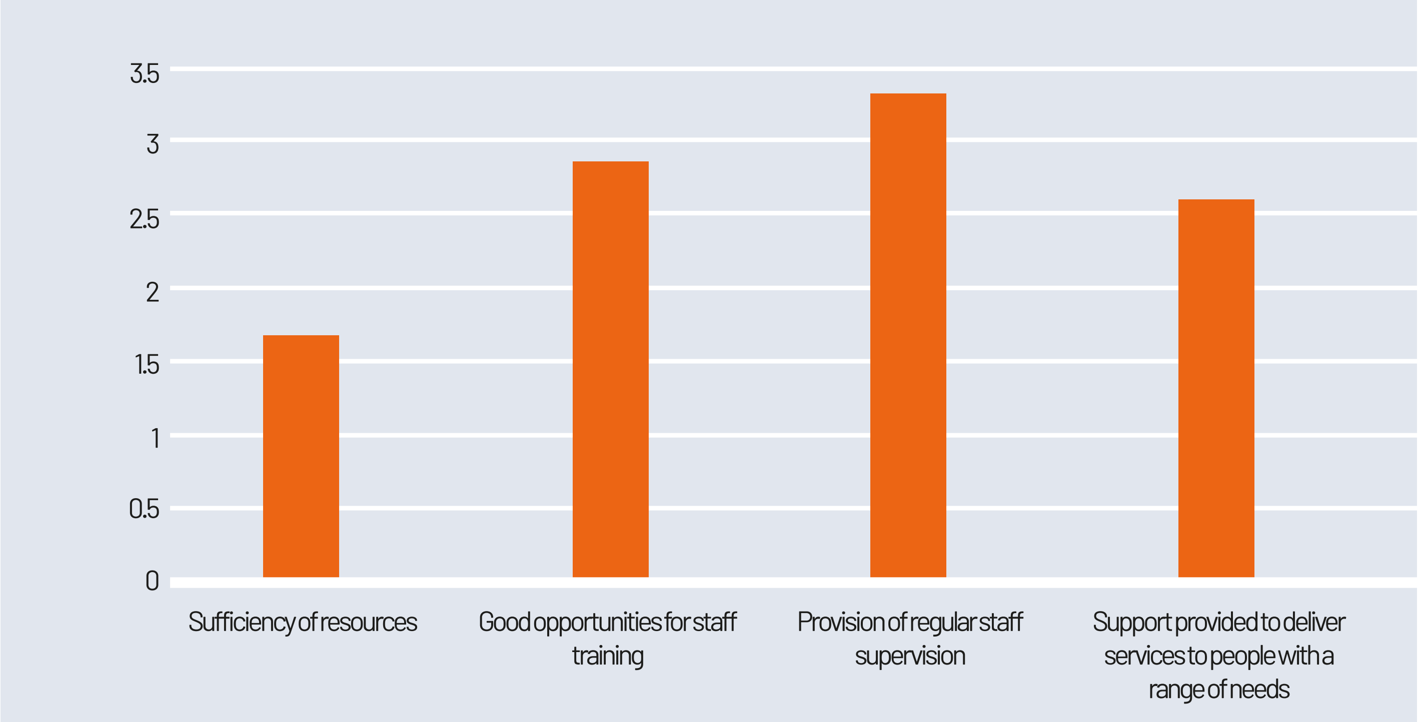
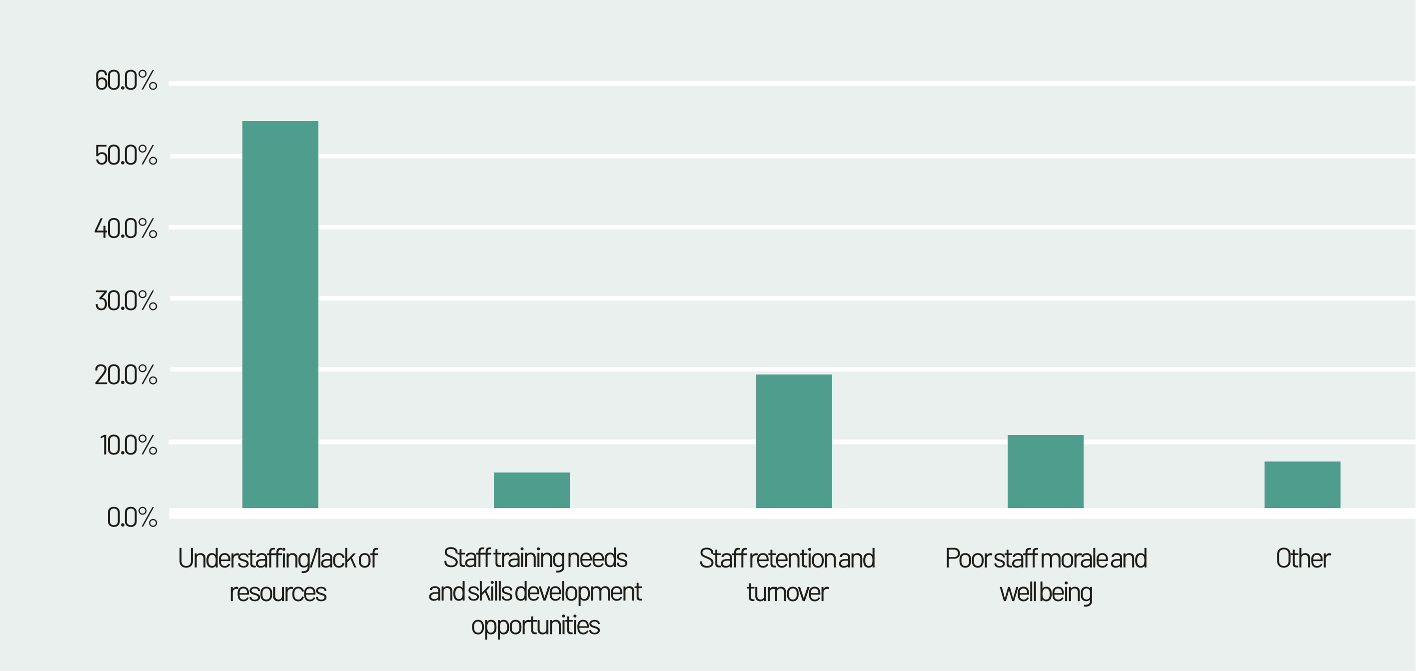


Figure 15: **Biggest workforce barrier that needs to be overcome to improve overall quality of care (%)**



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