Item No: 13

Meeting Date: **Wednesday 27th September 2023**

Glasgow City Integration Joint Board

Report By: **Jacqueline Kerr, Assistant Chief Officer, Adult Services / Interim Chief Social Work Officer**

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A Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde 2023 – 2028

Purpose of Report:	To update Glasgow City IJB on the Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde 2023 – 2028.

Background/Engagement:	The Health Board's Moving Forward Together: Greater Glasgow and Clyde's vision for health and social care document set the blueprint for the future delivery of Health and Social Care Services in NHSGGC. This remains in line with Scottish Government national and West of Scotland regional strategies and requirements and the projected needs of the GGC population. Strategies for Mental Health Services in Greater Glasgow and Clyde are also aligned to the Scottish Government's Mental Health Strategy and the NHSGGC 'Healthy Minds' report. The Strategy Refresh: • Widens the scope of the strategy document, reconfirms a joint approach and strengthens the links with strategies covering the whole complex of local mental health services. • Reflects changes in context and policy drivers and identifies changed or new recommendations in response. In particular, includes recognition of and response to the impact of the Covid-19 Pandemic both in terms of those needing, and the staff and services delivering, mental health care and support.

	• Continues the aims in the strategy to shift the balance of mental health care through a model that proposes an enhanced community mental health service provision.

Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☐ Council Corporate Management Team ☐ Health Board Corporate Management Team ☒ Council Committee ☐ Update requested by IJB ☐ Other ☒ • NHSGGC Health Board • NHSGGC Moving Forward Together Programme Board • HSCP Chief Officers Group • NHSGGC Mental Health Strategy Programme Board

Recommendations:	The Integration Joint Board is asked to: a) Note progress made against the Mental Health Strategy 2018 - 2023 outlined in the proposed strategy refresh; and b) Approve the Refresh of the Strategy for Mental Health Services in Greater Glasgow and Clyde 2023-2028.

Relevance to Integration Joint Board Strategic Plan:

A Mental Health Services Reference Group was established as part of the engagement approach and aspects / elements of the existing and draft refresh of the mental health strategy are reflected in the IJB Strategic Plan 2023 – 2026. The refreshed Strategy supports and contributes the strategic priority of the IJB to provide patients and service users with appropriate supports and services to assist them wherever possible to remain living within their own communities.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome(s):	The Refresh is relevant to all national health and wellbeing outcomes and, in relation to its primary aim to shift the balance of care, particularly to Outcome 2; “People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.”

Personnel:	The Strategy includes the intention to develop certain areas of service provision that will require personnel considerations and the requirement for targeted and specific training for staff groups to deliver the strategy. Staff engagement currently includes Area Partnership Forum membership on the Mental Health Strategy Programme Board and sub groups / workstreams. Staff engagement on specific issues will take place as detail emerges. The relevant HR policies and procedures will apply on implementation.

Carers:	The Strategy Refresh seeks to improve co-production, including and involving Carers.

Provider Organisations:	The Strategy Refresh seeks to further develop relationships with commissioned providers integral to pathways such as unscheduled care, which includes the Glasgow City Compassionate Response Distress Service (GAMH).

Equalities:	Mental Health is not experienced equally across the population, with higher risk of poor mental health in specific groups. These inequalities are driven by the wider determinants of mental health. In addition to social determinants, the strategy recognises the need to focus on inequalities including people with protected characteristics in developing equalities sensitive services matching care to need. Programmes of work will be developed to address mental health wellbeing within such communities and groups. The existing strategy was Equalities Impact Assessed and this applies to the Refresh. There is commitment to developing / updating Equalities Impact Assessment for proposals as part of ongoing implementation (e.g. Mental Health Assessment Units).

Fairer Scotland Compliance:	Ensuring compliance with the Fairer Scotland duty will be relevant when considering options for the rationalisation of the mental health bed estate and site impact.

Financial:	The Strategy refresh recognises the current environment. The associated financial framework proposes a phased approach to delivery.

	Decisions will be taken on a system wide approach. As part of developing future implementation thinking, consideration will include what elements of cross funding between adult and older people's services might support implementation of the Strategy as a whole. This approach will target developments initially to those community services which will derive the greatest benefit with equity of investment by the end point. This is essential to secure the wider ambition of this programme.

Legal:	None

Economic Impact:	None

Sustainability:	The Strategy Refresh supports the shift in the balance of care within available resources. Over the next two decades however, expanded and recurring funding for public mental health, wellbeing promotion and early intervention will be needed to more effectively create the infrastructure that prevents or reduces the need for downstream psychiatric service responses in secondary mental health care.

Sustainable Procurement and Article 19:	None

Risk Implications:	For implementation, mitigation of risk will initially focus on where there is existing / spare capacity.

Implications for Glasgow City Council:	None

Implications for NHS Greater Glasgow & Clyde:	Strategic planning for Mental Health Services continues to progress as a component of the Health Board's Moving Forward Together (MFT) programme.

Direction Required to Council, Health Board or Both.	
Direction to:	
1. No Direction Required	☒
2. Glasgow City Council	☐
3. NHS Greater Glasgow & Clyde	☐
4. Glasgow City Council and NHS Greater Glasgow & Clyde	☐

1. Purpose

1.1. To update and seek approval from Glasgow City IJB for the Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde 2023 – 2028.

2. Background

2.1. The Health Board's Moving Forward Together: Greater Glasgow and Clyde's (GGC) vision for health and social care document set the blueprint for the future delivery of Health and Social Care Services in GGC. This remains in line with Scottish Government national and West of Scotland regional strategies and requirements and the projected needs of the GGC population. Strategies for Mental Health Services in Greater Glasgow and Clyde are also aligned to the Scottish Government's Mental Health Strategy and the NHSGGC 'Healthy Minds' report.

2.2. The existing Mental Health Strategy proposes a system of stepped/matched care, allowing for progression through different levels of care, with people entering at the right level of intensity of treatment. The aims of the strategy include:

- Integration across services to provide a condition-based care approach.
- Shifting the balance of care further into the community.

2.3. A community based model will be more cost effective and deliver services earlier, better meeting the needs of the patients in the community as people access more care through and wholly within those community-based services.

3. Mental Health Strategy Refresh

3.1. The Strategy Refresh:

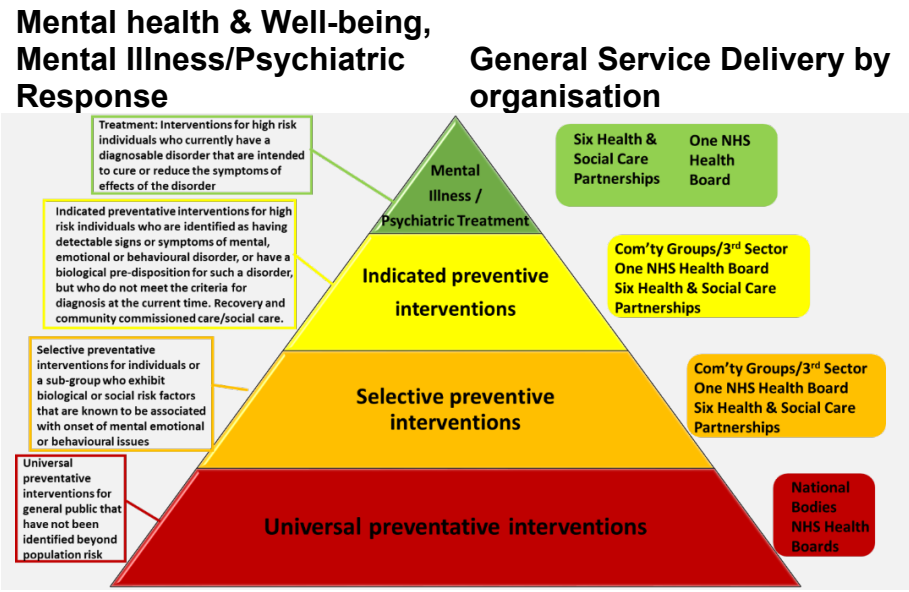
- Widens the scope of the existing strategy and establishes a joint approach to, or strengthens the relationship with, strategies covering the whole complex of mental health services in NHSGGC.
- Describes progress against the recommendations in the existing strategy and other areas. This includes creation of a regional CAMHS Intensive Psychiatric Care Unit (Adolescent IPCU) adjacent to the existing Adolescent inpatient facilities, Skye House located on the Stobhill site in NHSGGC.
- Reflects changes in context and policy drivers and identifies changed or new recommendations in response. In particular, includes recognition of and response to the significant impact of the Covid-19 Pandemic both in terms of those needing, and the staff and services delivering, mental health care and support.

3.2. The vision for the Strategy Refresh includes community focus on:

- Delivering Prevention and Early Intervention; including Mental Wellbeing and Suicide Prevention training for all staff, expanding computerised Cognitive Behavioural Therapy (cCBT) services and supporting wellbeing in primary care
- Expanding the development of Recovery Peer Support Workers in community teams and inpatient settings

- Improving the effectiveness of community services; developing group based Psychological Therapies and Patient Initiated Follow Up. PIFU gives patients control over follow up appointments allowing them to be seen quickly when they need to be, such as when symptoms or circumstances change, and avoiding the inconvenience of appointments of low clinical value
- Developing Unscheduled Care; commissioning non-clinical response services for situational distress; developing community mental health acute care services offering treatment as an alternative to hospital admission; and Mental Health Assessment Units diverting people with Mental Health problems who do not require physical / medical treatment from Emergency Departments
- Supporting faster discharge to the community; integrating health and social care to ensure joint prioritisation of resources; community services that support rehabilitation and recovery from complex mental health problems nearer to the home and in the least restrictive setting.

3.3. The service model (below) increases the level of psychiatric care delivered in the community. The Strategy refresh recognises that transitional finance is a challenge requiring alternative approach to support further community development. Longer term planning for wellbeing and early intervention will be needed to more effectively create the infrastructure that prevents or reduces the need for downstream psychiatric service responses in secondary mental health care.



4. Recommendations

4.1. The Integration Joint Board is asked to:

a) Note progress made against the existing Mental Health Strategy 2018 – 2023, outlined in the proposed Strategy Refresh; and
b) Approve the Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde 2023 – 2028.

A Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde: 2023 – 2028

25 05 2023

Document Version Control

Date	Author	Rationale
04/05/23	V McGarry	To CMT 04/05/23
12/05/23	V McGarry	Bed numbers updated - Child Psychiatry / Totals
17/05/23	V McGarry	Perinatal section – progress updated, service description moved to supplement
25/05/2023	D Harley	Narrative site number correction
03/08/2023	V McGarry	Recommendations numbering update

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1. Introduction: context, drivers and principles for change

1.1. Scope of this Strategy refresh

This strategy refresh updates on the NHSGGC five year adult mental health strategy 2018-2023 and expands on its scope to take account of the range of services relevant to the wider complex of mental health services and the continuing impact of COVID-19 as services go about restoring and refreshing the focus on Strategy changes, initially for the next 5 years.

The Strategy refresh approach to implementation will include:

- No wrong door, so any appropriate referral for secondary specialist mental health care will not be sent back to Primary Care with a suggestion of an appropriate response but discussed and progressed between secondary specialist services
- More people with lived and living experience, along with families and carers, will be involved in everything for co-production
- Prevention will be better explained as addressing wellbeing
- A focus on inequalities including people with protected characteristics and those affected by the socio-economic determinants of poor health.
- Improved access for Mental Health and situational crisis
- Commitment to more established points of access & clear referral pathways
- Self-management resources for people with long term mental health issues, that are accessible and do not exclude access to services where appropriate
- Workforce Strategy

COVID-19 Pandemic

The Scottish Government notes in its COVID-19 strategic framework February 2022 update[1] that "The past two years have tested the resilience of everyone in Scotland. There will have been very few of us who did not, at some stage, feel a strain on our mental health. It is crucial to understand that the mental health impacts of such a traumatic time will continue to emerge and evolve. The longer-term mental health effects will continue to be felt by many of us, across various levels of need. This will include mental ill-health in some cases." This sentiment also applies to the staff, who are to be thanked in demonstrating their commitment in the face of pressure and supporting patients. This strategy review and refresh recognises and responds to the significant impact of the COVID-19 Pandemic both in terms of those needing, and the staff and services delivering, mental health care and support at a time when demand for acute inpatient services is so high.

There are both positive and negative legacies of COVID-19 that will persist for a long time. Specific learning from the pandemic in areas such as Mental Health Assessment Units, digital developments, physical estate and infection control, will inform what we do.

The 2018 Adult Mental Health Strategy identified a range of principles on which service Strategies and implementation plans were based. The primary aims of increasing community based responses and increasing access to services remain relevant to and are inclusive of the whole complex of mental health services:

[1] Coronavirus (COVID-19): Scotland's Strategic Framework update - February 2022

1. **Integration and collaboration**
   A whole-system collegiate approach to Mental Health across Health and Social Care Partnerships (HSCPs) and the NHS Greater Glasgow and Clyde (NHSGGC) Board area, recognising the importance of interfaces and joint working with Primary Care, Acute services, Public Health, Health Improvement, Social Care and third sector provision.

2. **Prevention**
   Services should maintain a focus on prevention, early intervention and harm reduction as well as conventional forms of care and treatment.

3. **Choice and voice**
   Providing greater self-determination, participation and choice through meaningful service user, carer and staff engagement and involvement in the design and delivery of services. Staff wellbeing at work is recognised to be an important part of the provision of quality patient care.

4. **High quality, evidence-based care**
   Identification and equitable delivery of condition pathways, based on the provision of evidence-based and cost-effective forms of treatment.

5. **Data Analysis**
   Routine data collection and analysis is used to improve service quality, productivity and strategy implementation.

6. **Matching care to needs**
   - A model of stepped/matched care responding to routine clinical outcome measurement and using lower-intensity interventions whenever appropriate: “all the care they need, but no more”.
   - A focus on minimising duration of service contact consistent with effective care, while ensuring prompt access for all who need it – the principle of “easy in, easy out”.
   - Shifting the balance of care from hospital to community services where appropriate.
   - Equalities sensitive services

7. **Compassionate, recovery-oriented care**
   - Attention to trauma and adversity where that influences the presentation and response to treatment.
   - Recognition of the importance of recovery-based approaches, including peer support and investment in user and carer experience that generates community and social impact.

Existing strategies covering the complex of mental health services continue to be jointly progressed by the six Health and Social Care Partnerships (HSCPs) within Greater Glasgow and Clyde, in partnership with NHS Greater Glasgow & Clyde (NHSGGC). All remain committed to the need to take a whole-system approach to the strategic planning of Mental Health Services, particularly given the interdependence and connectivity across HSCPs in relation to Mental Health services. The refresh should be read in conjunction with the current individual mental health strategies and proposals.

The production of strategies recognised the beginning of the change and improvement process and were open to further modification as necessary as implementation plans to support delivery of the proposed recommendations developed. The implementation plan will be supported by a further revision of workforce, financial and risk management frameworks designed to reflect the dynamic nature of the proposed changes, with careful checks and balances at each major phase of implementation. The impact of COVID-19 on people’s individual and collective needs also continues to evolve and there remains therefore a commitment to engage further with key stakeholders to shape evolving plans.

1.2. Summary of the Proposed Service Changes and Improvements

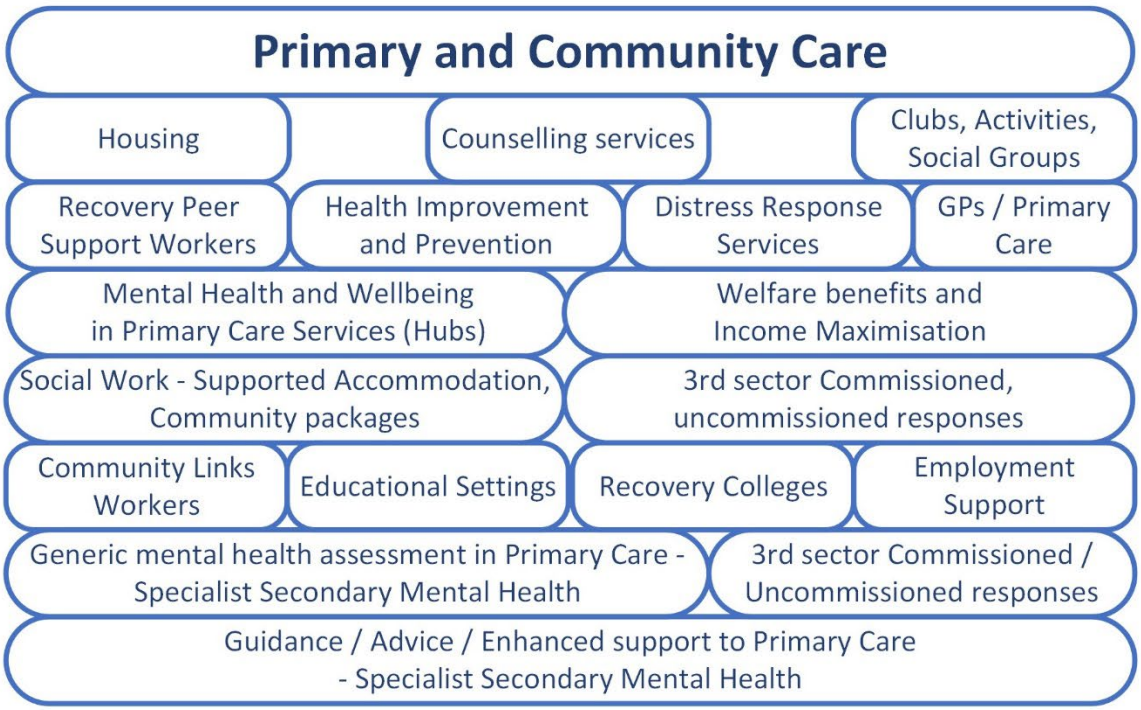
What causes mental health issues is very complex. It is important to understand that just because we may not know exactly what causes someone to experience a mental health issue or distress, this doesn't mean it is any less serious than any other health issue, any less deserving of recognition and treatment or any easier from which to recover. Mental Health issues and distress can have a wide range of causes. It is likely that for many people there is a complicated mix of factors and different people may be more or less deeply affected by certain things than others. Factors that could contribute to a period of poor mental health or distress can include:-

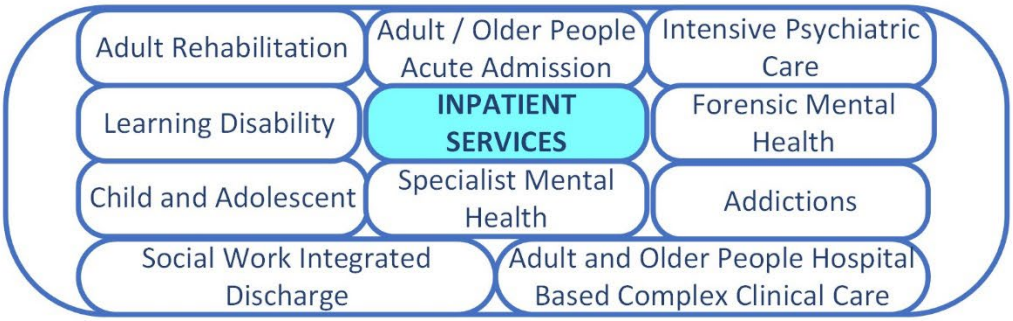
- Childhood abuse, trauma or neglect;
- Social isolation or loneliness;
- Experiencing discrimination and stigma including racism;
- Social disadvantage, poverty or debt;
- Bereavement;
- Severe or long term stress;
- Having a long term physical health problem;
- Unemployment or losing your job;
- Homelessness or poor housing;
- Being a long-term carer for someone
- Drug & alcohol misuse;
- Domestic violence, bullying or other abuse as an adult;
- Significant trauma as an adult;
- Physical causes e.g. head injury and / or neurological condition
- Neurodevelopmental vulnerabilities, especially those previously unrecognised

There are separate and specific strategies for organised health and social care service responses for each of the NHSGGC wide mental health complex of services (Health Promotion & Prevention; Child and Adolescent Psychiatry [CAMHS]; adult mental health; older people's mental health; alcohol and drug recovery; Learning Disability and also Forensic mental health).

The recommendations described later in each section of this refresh will require implementation through multiple delivery work streams or other related strategies as appropriate to how they are interrelated or interdependent, such as those that contribute to the response to, or reduction of, Adverse Childhood Experiences.

The delivery of service responses are many and varied as illustrated by the following:





All services set out the issues and recommended actions necessary to deliver their aims. Particular, but not exclusive, attention was drawn to the following service changes proposed:

1.2.1. Prevention, Early Intervention and Health Improvement.

A range of organised mental health service responses can all contribute to their own versions of prevention, early intervention and health improvement and do this in very different ways.

This refresh makes more of a distinction between services that promote people's mental health and prevent people's mental distress and illness from services that are organised to respond to people's mental illness when they are referred to secondary care mental health services in the community and in inpatient wards. The relevant services will:

- Up-scale Mental Health training and support for all non-mental health and mental health staff in Partnerships and related services including; trauma informed, ACE-aware (Adverse Childhood Experience), one good adult, Mental Health first aid.
- Support community planning partners to develop and implement strategies to address adverse childhood experiences and child poverty within their area.
- Work with multiple partners to build awareness of practical steps to promoting mental wellbeing and challenging stigma and discrimination with a priority focus on groups with higher risk, marginalised groups and people with protected characteristics.

1.2.2. Physical Health

- On-going application of the Physical Healthcare and Mental Health Policy approach for people not in mental distress.
- On-going application of the Physical Healthcare and Mental Health Policy approach for people in mental distress who don't need contact with specialist mental health services.
- On-going application of the Physical Healthcare and Mental Health Policy for people in contact with specialist mental health services.
- Improve assessment and referral pathways to ensure that people with a serious mental illness have their physical health monitored and managed effectively with no barriers to service access.
- Continuing the commitment within Mental Health Services to a programme of training and development for mental health staff to ensure that the delivery of physical healthcare meets current standards.

1.2.3. Recovery Orientated and Trauma-aware services

- Collaboration with people with lived and living experience of mental health distress and / or of mental health illness
- Work with partners to pilot the introduction of Recovery Colleges in the Board area
- Develop and implement models of Peer Support Workers in the community

1.2.4. Community and Specialist Teams

- A focus on maximising efficiency and effectiveness of our Community Mental Health Teams (CMHTs) with standardised initial assessment, Patient Initiated Follow up Pathway (PIFU), Clinical risk reference panel development, peer support in CMHTs to reduce inpatient care, consider new roles, and refresh clinical outcomes measures.
- Implementation of Esteem review outcomes.
- Development proposals for child, adolescent and adult eating disorders.
- Trauma informed clinical practice training.
- The introduction of a matched care approach to the provision of care and treatment for Borderline Personality Disorder.

1.2.5. Primary Care

- To assess post pandemic the implications of the new GP contract, particularly around the potential for additional service and support options for people before needing to be referred to secondary specialist mental health community and inpatient services.
- Work to manage and support those with long term physical conditions should be expanded and prioritised. There should be a focus on effective communication of physical and mental health condition management requirements being shared between clinicians in both Primary Care / GP settings and also specialty secondary care mental health services in the community and in hospital.

1.2.6. Social Care

- An even more integrated management of supported accommodation (or equivalent) and care home placements with 'health' bed management to optimise "flow" in and out of integrated Health and Social Care beds/accommodation/places.
- Consider commissioning 'step-down' intermediate care provision to maximise the opportunity to support people to live as independently as possible in community settings.
- Review specialist and mainstream care home commissioning needs, including to support people over 65 years of age potentially suitable for discharge as part of the re-provision programme
- Additional alcohol and drug recovery rehabilitation and harm reduction

1.2.7. Child and Adolescent Psychiatry

- Fuller implementation of the Child and Adolescent Mental Health Services (CAMHS) community specification, including supporting expansion of community CAMHS from age 18 up to 25 years old for targeted groups and those who wish it
- Additional transition planning to adult services and follow-up
- Implementation of the 2021 National Neurodevelopmental Specification for Children and Young People: Principles and Standards of Care
- Community waiting list initiatives

1.2.8. Perinatal Mother and Baby

- Increased investment in staffing for Mother and Baby inpatient services
- Review reimbursement support for families of Mother and Baby Unit (MBU) patients for transport, meals, accommodation
- Ongoing development of the new infant health service – Wee minds matter

1.2.9. Infant Mental Health

- Ongoing development and evaluation of infant mental health service – the wee minds matter team

1.2.10. Learning Disability

- Implement 'coming home', particularly focusing on developing plans to return people from where they are living out of area where this is appropriate for them
- Reduce reliance on bed-based models and support people who are at risk of admission, particularly where clinical need is not the primary reason.

- Provide a forum for multiple partner providers to explore and deliver on a range of alternative and innovative response support models for those individuals with complex needs

1.2.11. Community Services: Non-statutory Services

- Expand contact with non-statutory services for implementation plans and identifying priorities

1.2.12. Unscheduled Care

- Liaison / Out of Hours (OOH): provision of a single Adult Mental Health Liaison service across Greater Glasgow and Clyde, providing one point of access for referrals for each Acute Hospital, with defined response and accessibility criteria for departments.
- Crisis Resolution and Home Treatment / OOH: provide a consistent model of crisis resolution and home treatment across the NHS Board area available for community care and home treatment as an alternative to hospital admission
- OOH: streamline communications for all Unscheduled Care arising OOH including consideration of offering guidance to referrers, directing calls to local Community Mental Health Acute Care Teams (CMHACS) (or CMHTs and other daytime services)

1.2.13. Older People's Mental Health

- Focusing on early intervention to reduce admission to in-patient beds
- Continued investment and focus on Care Home Liaison Services to support Care Homes to maintain residents in their Care home environment
- Expanding access to psychological interventions, including non-pharmacological interventions for the management of ''stress and distress'' in dementia.
- Engaging with commissioning to further develop care settings in the community for care options for Older People with mental health issues as their condition progresses in terms of both individual care packages and residential care.
- A focus on reducing delays in discharge

1.2.14. Forensic Psychiatry Mental Health

- Focusing on maintaining safe and effective management of risk
- Continued investment in rehabilitation, repatriation of out of area placements and maintaining the flow of patients through levels of security and general mental health services

1.2.15. Shifting the Balance of Care / Bed Site Impact

- Collective approach for the complex of mental health services on site impact of end point inpatient investment and bed reductions
- Framework for collective engagement process
- Progress initial phase of bed reductions
- Reinvestment of mental health resources in community expansion

2. Strategic Context - Shifting the Balance of Care

2.1. Moving forward Together Transformational Plan and Clinical Services Review

The NHS GG&C extensive Moving Forward Together Transformational Plan, Clinical Services Review (CSR) and the Scottish Government's national vision of core principles set the main drivers for change.

2.2. Integration of Health and Social Care

The integration of Health and Social Care services under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014[2] has enabled Health and Social Care Partnerships (HSCPs) to re-examine how services are delivered to our services users to strive for improved outcomes through delivering and commissioning care in a more integrated, co-ordinated and efficient way. The specific actions for achieving this, along with achieving the statutory National Health and Wellbeing Outcomes, are set out in the respective Integration Joint Board Strategic Plans of HSCPs. In addition to the Service Improvements set out in the CSR, the 5 year strategy will build current developments and good practice delivered by HSCPs.

2.3. Mental Health Recovery and Renewal

The Mental Health Recovery and Renewal plan (MHRR) for Scotland forms part of the NHS Scotland recovery plan 2021-2026[3] which sets out key ambitions and actions to be developed and delivered now and over the next 5 years in order to address the backlog in care and meet ongoing healthcare needs for people across Scotland. The Plan commits to ensuring that at least 10% of frontline health spending will be dedicated to mental health with at least 1% directed specifically to services for children and young people by the end of this parliamentary session. The Plan contains over 100 actions, which focus on four key levels of need:

- Promoting and supporting the conditions for good mental health and wellbeing at population level.
- Providing accessible signposting to help, advise and support.
- Providing a rapid and easily accessible response to those in distress.
- Ensuring safe, effective treatment and care of people living with mental illness.

2.4. National Care Service

The National Care Service (Scotland) Bill[4] was introduced to the Scottish Parliament on 21.06.22. The bill sets out the principles for the National Care Service (NCS). Its stated aim is to ensure that everyone can consistently access community health, social care, and social work services, regardless of where they live in Scotland. Subject to parliamentary approval, there is provision for a power to transfer accountability for a range of services, including adult social care and social work services, to Scottish ministers from local government.

The development of the National Care Service will remain a key area.

[2] Public Bodies (Joint Working) (Scotland) 2014
[3] NHS Recovery Plan 2021-2026
[4] National Care Service (Scotland) Bill

2.5. Perinatal and Infant Mental health

The Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services (Mar 2019)[5] draws on the findings of the Perinatal Mental Health Network's NHS board visits, professionals' workshops and online survey of women's views, conducted in 2017-18, and the existing evidence base on service provision, to make recommendations on what services Scotland should develop to meet the needs of mothers with mental ill health, their infants, partners and families.

The report makes recommendations across all tiers of service delivery, with the aim of ensuring that Scotland has the best services for women with, or at risk of, mental ill health in pregnancy or the postnatal period, their infants, partners and families.

2.6. Child and Adolescent Mental Health

The Child and Adolescent Mental Health Services: national service specification[6] was launched in 2020 and sets outs a set of standards for CAMHS.

The Sottish Government also published the National Neurodevelopmental Specification[7] which identifies seven standards for services to support children and young people who have neurodevelopmental profiles with support.

2.7. Learning Disability

The Keys to Life: Implementation framework and priorities 2019-2021[8] are guided by four rights-based strategic outcomes which are closely aligned to the strategic ambitions in Scotland's disability delivery plan, A Fairer Scotland for Disabled People.

The 'Designing an Effective Assessment and Treatment Model, NHS Greater Glasgow and Clyde, 2018' report details engagement with people with learning disabilities and those who support them in exploring what was needed to be done next.

"We believe that people with learning disabilities should be given the right support so that they can live fulfilling lives in the community. This support should always be person centred, preventative, flexible and responsive. People should only be admitted to inpatient assessment and treatment services when there is a clear clinical need which will benefit from hospital based therapeutic intervention. Challenging behaviour, with no identified clinical need, is not an appropriate reason to admit people to inpatient assessment and treatment services"

NHSGGC has been heavily involved in the shaping of national policy, in particular;
Coming home: complex care needs and out of area placements 2018[9] highlights that some people with learning disabilities and complex needs are living far from home or within NHS hospitals; there is an urgent need to address this issue. This report is the first time that a collective and comprehensive overview has been made available in Scotland on both the characteristics and

[5] Perinatal Mental Health Network Needs Assessment Report 2019
[6] Child And Adolescent Mental Health Services: national service specification
[7] Children and young people - National neurodevelopmental specification: principles and standards of care
[8] Keys to life: implementation framework and priorities 2019-2021
[9] Coming home: complex care needs out area placements report 2018

circumstances of people with complex needs who are placed into care settings that are distant to their families and communities, or who remain in hospital settings beyond the clinical need of them to be there.

Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge Feb 2022[10] builds on the earlier 2018 report. The goal is to provide high-quality, local, community-based services where, regardless of complexity of need or behavioural challenge, people's right to live a full and purposeful life, free of unnecessary restrictions can be realised. The report includes a recommendation (subsequently supported by the Scottish Government) for a Community Living Change Fund[11] to drive the redesign of services for people with learning disabilities and complex care needs.

A number of reviews associated with the mental health act are also likely to have an impact on Learning Disability services.

2.8. Older People's Mental Health

The National dementia strategy: 2017-2020[12] builds on progress over the last decade in transforming services and improving outcomes for people affected by dementia and emphasised the vision of a Scotland where people with dementia and those who care for them have access to timely, skilled and well-coordinated support from diagnosis to end of life which helps achieve the outcomes that matter to them.

2.9. Alcohol and Drugs Recovery Services

Scottish Government strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths is described in the document 'Rights, respect and recovery: alcohol and drug treatment strategy'[13]. This highlights commitments to achieve outcomes in the following four key areas, delivering evidence based interventions through a public health approach:

- Prevention and early intervention
- Developing recovery oriented systems of care
- Getting it right for children, young people and families
- A Public Health approach to justice.

The Alcohol Framework 2018[14] retains three central themes, which are well accepted and understood:

- Reducing consumption
- Positive attitudes, positive choices
- Supporting families and communities

This document sets out the national prevention aims on alcohol: the activities that will reduce consumption and minimise alcohol-related harm arising in the first place.

[10] Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge
[11] Community Change Fund - Coming Home Implementation
[12] National dementia strategy: 2017-2020
[13] Rights, respect and recovery: alcohol and drug treatment strategy
[14] Alcohol Framework 2018

The national focus on preventing drug related deaths increased in 2019 with the establishment of the Drugs Deaths Taskforce (DDTF). It aims to improve health by preventing and reducing drug use, harm and related deaths. There are 6 priorities:

- Targeted distribution of naloxone
- Implement an immediate response pathway for non-fatal overdose
- Optimise the use of medication-assisted treatment (MAT)
- Target the people most at risk
- Optimise public health surveillance
- Ensure equivalence of support for people in the criminal justice system.

The national Drugs Mission was then launched by the Scottish Government in January 2021, including additional funding, focusing on:

- Whole family support
- Development of lived experience panels and community networks
- Residential rehabilitation

The national mission places significant responsibilities on ADPs to deliver on the Medication Assisted Treatment Standards and substance use treatment target to increase the numbers of people in treatment for opiate use.

The DDTF published the 'Medication Assisted Treatment (MAT) standards: access, choice, support'[15] in May 2021. The document lists 10 standards with 63 criteria aimed to enable 'the consistent delivery of safe, accessible, high quality drug treatment across Scotland'. The standards aim to put people at the center of their care and how it is delivered. They were developed following extensive consultation with multiagency partners delivering care, with individuals, families and communities with experience of problematic drug use. The 10 standards are:

1. Same Day Access - All people accessing services have the option to start MAT from the same day of presentation
2. Choice - All people are supported to make an informed choice on what medication to use for MAT and the appropriate dose.
3. Assertive Outreach an Anticipatory Care - All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT
4. Harm Reduction - All people are offered evidence-based harm reduction at the point of MAT delivery.
5. Retention - All people will receive support to remain in treatment for as long as requested.
6. Psychological Support - The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks.
7. Primary Care - All people have the option of MAT shared with Primary Care.
8. Independent Advocacy and Social Support - All people have access to independent advocacy and support for housing, welfare and income needs.
9. Mental Health - All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.
10. Trauma Informed Care - All people receive trauma informed care.

The Glasgow City ADRS Senior Management Team commissioned an independent review of Glasgow ADRS in Jan January 2021. This focused on the following key areas:

- Resource and capacity
- Workforce and development

[15] Medication Assisted Treatment (MAT) standards: access, choice, support

- Performance and governance
- MAT standards implementation
- Residential rehab.

2.10. Digital / eHealth

NHSGGC Digital Health and Care Strategy focuses on recovery priorities and transformation opportunities within the theme of "Digital on Demand".

A changing nation: how Scotland will thrive in a digital world[16] goes beyond the adoption of the latest digital technology and focuses on the adoption of digital thinking, the way we lead organisations, and how we embrace the culture and processes of the digital age. It sets out the measures which will ensure that Scotland will fulfil its potential in a constantly evolving digital world.

2.11. Finance

The Scottish Government is committed to improving Mental Health, and as part of its evolving National Mental Health Strategy identified investment in Mental Health services, providing a commitment to ensure funding grows to 2027. The Scottish Government's Resource Spending Review (May 2022) highlights the challenging financial climate and the constraints which exist in delivering investment in public sector services during the rest of this parliament. As a result of this and exceptional inflationary pressures being experienced across the sector it will be challenging to deliver a real term increase in funding. As a result, significant financial challenges remain;

- The balance of resource within Mental Health Services is not presently optimally deployed.
- Transitional monies need to be sourced to enable change.
- While the aims of the strategy are to increase community based services and improve access to services, changes in inpatient bed numbers will also be necessary to enable community and inpatient budgets to keep pace with inflationary pressures whilst keeping Mental Health in balance.

The purpose is to achieve marked improvement in the quality of people's lives and to optimise the utilisation of resources across the GG&C system in support of the strategy.

Cost of living

The current cost of living crisis, inflationary pressures, impact upon people's bills, childcare, housing, travel, energy and fuel costs are some of the social, physical and economic conditions in society that impact upon mental health. Financial restrictions will also impact on services' ability to deliver. The actions arising from the strategy refresh will recognise and aim to ameliorate the impact of these.

[16] Digital Education and Skills - A changing nation: how Scotland will thrive in a digital world

3. Public Mental Health

The term Public Mental Health means taking a systematic approach to working towards the best mental health possible for the whole population. Forming a key element of strategy, public mental health efforts work at multiple levels and across multiple sectors including those out with the health sector to address determinants of poor mental health as people's susceptibility to mental health problems can be influenced by settings and in turn by broader socioeconomic, cultural and political factors. Higher level recommendations are provided below with more specific recommendations indicated in the Prevention, Early Intervention and Health Improvement section as per the extant strategy.

3.1. Recommendations

Frameworks for action - The key elements of a public mental health approach are summarised both for adults and children and young people in separate evidence based strategic frameworks.

1. Review these existing frameworks, in the context of post-pandemic impacts and to ensure alignment with the new Scottish Government Mental Health Strategy (due Summer 2023) to ensure they are still fit for purpose.

Population Health

2. Use the results from the NHSGGC Health & Wellbeing, other surveys, and develop an ongoing programme of data analysis to support monitoring of changes within the population, understanding of needs and effective targeting of interventions.
3. Advocate for support or action to address where identified needs are not being met.
4. Review existing frameworks to ensure alignment with local and national strategies and ensuring they are still fit for purpose.

Inequalities - Mental health is not experienced equally across the population, with higher risk of poor mental health in specific groups. These inequalities are driven by the wider determinants of mental health. Groups who experience stigma and discrimination are also more likely to experience poor mental health. The pandemic has had a disproportionately negative impact on those who already had higher risk of poor mental health.

5. Programmes of work will be developed to address mental well-being within such communities and groups.

Finding the right help at the right time - Finding and accessing the right support at the right time is imperative to supporting good mental health and early or acute intervention when needed.

6. Explore how people seek support for mental health and undertake an options appraisal to determine how to improve navigation of supports
7. Review and refine online resources and supports to ensure they are fit for purpose, easy to use and accessible.

Partnership Working - Many of the opportunities and mechanisms for action and change sit out-with the direct control of the NHS or HSCPs: e.g. in communities, Local Authorities and Third Sector.

8. Work through our partnerships to sustain and develop key interventions that promote connectedness, including volunteering, with community planning partners.

9. Work closely with Third Sector Organisations to support the use of the Communities Mental Health and Wellbeing Fund, supporting training, evaluation and other identified needs, to strengthen evidence of impact and expansion

3.2. Progress:

Scottish Government funding (2020/21 and 2021/22) was used by Partnerships to complement local provision to support those at risk of isolation, mental health recovery, bereavement and loss and suicide prevention activities and to develop innovative interventions and activities to address mental health stigma.

HSCPs have worked closely with Third Sector partners to rapidly use remobilisation funding and to support them in disbursing the Communities Mental Health and Wellbeing Fund from Scottish Government to complement local provision to address a range of impacts during the pandemic: e.g. loneliness and isolation, bereavement and suicide prevention.

We are working with national directory providers and Third Sector to work on joint solutions to support navigation.

'Aye Mind' – a digital resource for those working with young people has been updated and work is being developed to understand and mitigate online harms.

4. Prevention, Early Intervention & Health Improvement

4.1. Recommendations

1. Continue to work to improve the quality of care experienced by looked-after children and young people, for whom HSCPs have Corporate Parenting responsibilities.
2. Continue to improve processes that promote more integrated working across Adult Mental Health Services and Children and Family services.
3. Support community planning partners to develop and implement strategies to address child poverty within their area.
4. Significantly up-scale Mental Health training and support for all staff in Partnerships and related services (including trauma informed, ACE-aware, one good adult, mental health first aid).
5. Work with multiple partners to build awareness of practical steps to promoting Mental Wellbeing and challenging stigma and discrimination (linking to initiatives such as Walk a Mile, See Me and the Scottish Mental Health Arts Festival) – with a priority focus on groups with higher risk, marginalised and protected characteristics.
6. Work with community planning partners to extend the development of community-based initiatives that build social connection, tackle isolation and help build skills, confidence and productive engagement, with particular attention to marginalised groups.
7. Coordinate and extend current Partnership work for the prevention of suicide through joint training, risk management and acute distress responses, including with primary care.
8. Continue to support initiatives to promote physical exercise and active transport amongst Partnership staff as well as the general population
9. Access to 'distress' services delivered as part of the Unscheduled Care Review (see later chapter in this Strategy).
10. "Chronic" (long term, persistent) distress responses in collaboration with Primary Care for adults, relating to the Link worker role out and utilising social prescribing and allied methods. A programme to coordinate reduced exposure to ACEs, and to mitigate the effects of ACEs once they occur, for example by developing a 'Family Nurture' strategy in every Partnership with a community infrastructure of support. This should include relational and parenting support, especially for families with ACEs risks.
11. A new collaboration with Education and Social Care services to conduct and behavioural problems in primary-school age children.
12. A new collaboration with Criminal Justice services to develop and implement a Mental Health strategy for young people involved in the justice system, including early intervention access services.

Additional 2023 recommendation

13. Support community physical activity provision for the general population, given the significant contribution to supporting mental health, mental health recovery and maintenance of positive mental health and wellbeing.

4.2. Progress:

Each HSCP has first phase implementation plans in place for the national Children's and Young Persons Community Mental Health and Wellbeing Framework.

Healthy Minds training modules are accessed by approximately 1,000 people per annum.

Other mental wellbeing training, commissioned early 2020, has been delivered to over 4,000 staff across NHSGGC, HSCP's, Local Authorities and the Third Sector. This includes; looking after your wellbeing, supporting others, building resilience, healthy minds health awareness, Suicide Talk and Safe Talk.

Sessions have been developed & delivered, in addition to a one day skills and awareness course, supporting the network of educational psychologists trained as Trainers to deliver self-harm training to teaching and other staff.

- A Suicide Prevention Concordat was agreed December 2020 and provides for collaboration between NHSGGC, HSCPs, Community Planning Partnerships and other partners such as Police Scotland to enhance local suicide prevention action planning. Initiatives include: delivery of suicide prevention training across the Board area, despite pandemic-related challenges
- progress in developing a cluster response policy in conjunction with Public Health Scotland as a national development
- continued clinical liaison to track progress in suicide prevention and patient safety developments for clinical services
- Developing a focus on Youth and Young Adults
- Improving data and intelligence, including the "more timely data" initiative to ensure the availability of more current information.
- suicide-related bereavement support

Third Sector Interface organisations (TSIs) in each HSCP area were tasked to lead the dispersal of the Scottish Government Community Mental Health and Wellbeing Fund (2021/2022). Each HSCP supported the TSIs in developing their selection processes. Grants covered a wide range of areas including telephone befriending sessions, a community café with 'pay it forward', community growing and events to bring vulnerable and isolated residents together. These benefitted many people facing socio-economic disadvantage, diagnosed with mental illness, affected by psychological trauma, experiencing bereavement or loss and people with protected characteristics. Glasgow City alone awarded grants to 308 organisations and it is hoped the government will continue to provide this fund via the TSIs on an ongoing basis.

A children & young people's mental health subgroup of the Public Health Improvement Group (PHIG) has been established to bring together representatives specific to children and young people which can support prevention in this population. We have been active partners in the development and delivery of the annual Local Child Poverty Action Reports (LCPAR) in each of the 6 Local Authorities within GGC NHS. LCPAR's describe the actions taken to mitigate the impact of poverty in childhood, impacting on life chances and well-being. We have enabled significant programmes of delivery from the Children and Young People's Mental Health and Well-being (CYPMHW) investments within our six partnerships, enhancing earlier intervention services. We have built capacity in all 6 Local Authority education areas by ensuring there are Self harm trainers skilled up to deliver self-harm training within school communities.

5. Physical Health

5.1. Recommendations

1. The continued application of the measures set out within the Physical Healthcare Policy, including:
   - Systematic assessment of Mental and Physical Health and the Health Improvement needs of patients must be embedded in the provision of Inpatient and Community Mental Health Services and address issues appropriate to the individual's quality of life and well-being.
   - Once identified, Physical Health Care needs must be included within the individual's care plan and other health care records. Any action taken must also be recorded within the care plan and included in discharge or care transfer documentation.
2. Mental Health Services must work closely with patients, community based, Primary Care and Acute Care Services to improve assessment and referral pathways to ensure that people with a Severe Mental Illness (SMI) have their physical health monitored and managed effectively with no barriers to healthcare access.
3. Continuing the commitment within Mental Health Services to a programme of training and development for its staff to ensure that the delivery of physical healthcare meets current standards

5.2. Progress:

The Physical Healthcare Policy was updated and launched Sept 2019. A training post has been appointed to deliver a programme of training and development for staff to ensure that the delivery of physical health care meets current standards, that physical Health Care needs are being included within the individual's care plan and other health care records, that action taken is also recorded within the care plan and included in discharge or care transfer documentation.

6. Recovery-Oriented and Trauma-Aware Services

6.1. Recommendations

Strategies proposed increased collaboration with people with lived and living experience, local Mental Health and SRN taking a co-production approach to:

1. Work with partners to pilot the introduction of Recovery Colleges in the Board area.
2. Develop and implement a model of Peer Support Workers, and pilot for one to two years (This proposal will be considered as part of the financial framework for the implementation plan).
3. Provide Training/Awareness on Recovery Oriented Mental Health Services to staff, patients and carers.
4. Develop a Recovery Planning Tool to be piloted in the Peer Support test of change areas to promote realistic medicine approach for clinicians working in partnership with the patient.
5. Deliver a number of Recovery Conversation Café Events to build Recovery activities across our communities.
6. Promote a recovery ethos within all commissioned and directly provided services.

6.2. Progress:

Recovery Conversation Café Events (2019) were delivered and discussions included Peer Support models that promote the benefits of lived and living experience of mental health in service improvement and/or delivery.

Recovery Peer Support Workers were introduced into Adult CMHTs 2020 in six Community Mental Health Teams across three HSCPs. The aim of these workers, who have lived and living experience, was to;

- support staff to further understand the broader perspective of people with mental health issues
- support people being discharged from hospital
- help them reduce their contact with community mental health teams
- reduce hospital admissions and how long people might stay in the event of readmission

East Renfrewshire HSCP tested a commissioned recovery peer support model in Sept 2020, partnering with a 3rd sector organisation with experience of employing people with lived and living experience of mental health and recovery to support others. This model widens support to include those with Alcohol or Drug related issues as well from those recovering from Mental Health issues. Adding to a pre-existing workforce with those who intentionally bring their lived and living experience into their work was experienced as new and different by service users and helped people to feel a sense of trust and from there build towards and explore new recovery opportunities.

Peer support workers are also embedded in the service, where a recent evaluation has detailed the positive contribution this role provides services users.

East Renfrewshire have also trialled a Recovery College on a very small scale through a third sector partner, RAMH. The organisation was able to run another recovery college programme through funding secured from the Community Mental Health and Wellbeing Fund coordinated by the Third Sector Interface. Future work will include developing an NHSGGC-wide definition of, and meeting the key principles for, a Recovery College which reflect;

- being founded on co-production
- is inclusive
- operates on College principles
- is physical (and includes virtual elements where appropriate)

A benchmarking exercise was carried out in 2022, with the help of the Adult CMHTs, with a view to better understanding the range of recovery focused approaches in effect across NHSGGC, highlighting areas of good practice, and helping teams reflect on areas for improvement in recovery focused service provision.

A series of recommendations were also created as a reference for services to consider as part of any service development, ensuring that the recovery ethos is embedded as the golden thread that runs through all aspects of mental health service delivery.

7. Primary and Community Care (non-specialist mental health care)

7.1. Recommendations - Primary Care

The Primary Care environment extends to whole communities and the first port of call when experiencing mental health problems for people living in our communities can often be their GP.

1. To monitor, evaluate and share learning from the PCMH (Primary Care Mental Health) Fund demonstrator projects.
2. To engage and be influential in the process to implement the new GP contract in particular relating to possible additional Mental Health workers and to address use and alignment with this strategy, as part of Primary Care Improvement Plans.
3. To examine current GP arrangements within existing PCMHTs and CMHTs and propose steps to ensure regular and effective decision making.
4. The Mental Health Strategy should be considered as a contributing element of the Primary Care Improvement Plan.
5. The relationship between the Primary Care and Mental Health Interface Group and Primary Care strategic planning should be reinforced and accountabilities strengthened.
6. Work to support addressing long term physical conditions should be expanded and prioritised – such as the PsyCIS / Safe Haven work-to ensure effective communication of physical and Mental Health condition management requirements are shared between clinicians in both Primary Care and Mental Health settings.

7.2. Progress – Primary Care

HSCPs have been looking towards developing 'mental health and wellbeing in primary care' services. Local outcomes have been identified to improve access (journeys into and through) to mental health and wellbeing support. This is to increase primary care and mental health system capacity and to deliver integrated responses to promote good mental health. By improving access to the right support and treatment at the right time, existing demands on the wider system will reduce.

The role of specialist secondary care MH clinicians in the Mental Health and Wellbeing in Primary Care Services will be to provide:

- enhanced primary care support for consultation / advice *,
- support to guide primary care management of MH issues,
- education/learning to primary care,
- generic non secondary care MH assessment and
- medication prescribing support.

** Advice will include referral guidance when required to secondary care specialist services, Child & adolescent mental health teams, CMHTs, OPCMHTs, PCMHTs as well as to more specific service responses for people with BPD, eating disorder, psychosis, Perinatal, Esteem, etc.*

Some tasks currently carried out by GPs will be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. This includes additional professional clinical and non-clinical services including Community Mental Link Worker (CLW).

Community Links Workers (CLWs) have been introduced to support GPs and GP practices to signpost to community, 3rd sector and voluntary services and supports. They can case manage some

individual patients and can support patients with very complex needs as part of the practice team. Community Links Workers provide support to the whole community regardless of health condition and do not exclusively support people with Mental Health difficulties. They will support any patient referred to them by the GP of whom some at least will be experiencing Mental Health issues. CLWs are commissioned through 3rd sector organisations and support patients with non-medical issues associated with loneliness, social isolation, lack of community connectedness and associated 'social' issues (housing, physical inactivity and financial issues). This is sometimes known as social prescribing.

It should be noted (at time of writing, April 2023) that planning and development within NHSGGC has been paused following guidance from the national MHWPCS Group which is yet to be reconvened by the Scottish Government. Currently there is no direction on funding for 2023/24 (or beyond) and any changes to the level of national MHWPCS investment will require refreshed local plans to be developed. Sustainability of Community Links Workers will also be subject to the need for recurring funding.

7.3. Recommendations - Commissioned Social Care

1. Integrate management of supported accommodation (or equivalent) and care home placements with NHS Bed Management to optimise "flow" in and out of integrated Health and Social Care beds/places. Services will need to become more time limited and outcome-focussed.
2. Consider commissioning 'step-down' intermediate care provision to maximise the opportunity to support people to go onto live as independently as possible in other community settings.
3. Review service provision for complex care and challenging behaviour to ensure adequate placements are available.
4. Review specialist and mainstream nursing home commissioning needs, particularly to support people over 65 years of age potentially suitable for discharge as part of the re-provision programme.
5. Self-Directed Support providers are fully engaged in a co-production way to support the discharge programme.

7.4. Progress – Commissioned Social Care

Social work is a complex group of services. Social work departments provide and fund a wide range of specialist services for children, adults and families, and other specific groups. The services aim to improve the quality of people's lives and help people to live more independently. This includes particular service areas such as mental health. People with mental wellbeing and health issues includes people requiring care, support or protection. They can have complex problems and can be vulnerable and need support at different times or sometimes throughout their lives.
Services include:

Support for families Child protection Child and adolescent mental health Adoption services Kinship care	Residential care Care at home Mental health and addiction services Day care Hospital discharge coordination	Offender services Providing social enquiry reports Supervision of community payback and unpaid work Supporting families of prisoners

Support for children with disabilities and their families Fostering Child care agencies Looked-after young people Day care Residential care Supporting child refugees Supporting trafficked children Support for young people involved in offending behaviour	Dementia and Alzheimer's services Adult support and protection Intermediate care Provision of Aids and adaptations Services to support carers Re-ablement services Supported living Supporting refugee families Supporting people with disabilities Supporting victims of people trafficking	Supervision of offenders on licence

With this range of services the current approaches to delivering social work services will not be sustainable in the long term. There are risks that continuing pressure on costs could affect the quality of services. As part of mental health and other care Social Work services need to continue to look at ways to make fundamental decisions about how they provide services in the future. Social Work and mental health are working more closely with service providers, people who use social work services and carers to commission services in a way that makes best use of the resources and expertise available locally. Additional work is to further build communities' capacity to better support vulnerable local people to live independently in their own homes and communities.

There remains a fundamental shift in the balance of care proposed within the complex of mental health strategies from hospital to community services and to both extend and maximise capacity within community based services.
As overall Mental Health Inpatient beds reduce, the system needs to ensure an appropriate level of reinvestment into community care services including the following developments:

- Purchase of additional alcohol and drug recovery rehabilitation services
- Community social and health care treatment to deliver alcohol and drug recovery harm reduction
- Funding of social work discharge teams and increased number of social workers in integrated hospital discharge teams with rehabilitation clinicians, including in decisions on supported accommodation and resource allocation.
- Development of care homes quality assurance team
- Expand MHO capacity
- Increase psychological support for commissioned care homes
- Rapid response MDT frailty
- Hospital at home
- Fixed term support extending additional social workers in MHO to support weekend discharges
- Increase legal Adults with Incapacity capacity
- A digital standardised Care home portal to facilitate family choice
- Enhanced supported living first response
- Care at home
- Purchase enhanced packages of care to support discharge
- Additional 150 home care posts permanent

- New tender for commissioned Learning Disability and Mental Health placements including housing first
- New mental health commissioning team
- New advanced telecare service
- Step down from hospital care complex needs
- SPA personalisation new demand 2022/23 maximising independence
- Employees update of hourly rate of adult social care staff offering direct care in commissioned services in third and independent sectors
- Mental health support for people hospitalised with COVID-19
- Additional community staff and training to support people with eating disorder
- Additional staff to increase clinical capacity in CMHTs, OPMH, Groups service, ADRS, Trauma to reduce people waiting for psychological therapies

7.5. Recommendation - Community Services: Non-statutory Services

1. Continue to work closely with non- statutory services to shape the content of the implementation plan, including identifying priority areas for reinvestment, opportunities to improve pathways, access to services and support.

7.6. Progress – Community Services: Non-statutory Services

Arising from engagement with non-statutory services post recovery further joint consideration will include implementation plans for:

7.6.1. Further embedding recovery focused approaches

- Recognition that experience of trauma and adversity underlies Mental Health difficulties for many people; and that compassion, respect, engagement and a recovery-based approach should be fundamental to therapeutic service responses.
- Recognition that there is more to recovery than symptom reduction and that clinical services should be complemented by an ethos that promotes participation, empowerment and peer support, including the involvement of peer support workers.
- These recovery-based principles should inform all aspects of someone's journey of care
- Better meeting the needs of people with multiple morbidities, with a particular emphasis on physical health.
- Self-Management should be a key feature and goal.
- Responding to the increased demands on carers in the community as a result of the proposed service changes, including the demands placed on young carers.

7.6.2. *Improving Access to Services*

- Make the most of community-based resources to offer early support.
- Consider further development of non-clinical responses to distress and suicidal behaviour, potentially including well-being centres, distress cafes, and short-stay crisis centres for people at risk of suicide.
- Align service user expectations with available help to facilitate straightforward access to the right kind of help and maximise the opportunities for self-management (e.g. through website and social media engagement, self-assessment, open access information and courses).
- Supporting services users and carers to navigate the service options and improve 'signposting'
- Where appropriate, move away from traditional clinical models of referral and discharge from services, towards self-directed care, open access and brief and low-intensity interventions - 'easy in, easy out'.

- A commitment to simplifying access routes (e.g. self-referral to PCMHTs) with the use of link workers and "choice"[17] appointments to build the therapeutic alliance and shared decision making, helping to work out how best to respond to more complex difficulties.
- Introducing a greater degree of flexibility into our commissioning processes to enable people to access a range of supports.
- The use of technological and IT solutions where possible to promote access to information and services.

7.6.3. Making Cultural Change

Addressing the culture change necessary to embark on much more of a collaborative and co-production approach with provider organisations, the independent sector, service users and carers to ensure the overall system of care is designed in the best way it can to meet people's needs;

- To support the shift towards care that is trauma-sensitive and psychologically informed.
- To meet the challenges of prevention, early intervention, recovery and assisted self-management.
- To strengthen the working relationship and knowledge base across statutory and non-statutory services.
- Developing a greater understanding of how risk is managed in the community across the service tiers.

[17] The Choice and Partnership Approach

8. Secondary Care Community Mental Health & Specialist Services

8.1. Recommendations

1. Progress work to ensure all of our CMHTs maximise their effectiveness and efficiency." There will be a focus on reducing non-patient driven variation, review processes for complex cases and clinical outcomes will be utilised for all service users as appropriate."
2. Review of ESTEEM to maximise efficiency, effectiveness and capacity.
3. Review of AEDS with consideration of investment in day service unit (This proposal will be considered as part of the financial framework for the implementation plan).
4. Extend a network of programmed care and treatment for people with Borderline Personality Disorder (BPD) Board-wide.

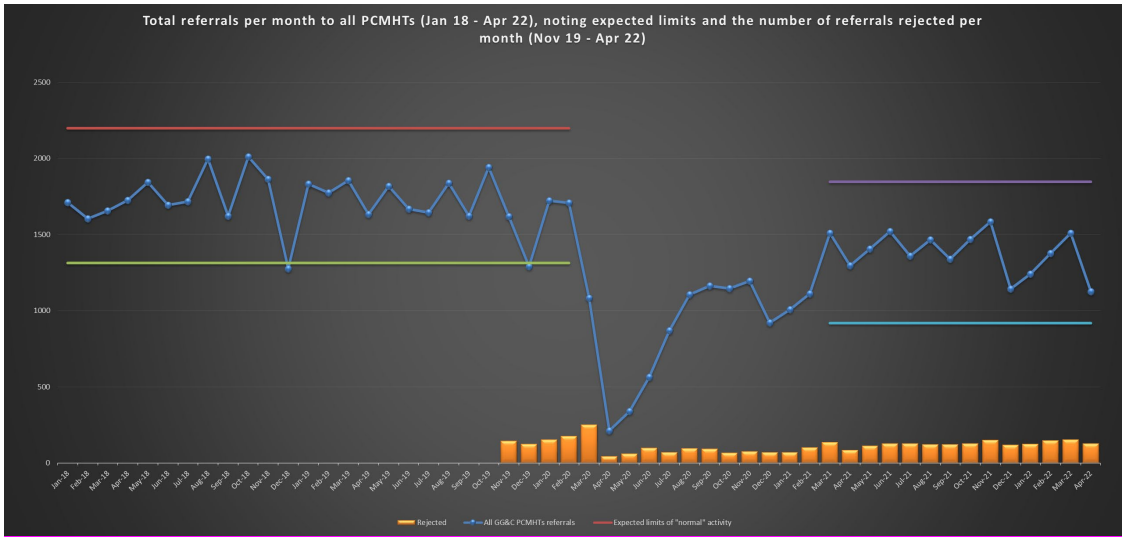
8.2. Progress - Primary Care Mental Health Teams

Primary Care Mental Health Teams were developed with the twofold intent of being able to offer General Practices more options for the high volume of patients who need specialist mental health secondary care when they present in practices with problems that have a psychological component (at least a third of all patients) and to prevent the unnecessary entry of individuals into other secondary specialist care Mental Health System services for common psychological problems.

These services are not about minor or 'mild to moderate' illness - they are designed to provide 'high volume, lower intensity' responses to common Mental Health problems, including depression, anxiety and lesser complex forms of Post-traumatic Stress Disorder (PTSD) and Obsessive Compulsive Disorder (OCD). There is a focus on brief psychological interventions, mainly Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT) and various forms of self-help and psycho-education.

The implementation of an outcome measure (CORE-Net) for all of the teams was to allow clinicians continuous outcome monitoring for all their patients.

The total referrals without full group work is returning to pre-pandemic levels.



The PCMH teams successfully implemented self-referral – which enables easier access and reduces the need for patient to first see their GP. Developments around 'lower-intensity interventions' are on-going and the teams will continue to consider ways of making use of the resource more efficient – for example through use of computerised self-help or clinician supported cognitive behavioural therapy or by directing people to services more suited to their needs and this will include third

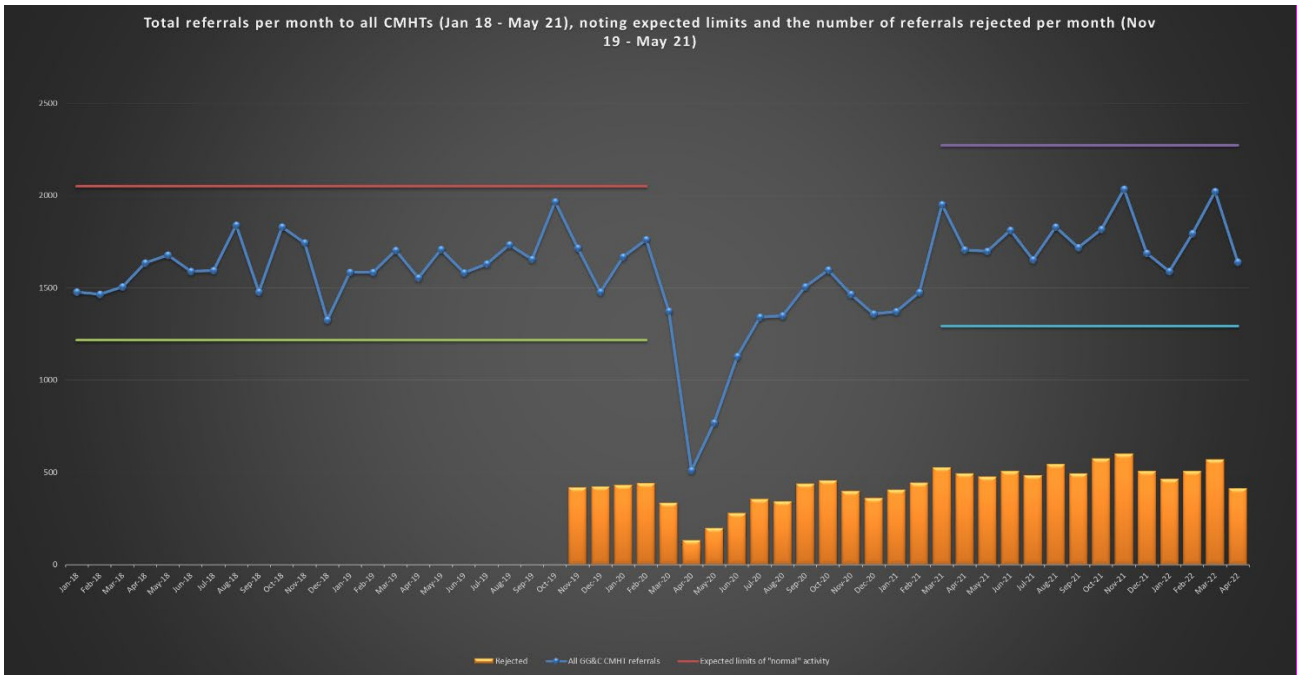
sector commissioned non-clinical services. Development in this area will be careful to avoid overlap and duplication in respect of primary care, models of recovery, community support and commissioning and prevention and early intervention and the development of the Mental Health and Wellbeing in Primary Care Services.

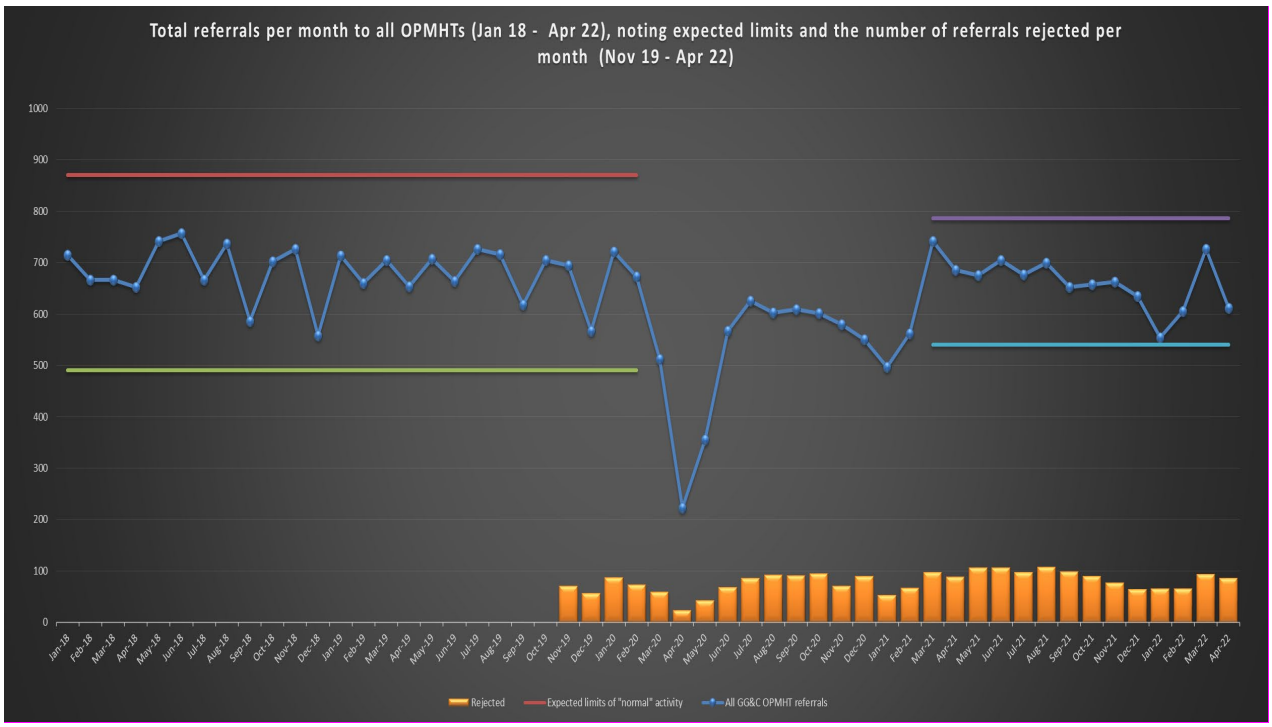
Further work will be progressed on Primary Care Mental Health Teams using the outcome measures more systematically across Community Mental Health and other teams. Additionally the re-instatement of full group work will also be an area for development and progress following the impact of COVID-19.

8.3. Progress - Community Mental Health Teams

The Community Mental Health Teams have continued to work on reducing non-patient driven variation. The COVID-19 pandemic event impacted on referrals to CMHTs.

The tables below highlight activity information across Community Mental Health Teams:





A standardised initial assessment tool across all CMHT's has been delivered with a planned rollout to crisis and inpatient services. This reduces variation in initial assessment and allows for a needs based and person centred approach to assessment and care planning.

The developed Patient Initiated Follow up Pathway (PIFU), as a way to facilitate a graded transition from secondary care services and support a recovery based approach to care planning, has been introduced. This is designed to improve efficiency of services while also supporting patients manage their care more collaboratively.

A Clinical risk reference panel continues to be developed and is designed to support clinicians in reviewing decision making and care planning for complex high risk cases.

A pilot of Peer Support was developed and implemented. Although affected by the ability to access people in inpatient care during COVID-19, the outcome of the pilot is to roll out Peer workers in CMHTs working into Inpatient wards across GGC as part of new financial framework priorities. A Recovery Planning Tool was to be piloted in the Peer Support test of change areas to promote realistic medicine approach for clinicians working in partnership with the patient.

Further work requires revisiting and refreshed for clinical outcomes. Initial progress was delivered in PCMHT psychotherapy and psychological therapies within CMHTs. Consolidation and rollout requires further consideration following COVID-19 in light of new ways of hybrid working and PIFU and will require a review on alternatives to CoreNet and quality standards and outcome data.

Further review current staffing data is being progressed through the establishment of CMHT Workforce Sub group which will also undertake further gathering of comparison data on CMHT activity and baseline patient experience data to inform the next phase of implementation planning.

There has been a significant increase in demand for assessment for attention deficit hyperactivity disorder (ADHD) since 2018. This will require a review of the pathways for neurodevelopmental disorders (including Autism) and tie in with the neurodevelopmental specification for children and young people.

8.3.1. Pharmacy

The Scottish Government allocated specific funding for four years (2021/22 to 2024/25) to be targeted towards Mental Health Pharmacy as part of the Mental Health Recovery and Renewal Fund. A number of transformational change projects have commenced. These will test the contribution pharmacy can make to the delivery of care within community based mental health services and to create a supportive infrastructure that will establish the capability of the service to sustain and develop its own workforce. In addition to Community Mental Health Teams, the pharmacy innovation projects will also span ADRS, CMHTs, CAMHS, Forensic Mental Health, Learning Disability and Older People's Mental Health.

8.4. Progress - Specialist Community Teams

There are a number of Mental Health teams that specialise in the assessment and treatment of specific conditions. These specialist services will also be reviewed to ensure they are equipped to meet future demand and include:

8.4.1. Esteem

This service which provides specialist early intervention for psychosis in young people, including those who have faced significant structural adversity and multiple traumas, works in a psychologically informed way to maximise recovery and promote self-management of complex mental health.

A 2018 service review focussed on: Eligibility and inpatient admission criteria, alternatives to inpatient admission, extended contact for some patients, employability and service development. The Esteem review was completed in 2019 with all recommendations described above adopted. It is noted that the COVID-19 pandemic has led to a 30% increase in demand with more first episode psychosis cases described across all health boards in Scotland.

Esteem has contributed to the development of, and works to, Scottish Government priorities through the Early Intervention in Psychosis in Scotland Action Plan (2019), supporting development of such services within other health boards.

8.4.2. Eating Disorder Services (EDS)

The Adult Eating Disorder Service (AEDs) was established in Glasgow and subsequently extended across the GG&C Board area to provide a coordinated multidisciplinary service for patients with moderate to severe EDs, working in conjunction with the CMHTS.

Prioritising intensive community intervention has enabled NHS GG&C to achieve the lowest inpatient bed use for ED across Scotland and the UK (from available data). In order to maintain and improve this further, consideration was given to measures that could reduce admissions to Adult Mental Health short stay beds. This included consideration of a proposal for the development of an eight place hospital based day unit. Other measures may include a service for people with an ED illness of a severe and enduring nature.

One consequence of the COVID-19 epidemic is a surge in the number and severity of eating disorder presentations. NHSGGC have utilised Recovery and Renewal funding across both the child and adolescent and adult eating disorder services to improve service capacity, physical health

monitoring, training, transitions from CAMHS into adult services, meal management, support in communities and expand access to psychological therapies.

A review of AEDS (2018) made a number of recommendations aimed at improving patient care, reducing clinical variance and taking more cases from the CMHTs;

1. Take psychiatric responsibility for AEDS ED cases
2. Developing a pathway to enable the core psychiatric needs of patient with primarily eating disorder needs to be held by the service rather than shared with the CMHT.
3. Enable direct transfer of patients with ED from CAMHS to AEDS This change was successfully implemented.
4. Increased the number of medical monitoring clinics
5. Improved care of patients with EDs in acute (and MH) settings
6. Work jointly with the Acute sector on the development of GGC guidelines for the management of eating disorder in acute hospitals. This guideline is now fully complete. Further improvement will come from a formalised medical link to support the medical management of eating disorders in MH beds ideally in a new specialist unit.
7. Develop a day unit / inpatient facility
8. The principle of a hospital based day unit was fully supported however COVID-19 made this impractical. Development of a specialist inpatient treatment facility remains a priority.
9. Develop a new pathway including medical monitoring for severe and enduring presentations
10. Develop the psychiatric role within AEDS to include a treatment change promoting greater evidence based therapy alignment, creating improved capacity for those patients actively engaged in treatment. This is alongside a new pathway for patients with a severe and enduring illness course that protects CMHTs from having to hold and monitor these cases if they are unable to engage in active treatment. This pathway will allow patients to be medically and psychiatrically risk assessed for a fixed timeframe instead of discharging to secondary care. This service development is in active consultation and discussion currently (October 2022).

8.4.3. Glasgow Psychological Trauma Service

Glasgow Psychological Trauma service is a multi-disciplinary Mental Health Service which offers assessment, training, consultation and multi-disciplinary psychological interventions to vulnerable service users who present with complex post-traumatic stress disorder (CPTSD) following experiences of significant trauma. The Trauma Service also delivers some National and Regional services across Scotland including a national service for trafficked individuals, Future Pathways Scotland and Major Incident Psychological Responses. External funding is provided for those services.

Training and consultation ensures all services are trauma informed and staff supported and equipped in their contact with trauma survivors in line with NES Transforming Trauma Framework. This leads to early identification of service users and their needs reducing unnecessary service contact time and eliminating failure demand.

Internal pathways between Community Mental Health Teams and Trauma team are established and maturing. Recent innovation has increased pathway flow with CMHTs providing additional support back to Trauma team to meet demand for trauma input.

8.4.4. Borderline Personality Disorder Network

People with a Primary or Secondary diagnosis of Borderline Personality Disorder (BPD) occupied an average of 24 adult acute inpatient admission beds across the system at any given time.

Individuals with BPD account for substantial levels of service utilisation across a range of settings including CMHTs, Primary Care and Acute Services. Due to the risk of self-harm and suicide, BPD accounts for substantial levels of contact with Crisis and unscheduled care services. BPD is the commonest Mental Health diagnosis apart from substance misuse among high-frequency repeat presentations at A&E. As a diagnosis, it accounts for a disproportionately large number of completed suicides that were investigated, underlining the risks associated with the disorder.

The community BPD network has been established offering at least one of the two therapies (MBT, DBT) across the whole board area. The network includes colleagues from Psychology and Psychotherapy Teams. The future model of delivery will be considered as the network develops.

Coordinated Clinical Care (CCC) training is now being delivered to community and crisis mental health services staff to address staff experiencing challenges in working with people with such conditions. Additional training and support is required to improve skills and support an empathic attitude. A key component is a focus on minimisation of harm induced by the words or actions of the clinician through promotion of rational prescribing and considered use of inpatient admissions. Initial limited feedback from service users/BPD Dialogues Group identifies a difference in attitude and response from their mental health / crisis team staff member who had completed the training. A more empathic and curious stance from staff resulted in de-escalation of a developing crisis.

The network works closely with the Psychological Therapy Group service and refers patients experiencing emotional regulation difficulties to the Emotional Coping Skills (ECS) package. STEPPS (Systems Training for Emotional Predictability and Problem Solving) is another evidence-based, structured psycho-educational group approach that was developed as an intervention for people with Borderline Personality Disorder (BPD) as part of its therapeutic toolkit.

8.4.5. Post COVID-19 Mental Health Team

The Scottish Government published a report by Dr Nadine Cossette on the mental health needs of patients hospitalised due to COVID-19 which contained a number of recommendations. One specific outcome for NHSGGC was the establishment of a post COVID-19 mental health team to support the mental health needs of patients hospitalised as a result of COVID-19 through screening and signposting or referral onto mental health or other services where appropriate.

9. Older People's Mental Health

9.1. Recommendation

1. A community framework, which sets out the full range of services and supports that should be accessible to Older People, is being implemented. The purpose of the framework is to ensure equity of services across all individual Health and Social Care Partnerships. The framework acknowledges that services will be developed and delivered in different ways across each HSCP, reflecting of their individual population needs.

9.2. Progress

Existing Strategic priorities for Older People's Mental Health are:

- prevention, early intervention and harm reduction
- providing greater self-determination and choice
- shifting the balance of care
- enabling independent living for longer
- Public Protection
- The third national Dementia Strategy (21 commitments.)

9.2.1. Community Services

A community framework, which sets out the full range of services and supports that should be accessible to Older People, is being implemented. The purpose of the framework is to ensure equity of services across all individual Health and Social Care Partnerships. The framework acknowledges that services will be developed and delivered in different ways across each HSCP, reflecting of their individual population needs.

Each health and Social Care Partnership will undertake post pandemic review of the community supports in their area with the aim of identifying gaps and areas for future implementation.

Community prevention approaches should support wellbeing, enable independent living and the self-purpose needed with this group at risk of isolation, increase in alcohol consumption etc. Local community activity / supports are required to maximise health and wellbeing in the longer term for the ageing population.

9.2.2. Access to, and Interface with, Services

In order to ensure that Older People have access to the right service at the right time in the right place we are aiming to increase clarity about the pathways and access to services both for patients, their families and health and social care services and staff. Services will adopt a 'no wrong door' approach to referral and where required, will facilitate joint working work with partners and stakeholders to ensure a patients assessed needs are met by the most appropriate service.

There are a number of aspects to this work being taken forward to further improve access to services is efficient, effective and equitable

- Transition of patients between Adult to Older People's Mental Health
- Access to and support for Older People from Specialist Mental Health Services and services with no upper age limit, e.g. Alcohol, and Drug Recovery Services
- Interface with General Practice and Community Health and Social Care Services for referral to services and access to support

- Interface and pathways with Acute Care.
- Interface with Acute Care Services at its Front Door and Emergency Care Hubs

9.2.3. Services for People with Dementia

Areas of development for national Dementia Strategy include:

1. Ongoing monitoring and review of Dementia Post Diagnostic Support, the models used within the different HSCP's and the effective utilisation of additional funding to support provision
2. Adoption of the Dementia Care Co-ordination approach and pathway developed by Inverclyde HSCP with support from Healthcare Improvement Scotland, should be implemented by each of the Health and Social Care Partnerships in a way that reflects the services, supports and structures that are currently in place and the needs of their populations.
3. The formal adoption of the referral pathway for the identification, diagnoses and support for Young Onset Dementia.
4. Facilitating clear routes into clinical research, offering patients access to available clinical research including dementia treatment trials.
5. An NHSGG&C wide group established to review the operational process and practice of OPMH Community Teams, with the aim of identifying sharing and adopting good practice;
    - review and revise the existing service specification, identify changes to ensure a consistent service specification is in place
    - contribute to the review of the OPMH Community teams workforce
    - make recommendations for a series of performance indicators which act as a useful barometer for the service and the data for which can be gathered via existing systems

These priorities are guided by a set of principles

- OPMH's future development should primarily be viewed through the prism of older people's services rather than adult mental health.
- The principles underpinning the wider Older People strategy should also apply here; i.e. risk enablement not avoidance; a system that responds to the reality that care needs are not static, but can increase or decrease.
- The overall system design is patient-centred, with professional and organisational supports working into that
- We should think of "care needs" rather than assuming hospital beds are required and there is a presumption that a shift in the existing balance of care is possible,
- We will develop a future service model based on gradations of care up to and including in-patient beds
- In-patient beds should be located in the best estate, with geography a secondary consideration
- Emerging MFT principles around providing community-based care as locally as possible should apply, with a proviso that hospital care won't always be local
- Any shift to non-hospital based care must be resourced from ward reinvestment, both in terms of staff ratios and skill mix
- Maximise the opportunities around integration
- Timescales will be stepped and risk assessed at each stage of beds/ward reduction change programme

- Engagement across the clinical community at all stages of conception and implementation of the strategy
- Engagement and co-production with service users and carers

10. Child and Adolescent Mental Health

10.1. Recommendations

1. Develop and recruit to an MDT workforce plan to increase capacity at Tier 3 to reduce the waiting list backlog and meet the waiting times standards
2. Undertake Tests of change to expand the core MDT in CAMHS to included other professional groups such as Physiotherapy, Pharmacy and Art therapy
3. Engage with Young people and families to co- create a digital resource that will support access to information on available mental health supports. Through this work consider how self-referral to CAMHS and other services can be facilitated.
4. Deliver a programme to refresh the principles and compliance to CAPA for all CAMHS team
5. Complete and extend the condition specific Care Bundles. Implement the application of the Care Bundles through a Board wide launch and L&E plan with robust evaluation.
6. Implement Welcome conversation for all CAMHS staff to listen about what matters to our staff. Ensure there is a review proves for themes in exit interviews continue to showcase and appreciate submissions to our Learning from Excellence system
7. Continue to develop bespoke induction and personal development opportunities for our staff that focus on skills development and wellbeing
8. Work with adult services to agree the Targeted groups of young people who will be supported through strengthened transition care planning.
9. Create pathway development posts and tests of change to develop pathways and consider how and where young people can be best supported
10. Transition care planning be undertaken by all young people who require to transition to Adult Mental Health Service
11. Extend capacity to undertake research to better understand what our Children and Young People want and expect from us and what works to help them manage their mental Health
12. Develop a workforce plan across CAMHS and Community Paediatrics to Increase capacity to undertake specialist Neurodevelopmental assessments
13. HSCP's to work with partner agencies to develop supports for children and young people that helps them thrive.
14. Creation of a regional CAMHS Intensive Psychiatric Care Unit (IPCU) adjacent to the existing Adolescent inpatient facilities, Skye House located on the Stobhill site in GGC.
15. Establishment of delivery of regional CAMHS services for children and young people with learning disabilities, forensic needs and those who are in secure care.
16. Develop services and tests of change involving Allied health professionals and psychology over 22/23 to ensure services develop to meet the needs of the young people and families we work in partnership with.

10.2. Progress

Most young people requiring Child and Adolescent Mental Health Services (CAMHS) will present with mental health problems that are causing significant impairment in their day-to-day lives, and where the other services and approaches have not been effective, or are not appropriate. These presentations can result in both the need for scheduled and/or unscheduled care.

10.2.1. Access

CAMHS services are currently accessed via professional referral (GP, Education etc). CAMHS services are striving to reduce the waiting lists and to meet waiting times standards. The service specification

describes that CAMHS should see children within 4 weeks of referral and treat within 18 weeks. CAMHS are also asked to support self-referral.

The CAMHS service specification asks that CAMHS publish information in a clear, accessible format about what and who CAMHS is for, and how children, young people and their carers can access CAMHS. The format and substance of this will be informed by consultation with young people, and will be provided via the NHSGGC website and social media channels. In addition CAMHS are asked to support self-referrals and support an 'Ask once, get help' principle

10.2.2. Effective / Efficient / Sustainable

CAMHS continue to operate the Choice and Partnership Approach (CAPA)[18]. CAPA is a service transformation model that combines collaborative and participatory practice with service users to enhance effectiveness, leadership, skills modelling and demand and capacity management. CAPA brings together:

- The active involvement of clients
- Demand and capacity ideas/Lean Thinking
- An approach to clinical skills and job planning.

CAMHS offer a range of therapeutic and treatment options, delivered through an MDT. Work is underway to develop standardised and evidence based Care Bundles, which will clearly describe what a child or young person can expect from CAMHS and for clinicians a pathway to the delivery of the treatment in keeping with the psychological therapies matrix.

10.2.3. Transitions

The Mental Health Recovery and Renewal plan requests CAMHS to extend transitions for targeted groups and those who wish it, up to the age of 25yrs. NHSGGC has developed transition guidelines in partnership with adult services and has already strengthened governance and planning across the mental health complex. This will include the relevant elements of the neurodevelopment specification and transition into adult services.

10.2.4. (Adolescent) Intensive Psychiatric Care

There is currently no direct inpatient service provision for adolescent patients who require Intensive Psychiatric input in NHS Scotland. This means patients are often referred to, or remain cared for, in services that do not fully fit their needs.

10.2.5. Regional Pathways

Scottish Government funding has been provided to review the current pathways and establish capacity for extended Learning disability and forensic pathways and support into secure care services.

10.2.6. Eating Disorders

Referrals have been increasing year on year since 2017. The eating disorder response has been expanded and developed in line with evidence-based practice. This includes expansion of Specialist

[18] The Choice and Partnership Approach

Dietetic roles, extension of psychological therapies into family-based therapy and cognitive behavioral therapy.

11. Perinatal Mother and Infant Mental Health Care

Perinatal refers to the period during pregnancy and up to one year after the baby is born. During this period new and expectant parents (mums, dads, partners) can experience issues with their mental health also known as perinatal mental health problems. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period. These illnesses can be mild, moderate or severe, requiring different kinds of care or treatment.

11.1. Recommendation

1. NHS GGC Perinatal services aims to provide assessment and treatment of woman and infants who are at risk of, or who experience, significant mental disorder whilst pregnant or in the 1st year postnatal.

11.2. Progress

Implementation of recommendations in the Delivering Effective Care report[19] resulted in the introduction of additional staffing across the Mother and Baby Unit and in the Community Team, an increase in Psychology resource with the aim of improving timely access to psychological therapies and interventions, Coordination and delivery of evidence based parent-infant interventions. A national consultation is under way regarding the provision of additional Mother and Baby inpatient Unit (MBU) beds across Scotland.

11.2.1. Mother and Baby Inpatient Unit

The West of Scotland MBU is situated in purpose-designed facilities at Leverndale Hospital. It allows for the joint admission of mothers accompanied by their babies, where the woman requires acute inpatient mental health care. The unit is staffed by a multi-disciplinary team of professionals across many disciplines. The unit offers a wide range of therapies including biological, psychological and psychosocial interventions including interventions to enhance the mother-infant relationship.

Work is ongoing to;

- Promote psychologically informed care within the ward
- Build relationships with wider regional perinatal services
- Establish Psychology Pathways within the MBU (ensuring speedy and equitable access to psychological
- Develop therapeutic options available within ward
- Develop the peer support worker role.
- Develop a Fathers and Partners pathway to provide a systemic pathway to care and ensure they are included in the patient's journey

11.2.2. Community Perinatal Mental Health

The community team is a specialist service providing assessment and treatment for women who have, or are at risk of having, significant mental disorder in pregnancy or the postnatal period, currently up to 12 months postnatal. The service will also see women with pre-existing severe mental disorder for pre- pregnancy advice on risk and medication management. Work is continuing to expand the service to allow assessment for new patients to be seen between 6 and 12 months

[19] PMHN-Needs-Assessment-Report.pdf (scot.nhs.uk)

postnatally. The PMHS will work in partnership with partners and families, maternity services, primary care (including health visiting and Family Nurse Partnership), adult social services, children & families social services and other agencies, to design, implement and oversee comprehensive packages of health and social care to support people with complex mental health needs.

11.2.3. Infant Mental Health

The Infant Mental Health Service is a specialist community multidisciplinary team who can draw on a range of expertise and experience to offer needs-led support for infants and families. A key aim of the service is to ensure that the voice and experience of the infant is held at the centre of work with families across the health board.

11.2.4. Maternity & Neonatal Psychological Interventions (MNPI)

The multi-disciplinary Maternity & Neonatal Psychological Interventions (MNPI) Team will address the common and/or mild to moderate psychological needs of the maternity and neonatal populations by providing in-patient and out-patient assessments and a range of evidence based psychological interventions. The central focus in all of these interventions is to enhance the parent-infant relationship, improve parental and infant mental health and to prevent a range of psychological difficulties (emotional and cognitive) in childhood and later life. The team is working to:

- Improve access to maternity and neonatal psychological interventions
- Improve engagement with maternity services
- Improve support to specialist areas
- Improve support to maternity and neonatal staff and improved awareness of psychosocial issues in this staff group
- Improve data collection, outcome monitoring and quality improvement
- Improve pathways of care and support to community and universal services
- Improve staff confidence and expertise

Work is ongoing to improve and embed access to a range of therapies including clinical psychology, parent-infant therapy and occupational therapy. There has been significant progress made in the interfaces between perinatal mental health, IMH and MNPI. Pathways of care have been strengthened to ensure access to appropriate services and transitions of care between teams. This includes developing and delivering psychological therapy groups within the service i.e. perinatal anxiety management group, perinatal Emotional Coping skills group, Compassion Focussed Therapy group.

12. Learning Disability

12.1. Recommendations

Coming Home 2018 makes 7 recommendations under three themes;

1. Strengthening Community Services
2. Developing Commissioning and Service Planning
3. Workforce Development in Positive Behavioural Support

The 'Designing an Effective Assessment and Treatment Model, NHS Greater Glasgow and Clyde, 2018' report makes a number of recommendations;

4. Create a shared vision with as many stakeholders as possible, including families and people with learning disabilities.
5. Hold yourselves accountable to the vision, and share it widely so that others can hold you accountable too.
6. Ensure the principles and values already identified are clearly embedded in the vision.

Develop a shared strategy. Coming Home 2022 recommends;

7. The current sample Dynamic Support Register should be developed into a tool for national use.
8. "By March 2024 we want and need to see real change with out-of-area residential placements and inappropriate hospital stays greatly reduced, to the point that out-of-area residential placements are only made through individual or family choices and people are only in hospital for as long as they require assessment and treatment."

Specifically, the community living change fund is to be used to:

9. Reduce the delayed discharges of people with complex needs.
10. Repatriate those people inappropriately placed outside of Scotland.
11. Redesign the way services are provided for people with complex needs.

12.2. Progress

Plans in respect of Learning Disability are consistent with wider Mental Health strategy and the complex of mental health services with a strong focus on integrated practice towards stepped matched care, improvements in quality and effectiveness of community services and fewer inpatient beds and out of area care.

East Renfrewshire leads on redesign of Learning Disability inpatient services and an NHSGGC Programme Board has been established to provide support and oversight of developments across HSCPs. Similar to all strategies across mental health, aspirations are to develop community alternatives to hospital admission, discharge people who have been delayed for some time and reconfigure inpatient services to better support community services and third sector partners. A Community and Inpatient redesign Group brings together local leads with responsibility for development of community and inpatient services and ensures parallel progress leading to Inpatient reconfiguration.

HSCPs are developing their own approaches to increasing community support for those at risk of admission with the overarching strategic aim to reduce reliance on the bed base and develop more responsive ways of supporting people earlier, in partnership with people, third sector and the wider system. A Multi-Agency Collaboration Group has been established given the need to enhance third sector alternatives and improved joint working across statutory and third sector partners. This

group is made up of senior reps from third sector organisations, social care, clinical staff and commissioning and aims to influence commissioning and frontline practice and encourage wider joint working within HSCPs and across HSCPs where this would be helpful.

12.2.1. Coming Home

A variety of responses to 'coming home' have been developed across the HSCPs, including;

- Local review all of the people living out of area and plans to support people to return to the area where this is appropriate for the person. Reviewing and refreshing outdated institutional models of respite and residential support, taking a co-production approach.
- Further embedding integrated systems and ways of working. Increasing the range of services providing the right support from the right people at the right time. For this reason, including supported living in either shared or individual settings.
- Flexible working with inpatient services and future plans to increase the range of person centred solutions which can be delivered by joint working with the inpatient team.
- Further embedding the risk register / management process into current review systems, providing detail on crisis responses available in an area.

It is clear from extensive work taking place there are a very broad range of multi-layered issues. Varying solutions are emerging across the partnerships based on local needs, demographics, availability of skilled third sector providers and therefore our challenge is to support the development of these local ways of working and at the same time create and deliver on a Board wide plan which ensures people across NHS GGC receive robust flexible support when they need it most.

Consistency can be achieved by ensuring we have broadly consistent approaches to the variety of issues in terms of management of risk, threshold for hospital admission, adaptability in how we use our inpatient and other community resources; however it is inevitable this will achieved in different ways across NHS GGC.

12.2.2. Bed modelling

There are 27 beds across two facilities and the aim is to reduce reliance on bed-based models and re-invest resources in Community Services designed to support people who are at risk of admission, particularly where clinical need is not the primary reason for admission. Our aspiration is to reduce to around 18 to 20 beds and our modelling supports this ambition. Redesign of the inpatient estate will require capital investment and this will be closely linked with the wider Mental Health strategy to ensure system wide capital and estate planning includes plans for Learning Disability.

Providing more accessible information to patients about the service prior to and within the first few weeks of admission, providing more homely and quieter areas within the units, providing more opportunities for patients to maintain and develop their daily living skills, staff training in the impact and influence of power, and improving communication with all involved from hospital admission to discharge.

Patient hospital attendance as a 'day patient' tailored more specifically to individual patient needs allowing immediate access to full inpatient care if the patient requires this rather than establishing a day hospital. Adults with Learning Disability needs are so heterogenous that a day hospital could not be designed to meet all needs.

12.2.3. Outreach

Increasing the flexibility and range of options provided by the inpatient service and the ability of

community services to support patients in a person centred way and adapting the service during the most difficult periods, smoothing out the interface between inpatient and community services rather than adding to it by introducing additional layers of specialist services or teams (outreach or crisis)

12.2.4. Inpatient referral

All Learning Disability Psychiatrists referring patients at risk of admission and/or placement breakdown i.e. at a much earlier stage than currently to test what inpatient assessment and support can be provided other than admission.

Establishing a register of people at risk of admission or placement breakdown, to help identify people earlier and keep track of actions taken to reduce the risk.

Referrals to be discussed by the bed management group to consider for day patient attendance or part-time admission.

Inpatient teams prompted to explore the options for providing more robust post-discharge support. Shifting the current inpatient admission service to one of inpatient assessment & support as well as admission, and starting to provide more flexible inpatient support for those at risk of admission and/or placement breakdown.

Making accommodation more homely and flexible with more options for individualised and quieter living areas, maintaining independent living skills and links with local communities.

Addressing the mismatch between the understanding of inpatient and community staff about each other and the way they work.

12.2.5. Community Living Change Fund

A Learning Disability programme board has been established to adopt a whole system approach to:

- Agree a programme of work for the community living change fund, over three years, which leads to reduction in demand for beds and creates local and, where required, shared alternatives.
- Agree a financial programme which bridges the programme and leads to the reduction of beds and transfer of resource to fund longer term alternatives.
- Seek to return people from Out of Area, and where there are savings commit to a proportion of these funds being redirected to new local arrangements aligned to strengthening community services.

This will include two key work streams:

Community and Inpatient redesign to support the development of local services to improve the response to people at risk of admission / OOA. The group will also lead on the development and implementation of improved joint working across the system –embedding pathways, standards and support the development of workforce modelling and proficiency utilising effective and efficient ways of working.

Multi-agency collaborative commissioning to provide a forum for teams, commissioning and third and independent sector partner providers to explore and deliver on a range of alternative innovative and responsive support options for those individuals with complex needs. Exploring the availability of alternative short term accommodation opportunities for people who are reaching crisis as an alternative to hospital admissions will be key to this.

13. Alcohol and Drugs Recovery (ADRS)

13.1. Recommendations

1. Implement the recommendations of the Alcohol and Drugs Recovery Services (ADRS) reviews
2. Implement the Medication Assisted Treatment (MAT) standards
3. Move to deliver inpatient services from a single site within NHSGGC (from the NHSGGC Clinical Services Review)
4. Improve digital / eHealth systems, the access to, and use of these to reduce duplication and improve reporting of performance. (*ADRS teams comprise of health and social care staff using different recording systems)*
5. Review post-pandemic accommodations needs
6. Review and revise team structures to ensure board wide co-ordination of locality delivered services and consistent approach to delivery between the six ADPs, minimising the impact of varying priorities in each HSCP.
7. Ensure alignment of ADRS and mental health planning in relation to:
    a. MAT standard 9, where mental health care pathways are required to ensure 'All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery'
    b. In-patient services
    c. Crisis outreach services in relation to mental health crisis pathways and services
    d. The development of Mental Health and Wellbeing in Primary Care Services
    e. The duty on HSCPs to respond to Mental Welfare Commission "Ending the Exclusion" report on joined up mental health and substance use provision to people with co-occurring conditions
8. Ensuring access to residential rehabilitation services across the Board area, participating in regional and national commissioning work to influence this
9. Recognising the impact on families of substance use and ensuring provision of support for family members in their own right, in line with the Whole Family Framework for Alcohol and Drugs

13.2. Progress

There is a work stream established in GADRS to take forward the implementation of recommendations from the review. Inverclyde and Renfrewshire concluded service reviews prior to COVID-19, which still require full implementation.

The Crisis Outreach Service is a recently implemented assertive outreach service based at Eriskay House, Stobhill Hospital. It provides a rapid outreach response to individuals who are in addiction crisis of drugs, alcohol and non-fatal overdose of street drugs. The team provides a period of assessment, engagement and brief interventions, including Naloxone provision, Dry Blood Spot Testing, Injecting Equipment Provision (IEP), safer injecting advice, alcohol brief interventions and supported access to community teams, to people with highly complex needs. The team liaises and interfaces with Mental Health assessment units, GADRS Community Addiction Teams (CATs), A&E, Scottish Ambulance Service, Police Scotland, Third Sector and Voluntary Services.

The Enhance Drug Treatment Service (EDTS) is an innovative and unique service in Scotland, it aims to engage with those patients who traditionally do not engage well with treatment services, offering injectable diamorphine, oral Opiod Replacement Therapy (ORT) and other medication. The service

links to other treatment services including the Complex Needs Team, CATs and the Blood Borne Virus (BBV) team. Patients receive support with social care and housing. The service was launched in November 2019, however due to the impact of COVID-19, including social distancing measures, and a shortage of diamorphine which affected supplies for almost 12 months, the service has been unable to increase patient numbers as planned.

The development of a new drug checking programme for Scotland, funded by the Scottish Government through the Drugs Death Task Force and the Corra Foundation, was launched in January 2021. This initiative will see the creation of infrastructure to support the delivery of three city-based projects in Scotland. These projects will enable members of the public to anonymously submit drug samples for forensic analysis, and subsequently receive individualized feedback of the results together with appropriate harm reduction information. Glasgow will be one of the three cities to participate in this project.

In 2017 NHSGGC and Glasgow City Council submitted proposals to develop a co-located Heroin Assisted Treatment Service and Safer Drug Consumption Facility (SDCF). Whilst the proposal for the heroin assisted treatment service could be progressed without any alteration to current legislation, and the EDTS was opened in November 2019, the Lord Advocate did not feel that the SDCF proposals could, at that time, be progressed. Following recent discussions with Scottish Government, Crown Office and Procurator Fiscal Service and Police colleagues, a new SDCF proposal has been submitted to the Lord Advocate, seeking to work within the current legislative framework. The SDCF will provide an opportunity for staff to engage with service users, who may otherwise have no or little contact with treatment services, and offer harm reduction advice, whilst also highlighting pathways into treatment, including EDTS.

The Renfrewshire Recovery Hub (CIRCLE) is a newly established recovery service within Renfrewshire, offering unique recovery support to people with mental health and substance misuse difficulties. Its primary focus is to provide recovery opportunities enabling individuals' authority over their own lives, recognising the many pathways to recovery, building a service that is person centred, focuses on strengths and resilience of individuals, families and communities. The workforce is recovery orientated and service provision is led by individuals with lived and living experience. A comprehensive activity program, offering opportunities for recovery, will include; volunteering, peer support, education and employability, low level psychological support through anxiety management, and other activities. The service will act as a central recovery hub with recovery activity delivered across local communities throughout Renfrewshire.

14. Unscheduled Care

14.1. Recommendations

14.1.1. Community response

1. Integrate crisis, home treatment and OOH models so that they are provided consistently across the Board area.
2. Develop a framework for the operation of a Community Mental Health Acute Care Service (CMHACS)* model across NHSGGC which includes the following:
    a. Home / Community Treatment capacity - with individuals offered treatment safely in a community setting as an alternative to hospital admission.
    b. Management of access to adult inpatient services - with CMHACS taking lead responsibility in collaboration with Bed managers to facilitate admissions to hospital.
    c. Supporting early discharge from hospital – by working to minimise the length of stay in acute inpatient settings by supporting discharge where the clinical risk can be managed within the community.
3. Community services interface with new “distress” pathways as described in (11) below.

Additional 2023 recommendation

4. Where patient groups are not covered, ensure effective links between CMHACS with other community responses.

14.1.2. Emergency Department (ED) and Acute

5. There is a single Liaison service Board-wide, providing cover to EDs 24/7.
6. Liaison will provide one point of access for referrals for each Acute Hospital, with defined response and accessibility criteria for supporting departments such as AMU, IMU & MAU
7. Liaison services to provide input to the EDs, AMU, IMU etc and inpatient wards from 8am to 8pm on weekdays, and 5pm at weekends. A single OOH Liaison team provides cover at other times, coordinated centrally and pooling staff resources where needed with the CMHACS
8. Implement a face to face response time of <1h for referrals from ED, including some prompt productivity changes to support this new target.
9. Secure recurring investment for liaison services transformational posts received and to enhance and develop CMHACS to cover GGC area (currently funded non-recurringly from Scottish Government funding). (This proposal will be considered as part of the financial framework for the implementation plan)
10. Pathways from primary care, police, NHS 24 and self-referral will be clarified.
11. An alternative care pathway is developed, which diverts all assessment and treatment for people with Mental Health problems who do not require medical treatment (or otherwise to be managed by a clinical unit for behavioural reasons) out of the main ED. Those pathways would work with third sector organisations in collaboration with health services to provide a compassionate, therapeutic and safe response without “leading” with diagnosis and risk assessment. This will include planned "tests of change" around e.g Distress Hubs; Crisis cafe models
12. Review the number of acute assessment sites Board-wide, with consideration of the potential to reduce the current number of acute admission sites. (Note: there is an extant plan to reduce from 6 to 4 with the closure of Parkhead Hospital in Spring 2018 and the transfer of the remaining 15 bed acute admission ward from Dykebar to Leverndale Hospital.)

Additional 2023 recommendation

14.1.3. CAMHS

13. To establish CAMHS Unscheduled Care provision planned regionally and integrated with regional adolescent inpatient pathways. And to establish/extend capacity and provision of CAMHS Liaison Services delivered by paediatric acute inpatient and outpatient services.

* Recommendations have been updated to reflect a revised approach, replacing the proposed Crisis Response and Home Treatment service with a Community Mental Health Acute Care model.

14.2. Progress:

Unscheduled care responds to a lot of activity in the Mental Health system. People seeking this kind of help are usually exposed to immediate and serious risks to their health or safety. Unscheduled care services also carry most of the risk associated with Mental Health care. Demand for "unscheduled" can be predicted and a key goal for the Strategy is to match demand to a prompt and effective response consistently across the Board area. While recognising that some flexibility is required to meet local needs, there is scope for a more standardised approach to maximise efficiency and effectiveness.

14.2.1. Community response

Distress Response Services have been established across the HSCPs, mostly commissioned through local mental health associations alongside the national NHS24 Distress Brief Intervention Service which is also commissioned through the Scottish Association for Mental Health (SAMH). Further work to look at options for reducing variation and increasing consistency of response is proposed.

Plans are being developed for a Community Mental Health Acute Care Service (CMHACS) as an alternative to the previously proposed community response home treatment service (CRHT). The CMHACS will be a comprehensive mental health acute care service whose first goal is to provide mental health care, treatment and support as a credible alternative to hospital admission or prolonged inpatient care, promoting emotional strength and reducing the impact of mental health crisis through intervention, education, prevention and community collaboration. Core functions will be to offer short term intensive community based treatment, manage all requests for access to inpatient care and provide assessment of suitability for home treatment as an alternative to admission. The service will also work in collaboration with acute mental health inpatient services to facilitate and support discharge from hospital for individuals that home treatment is deemed to be appropriate for. Medical recruitment is proving to be a challenge and will need to be addressed to support this development.

Reducing the number of points of contact out of hours within each HSCP and across the Health Board and linked more directly with Social Work responses is also proposed.

14.2.2. Emergency Department (ED) and Acute

The COVID-19 pandemic forced considerable change to the delivery of unscheduled care services and accelerated the implementation of Mental Health Assessment Units (MHAUs). These units are being retained as a long term approach.

MHAUs ensure that people experiencing distress and with a Mental Health presentation get the most appropriate and timely care treatment response, diverting people with Mental Health problems who do not require physical / medical treatment from the main Emergency Departments. MHAUs support the principle of joint working and shared responsibility and are directly accessible by 1st responders (Fire, Police Ambulance) and GPs. Originally only for adults, Older People are supported and Child and Adolescent Mental Health Services (CAMHS) staff are now attached to the units out of hours to support young adults and adolescents. These closely link with the Out of Hours G.P service, NHS 24 and the NHS 24 Mental Health Hub, the Flow and Navigation Hub, the Urgent Resource Care Hub (URCH) and the Glasgow City Compassionate Distress Response Service (CDRS). MHAU staff and the Scottish Ambulance Service provide a first responder service for mental health assessment within a patient's home. The digital Consultant Connect system provides support for GP surgeries across NHSGGC to access same day mental health assessment for patients presenting in mental health crisis.

These units were funded 'at risk' and clarity is required on how they will be funded on a sustainable basis.

A single Acute Hospital Liaison service has been established covering all acute hospitals within NHSGGC ensuring cross-cover on all sites with guaranteed response times, including up to 1 hour to Emergency Departments or longer, appropriate to the support required.

Crisis, Liaison and Out of Hours Teams services have been reconfigured to address historical gaps and ensure mental health support is provided 24/7.

14.2.3. CAMHS

An unscheduled/intensive and liaison review was completed in January 2022 and has moved into implementation. The review aimed to meet the requirements of the CAMHS specification and ensure a 24/7 response across unscheduled and liaison pathways and intensive responses to be developed to meet the needs of young people. Work will be developed to deliver the regional approach with regional inpatient services.

15. Forensic Mental Health

15.1. Recommendation

1. Delivery, alongside mental health rehabilitation services, of low secure inpatient accommodation in a dedicated unit which offers safe and secure accommodation for patients whose presenting behaviours cannot be safely treated within an open ward and who require a higher level of security over a longer period of time, expanding the offer available within forensic and mental health rehabilitation services.

15.2. Progress

Implementation proposals to increase low secure rehabilitation and increase integration with general adult psychiatry Intensive psychiatric care, acute admissions and intensive rehabilitation are in development.

Continuing pathway review with general adult and rehab psychiatry pathways and development of the forensic rehabilitation function in parallel with adults & rehabilitation.

16. Shifting the Balance of Care

16.1. Recommendations

1. Short stay acute assessment beds be reduced, alternative capacity in community services to manage the rebalanced system of care. Consideration of the location of proposed bed closures and the implications for hospital sites will be considered as part of the development of an Implementation Plan. It was not anticipated the potential risks of reducing the number of IPCU beds could be mitigated to a level that would result in a ward closure. Review the number of acute adult assessment sites Board-wide, with consideration of the potential to reduce the number of acute admission sites. (Note: the existing plan reduces sites from 6 to 4 with the closure of Parkhead Hospital completed 2018 and to transfer the 15 bed acute admission ward from Dykebar to Leverndale Hospital.)
2. In order to support the bed reductions (set out below), while managing existing and future demand for inpatient care, the recommendation would be for the development and adoption of acute care pathway across all acute inpatient sites, which would allow for clarity about the role and purpose of an acute inpatient service within a redesigned mental health system. This would also allow for greater operational consistency in the implementation of care pathways and reduce variance across sites.
3. An emphasis on quality improvement processes within inpatient care settings and a rollout of SPSP and AIMS across all acute inpatient sites. This would, in conjunction with greater operational consistency in implementation of care pathways and standards, reduce variation across inpatient sites within NHS GG&C.
4. A greater focus on addressing delays in discharge and ensuring a pro-active approach to discharge planning. This would include closer integration with community and social care services to ensure joint prioritisation of resources and smoother patient flow across inpatient and community settings.
5. Ensuring that individuals are appropriately placed within acute inpatient services based on need rather than availability. This would require further work around developing and clarifying interface arrangements across care groups, in line with the newly developed Acute care pathway.
6. A further recommendation would be around the harmonisation of bed management and data collection to ensure dynamic monitoring of inpatient bed availability as well as ensuring a focus on patient flow.

Mental Health Rehabilitation and Hospital Based Complex Clinical Care (HBCCC) Beds

7. Operational consistency across all rehabilitation services via standardised care pathways that are co-ordinated and reviewed on an integrated system wide basis. In this model there would be system wide access to rehabilitation beds across GG&C when necessary, and a system-wide bi-monthly review of admissions, discharges and bed-utilisation. This system-wide review should include social work professionals and overall, a more integrated approach should be taken to co-ordinating the system of care across rehabilitation services and community provision.
8. Admission to dedicated inpatient rehabilitation services needs to be reserved for a subgroup of people with specific complex Mental Health presentations and a profile of need responsive to rehabilitation. There is wide-variation in how rehabilitation beds are used across the system. The proposed changes to rehabilitation services would include system-wide implementation of agreed standards for assessing suitability for rehabilitation, referral guidelines and what is delivered in the care pathway.
9. Inpatient rehabilitation services designated as either “Intensive” or “High Dependency” Rehabilitation & Recovery Services. Intensive wards would reduce prolonged lengths of stay

to promote patient throughput, with high dependency wards equally reducing prolonged lengths of stay.

10. The recommendation is that a non-hospital based unit(s) for service users requiring longer term, 24/7 complex care is commissioned. The implementation plan will consider whether these should remain NHS beds or whether an alternative model should be commissioned.
11. There should be a move to benchmark bed levels proposed by Royal College of Psychiatrists for adult rehabilitation services, equating to a reduction of approximately 50 beds. The detail of this will be developed as part of the implementation plan, including the timescales, recommended locations for residual hospital beds and reinvestment proposals. This work will include the development of a risk management framework to ensure the system of care is able to cope with each phase of the proposed reduction in beds.

16.2. Progress

Changing bed numbers and where they are located is very complex, even when reinvesting funds back into community mental health services.

The complex of Mental Health Services' includes Child and Adolescent Mental Health (CAMHS, Older People's Mental Health (OPMH), Adult Mental Health Care, Mental Health Social Care, Alcohol and Drugs, Learning Disability and Forensic Services. Existing Strategies identified proposals to shift the balance of care to more community options and to deliver increased specialist in-patient care where identified. The various individual plans for each of the mental health services for beds is as follows:

16.2.1. In Patient Beds and Care Home Provision

Continue with the journey on shifting the balance of care, moving away, where appropriate, from institutional, hospital led services towards to investment in local people, neighbourhoods and communities to enable services to be delivered locally and support people in the community.

Analysis confirms that NHSGGC remains a relatively high user of Older People's Mental Health in-patient beds. In addition, day of care and other audit activity has consistently confirmed high numbers of patients who could more appropriately be supported in other settings, including care homes and within the community. As we move forward it is the aim to reduce the overall number of in-patient beds, whilst utilising the best estate.

The following areas have been identified as key to supporting this.

- reinvest in our community services, as indicated across the strategies
- strengthening the responses to patients in crises situations to prevent admission wherever possible
- review the current provision for those patients who can no longer live independently at home.
- Via case note review and audit (in collaboration with info services and clinicians), we will seek to develop a robust understanding of who is using OPMH inpatient beds and their journeys into these beds. This will help inform what sort of alternative care arrangements would be effective.
- Focusing on early intervention to reduce admission to in-patient beds. Options include providing a short period of intensive input at home, supporting patients and their families through period of crisis.
- Continued investment and focus on Care Home Liaison Services to support Care Homes to maintain residents in their Care home environment, and prevent and reduce admissions to in patient settings

- Expanding access to psychological interventions, including non-pharmacological interventions for the management of 'stress and distress'' in dementia.
- Engaging with commissioning colleagues to further develop care settings in the community that are equipped and supported to deliver care to Older People with mental health issues as their condition progresses
- A focus on reducing delays in discharge back to home or an appropriate care setting in line with the persons care needs.

Reducing the total number of beds and wards generates a huge number of options for which inpatient bed services could be delivered and on which sites. Pragmatically therefore implementation proposals will consider the first phase of bed changes within an overall end point. This is so the first step of changes can be pragmatically tested for safety and quality purposes. It means we stay within broad end point principles and the overall direction of the Strategy. It also means initial phased implementation moves do not pre-empt endpoint solutions but also allow an evolving end point based on what we learn in practice due to our experience of change along the way.

Mental Health Inpatient Service	Current Strategy End point Bed Nos.	Refresh End point Bed numbers		Initial Phase Change endpoint	
Child Psychiatry	6	6		6	No change
Adolescent Psychiatry	24	24		24	No change
Adolescent Eating Disorder / Intensive	0	4		4	Increase in beds for adolescents with greater acuity of need and site linked to Adolescent service and Adult Eating disorder service
Eating Disorder (Adult)	4	10		10	Increase in beds to meet identified need and site linked to adolescent eating disorder beds and adult acute beds
Perinatal (Mother & Baby)	6	8		8	Increase in beds to meet identified need
Alcohol and Drugs Recovery	35	25		25	Reduced beds to meet need and maximise expertise
Learning Disability Assessment & Treatment	28	20		20	Reduced beds and move from isolated site to increase support options
Learning Disability Long Stay	8	0		0	Reduced beds to social care community support
Forensic Learning Disability	9	9		9	No change
Forensic Medium Secure Care	74	74		74	No change
Forensic Low Secure Care	44	59		44	Increase in forensic rehabilitation to meet need, repatriation of out of area placements and patient throughput efficiency
Intensive Psychiatric Care Unit	44	44		44	No change – review of secure acute assessment for people from prisons and Courts
Adult Acute Short Stay Assessment & Treatment	285	232		285	No initial phase 1 change due to full capacity. Consideration of possible future distribution of beds.
Adult Rehabilitation and Hospital based Complex Clinical Care including Enhanced Intensive Rehabilitation	128	87		113	One ward reduction to allow testing change in inpatient focus including Enhanced Intensive Rehabilitation beds to facilitate patient throughput efficiency in IPCU & Adult Acute Assessment & Treatment and repatriation of people and funding contribution to community rehab service
Older People Acute Short Stay Assessment & Treatment	205	119		205	One ward reduction to allow testing and funding of Community service and change in inpatient – transfer of resource to community alternatives and consideration of possible future distribution of beds and functional and dementia split
Older People Hospital based Complex Clinical Care	152	60		132	Two ward reduction to allow testing and funding of Community service and change in inpatient – transfer of resource to community alternatives and further options of distribution of beds and functional and dementia split
Total	1052	781		1003	

16.2.2. Overview

Current Mental health beds in NHS GG&C

- 1,052 mental health beds
- distributed across thirteen sites and
- 65 wards

Changing mental health bed numbers and the number of wards on any site affects services on all sites. When reducing or increasing bed numbers and wards a key question is which wards should be placed where and for what purpose.

Start Point Initial Phase Distribution of Mental Health beds across GG&C

Bed Numbers by Location	Addictions	Adolescent	Adult Long Stay	Adult Rehab	Adult Short Stay	Child Psychiatry	Eating Disorders	Elderly Long Stay	Elderly Short Stay	Forensic LD Low*	Forensic Low Secure	Forensic Medium Secure	IPCU	LD Assessment & Treatment	LD Long Stay	Perinatal	**Bed Total**		**Nos. Wards on Site**
Blysthwood														*16*			***16***		***1***
Dumbarton Joint								*12*									***12***		***1***
Dykebar			*12*	*8*	*15*			*42*									***77***		***4***
Gartnavel Royal	*20*		*18*	*12*	*80*			*20*	*45*				*12*	*12*			***219***		***12***
IRH Orchard View, Langhill, Larkfield			*12*		*20*			*30*	*20*				*8*				***90***		***5***
Leverndale			*35*	*11*	*94*				*38*	*9*	*44*		*12*			*6*	***249***		***16***
Netherton															*8*		***8***		***1***
Darnley - G4								28									**28**		**1**
Rowabank Clinic												*74*					***74***		***8***
RAH									*40*								***40***		***2***
Royal Hosp for Children						*6*											***6***		***1***
Stobhill	*15*	*24*	*20*		*76*		*4*	*20*	*44*				*12*				***215***		***12***
Vale of Leven									*18*								***18***		***1***
Total	**35**	**24**	**97**	**31**	**285**	**6**	**4**	**152**	**205**	**9**	**44**	**74**	**44**	**28**	**8**	**6**	**1052**		**65**

** LD – Learning Disability*

Mental Health Services benefit from a collective approach across HSCPs and NHS GG&C. This will include co-ordinating the delivery of all the mental health family inpatient services.

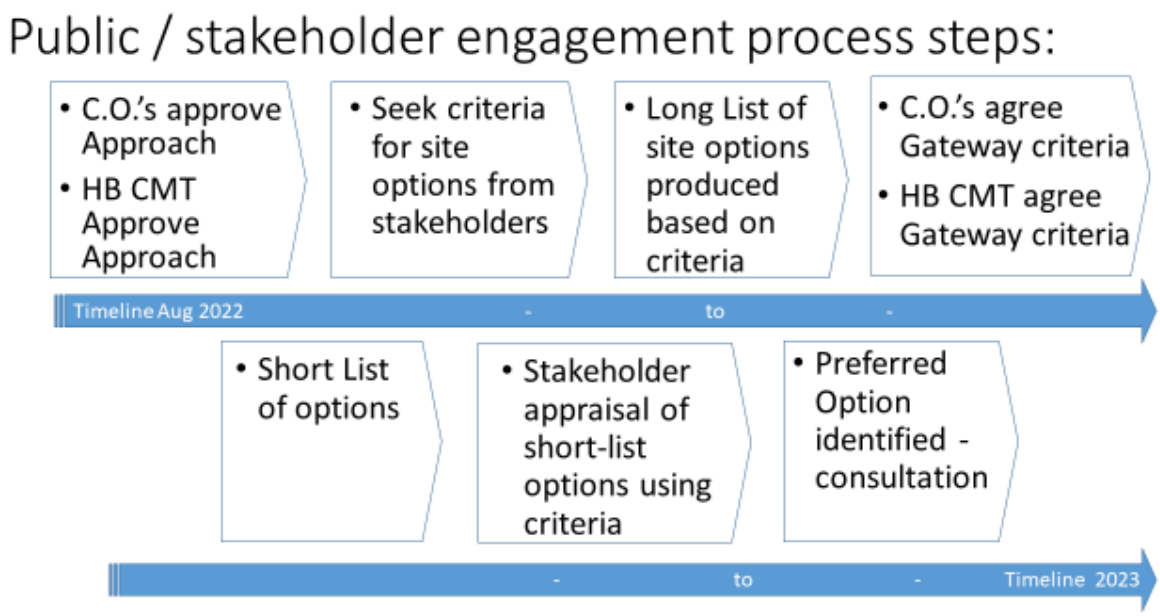
Dependences include that although sites are linked to community services people who need to be admitted can be admitted to any site. Particular wards and sites within NHSGGC/HSCPs do not solely belong to particular localities, but are managed on behalf of the whole system.
Some of the specialist services such as Perinatal Mental Health and the Adult Eating Disorder Service are single wards and also provided to anyone from within the six HSCPs and Health Board-wide area.

- Consultant Psychiatrist on-call cover is for Adult Mental Health, Learning Disability, Alcohol & Drug services, Older People's Mental Health Services is provided out of hours by one rota operating North and one rota operating South of the Clyde. There are single rotas for Forensic and Child and Adolescent Mental Health Services (CAMHS) operating Board-wide.
- Junior doctor out-of-hour rotas are managed system-wide to maintain cover while adhering to the European Working Time Directive.

- In some care groups with smaller critical mass of staff (e.g. clinical psychology in Learning Disability and in Alcohol and Drugs) system wide approach provides cover when required during vacancies, maternity leave and illness.
- During times of challenge ward nursing cross cover is also routine within sites, across sites and across the different mental health complex of specialty inpatient care.

Initial bed rationalisation has been delivered through incremental changes to acute sites (Parkhead), rehabilitation sites (Phoenix House) and also to older peoples hospital based complex clinical care nursing home site accommodation (Rowantree / Rogerpark).

The next step will be agreement to progress site impact engagement as follows:



Engagement on site impact across the range of sites and whole mental health complex of services will be the next main enabler for implementation progression.

17. Service User & Carer Engagement

17.1. Recommendations

1. Ensure staff are aware of their roles and responsibilities in respect of duties and powers of Carers Act for adult (including older adult) carers and young carers.
2. Ensure staff are promoting adult carer support plans and the young carer statement.
3. Supporting delivery and achievement of the Triangle of Care standards
4. Develop performance indicators to evidence impact of the above.
5. Service users' and carers' experience of their care, in line with the national health and wellbeing outcomes, should be regularly monitored and evaluated
6. Ensure that service user and carer networks are a core component of future service planning and implementation

17.2. Progress

Involving service users and their representatives in service planning is a core component of the development of the Service Strategies. Service user involvement and representation has been provided through the Mental Health Network.

Each HSCP commissions Advocacy services to ensure the rights of individuals who are subject to the Adults with incapacity (Scotland) Act (2000); Adult support and ,Protection (Scotland) Act (2007); the Patient Rights (Scotland) Act (2011); Charter of Patient Rights and responsibilities (2012); and the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Advocacy Services are provided via a procurement process and are monitored to ensure they meet the requirements of the agreed specification of service provision.

Service user involvement will remain a core component of the implementation plans that are to be developing.

17.2.1. Carers

Supporting carers is a key priority at a local and national level. To date, we have rolled out 'the Triangle of Care' tool across all mental health services to improve carer engagement and support. The Triangle of Care is a therapeutic alliance between each service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing. HSCPs are working on an on-going basis to support the delivery and achievement of these aims.

Key Messages from Service Users and Carers

- Carers – given the increased emphasis on home treatment particularly when people are ill it is imperative that carers are better supported in order to enable them to continue their vital role in the longer term. Carers should be supported to both be effective in their caring role and enabled to look after their own health.
- Poverty – Scotland's new Mental Health Strategy explicitly recognises the links between poverty and poor Mental Health. Models of support that are to be developed must be able to encompass this work.
- Social isolation – the Scottish Government recognises the damage social isolation causes, future models of "recovery" must encompass the social dimension and help ameliorate the impact of poor mental health.
- Rights –People can sometimes feel disempowered by the mental health system. A rights based approach should mean people enjoy a better relationship with services and a greater say in their care and treatment, leading to greater personalisation of their support.

- Prevention – A large amount of resource is directed at supporting people who have a repeated number of episodes of mental ill-health. A system wide approach that looks at learning from mental health crisis on a personal level and embraces preventative planning could greatly reduce service usage for such individuals.
- Engagement – Early engagement with key stakeholder groups is crucial in order to identify solutions to the issues faced, e.g. people with a lived and living experience and mental health carers as well as 3rd sector groups.

The Mental Health Network (of people and carers, with a lived and living experience of mental health issues) are commissioned within NHSGGC to support service user engagement and also sit on the board-wide Mental Health Strategy Programme Board and support the strategy.

A process to engage with public and staff on what is important to them when considering changes to bed numbers and site impact is in development. Pre-engagement is taking place with heads of services and leads from Third Sector Interface organisations in each HSCP, including leads from groups that represent people with protected characteristics to support co-production of the process itself.

Public and staff engagement on site impact has been delayed by COVID-19 and will continue in more normal times.

The Borderline Personality Development Network have formed a 'BPD Dialogues' group. This is a group of people who have a diagnosis of Borderline Personality Disorder and lived and living experience of using NHS services in Greater Glasgow and Clyde (NHS GG&C). They contribute to the planning and development of better services for people with a diagnosis of personality disorder through:

- Designing information leaflets and resources for people with the diagnosis, and their families and friends
- Contributing to the content and delivery of staff training on BPD
- Providing feedback on any aspect of the BPD implementation plans from the perspective of having lived and living experience

Other work streams are looking to develop similar engagement groups. e.g. CAMHS - An eating disorder reference group has been set up with representation from a member with lived and living experience and a third sector representative.

Performance indicators are to be developed with user and carer input to evidence staff are:

- aware of their roles and responsibilities in respect of duties and powers of Carers Act for adult carers and young carers;
- ensuring staff are promoting adult carer support plans and the young carer statement; and
- supporting delivery and achievement of the Triangle of Care standards

18. Workforce

18.1. Recommendation

1. Future workforce requirements and implications will continue to be assessed as part of the development of the implementation plan. It will be important to ensure on-going professional and staff side representatives have the opportunity to engage fully in this process and for the outputs to dovetail with HSCP Workforce Plans

Additional 2023 recommendation

CAMHS

2. Create dedicated strategic CAMHS pharmacist posts across Tier 3 (specialist multidisciplinary teams) and Tier 4 in line with services across the rest of the UK.

18.2. Progress

Mental Health services face several workforce issues which are relevant to this strategy, and these are summarised below. However, given the nature of the bed reduction changes proposed within this strategy, it should be noted that the following section focus primarily on health staffing issues.

In particular, workforce issues that require to be taken into account include the following:

- An increase in retirements, associated with:
  - An ageing workforce
  - Mental Health Officer Status
  - Changes to NHS pension provision
- Recruitment and retention, an issue for all professions, specialties and localities, but particularly intense in some areas;
- Nursing workforce standards
  - Application of the national workforce and workload planning tool
  - Nursing staffing standards for inpatient care

Specific issues relevant to the main professional groups and services are set out below.

18.2.1. Nursing

Full implementation of the 5 year strategy anticipates a reduction in Mental Health beds across GG&C, which will result in a reduced inpatient nurse staffing compliment. However, given current challenges in filling a number of nurse vacancies and anticipated turnover and retirements, the Programme Board remains confident that a phased approach to the implementation of the strategy will see the successful redeployment of all staff into the future service model. Such change would be managed in partnership with staff-side representatives, and in accordance with organisational change policies.

For those remaining hospital wards, there is a need to ensure that nurse staffing levels continue to meet the needs of the patients. The Royal College of Nursing (RCN) recommends a minimum percentage skill mix of registered to unregistered nurses at a ratio of 65:35. Further local NHSGGC work is equally based on a body of evidence that reports safer and improved outcomes for patients where there are more registered staff working on the wards. Future staffing levels and skill mix will therefore be measured against national workforce planning tools and it is likely this will result in a need to reinvest funding into some wards to improve skill mix.

18.2.2. Medical

Psychiatrists hold an essential role in diagnosing and treating complex and high risk patients and overseeing compulsory treatment under the mental health act. Additionally, medical staff have a clinical leadership role, supporting multidisciplinary mental health teams to work effectively.

NHS GG&C has traditionally been able to recruit to consultant posts, though Speciality And Specialist (SAS) Grade doctor posts were often more challenging. There are likely to be recruitment problems in some specialties in future.

Career-grade doctors typically work to a defined catchment area, and are expected to manage their workload across inpatient, community and specialist teams depending on the needs of the service. Referrals to CMHTs have been increasing by 3% per annum in recent years, and a proportion of this activity has been absorbed by the posts set out above.

As service gaps appear, clinical safety and service viability usually means that locums must be used and this can have disadvantage if it results in changes to clinical leadership and reduced continuity of care, such as occurred during COVID-19. Board-wide locum costs for medical staff across Mental Health, Learning Disability and Addictions services were contained in 2016/17, and were largely generated by vacancies relating to retirement and maternity leave which could not be filled using existing staff. Assertive use of local cover arrangements, GG&C locum bank staff and new arrangements with commercial agencies led to a reduction in costs of about 25%. However, the cost of locum cover is an ongoing challenge to NHSGGC.

Redeploying medical staff in response to the changing requirements of the strategy (for example from inpatient to community work) can often be achieved by negotiation over existing job plans. Any requirement to move consultant posts across localities would require meaningful engagement, time and careful planning and balancing of service need, medic wellbeing and career development to mitigate staff losses to avoid the risk of service gaps needing to be filled by non-NHS locums.

Psychiatrist involvement will always be required for the diagnosis and treatment of complex and high-risk patients, and in relation to mental health act work. With potentially fewer psychiatrists available, there will be an increasing need for medical staff to focus their resources on these groups of patients with role / task sharing with other disciplines in place to manage less complex and lower risk patients.

18.2.3. Psychology

Overall, in recent years, across NHSHHC, there has been a slight increase in clinical psychology staffing however some care groups have seen a reduction.

Some of the main challenges faced in the Clinical Psychology workforce are:

1. The small critical mass of Psychology staff in certain care groups including Learning Disabilities, Alcohol and Drugs and Older Adults.
2. Services have small numbers of clinical psychologists and other psychological therapists meaning they are vulnerable to not being able to provide care as expected when vacancies and forms of leave occur.
3. A significant number of staff have MHO status and can retire within the next five years.

4. Both a national and local analysis of gender and part-time working profile suggests that the Psychology workforce is a largely female profession and that many who join the profession reduce working hours within 3 years post training

The Scottish Government has recognised the importance of evidence based interventions for service users. A key element of this approach has been the development of a strategy to increase access to evidence based psychological therapies for many health conditions.

A major challenge in recent years within NHS GG&C has been achieving and maintaining the HEAT Standard on Access to Psychological Therapies across all Care Groups.

As the Scottish Government's Strategy develops this will continue to be a challenge and it will be a core element of NHS GG&C's Mental Health Strategy. Maintaining and increasing a critical mass of clinical psychology staffing will be an important part of the strategy.

18.2.4. Occupational Therapy

Occupational Therapy continues to have a role to play in the work streams of the GGC 5 year strategy. With its roots in person centred recovery focused practice, occupational therapists play a crucial role in helping people maintain their optimum level of independence within their communities. This is important at all stages of the patient journey from community and hospital to discharge. Shorter admissions will require robust discharge and support packages and planning to begin at the point of admission. Occupational Therapists will continue to make an essential contribution to this part of the pathway in terms of assessment and making recommendations about the level of support required for successful discharge. In addition consideration should be given to the review of such packages over time by an occupational therapist in order that adjustment of resource can be made based on need.

Within mental health services in the board, the majority of the Occupational Therapy workforce remains within secondary care services. There is growing evidence nationally that supports earlier intervention to Occupational Therapy gives better outcomes to patients. By working with people earlier in their journey, it enables occupational therapists to facilitate supported self-management techniques. This has been recognised by some of the HSCPs in GGC and they have included occupational therapy posts as part of their plans for the development of the Mental Well-Being Hubs. A newly developed service in Renfrewshire HSCP has introduced mental health occupational therapists into primary care. This service works alongside GPs and other primary care providing assessment and intervention with the principle of early intervention and supported self-management at the core of service delivery.

Occupational Therapists are experts in vocational rehabilitation. Employment and meaningful occupation/therapeutic activity are important to recovery and maintaining positive mental health. Earlier intervention by Occupational Therapists is likely to impact positively on people sustaining their employment, making reasonable adjustments at an early stage and helping people to find appropriate work which in turn assists with recovery. The recent legislation enabling occupational therapists to sign Fit Notes requires exploration with the development of an agreed governance framework within GGC.

A newer area of development for occupational therapists in mental health relates to neurodevelopmental work. Within Glasgow HSCP occupational therapy staff have been involved in the waiting list initiative, assessing people for ADHD. Specific to the profession has been the development of the occupational therapy SPARKS programme, a bespoke group work programme for people diagnosed via the WLI, with ADHD. This continues to be in the developmental stages and

is being delivered by staffing working additional hours. If a GGC service was to be developed then it will be crucial that occupational therapy is core within its structure.

There is not a standard workforce model in place within the organisation for Occupational Therapy. Within mental health services an occupational therapy data base has been developed which captures detailed and up to date analysis regarding workforce. This system is now being tested across other care groups within Partnerships.

18.2.5. Psychotherapy

Psychotherapy departments across NHSGGC include colleagues with a variety of backgrounds. Psychotherapists and Psychotherapy practitioners offer individual and group psychodynamic psychotherapies. Services include specialist city wide Personality Disorder and Homelessness team (PDHT), working with complex Personality disorder. Psychotherapy is currently exploring the future model of delivery and, similar to other services, have workforce planning issues.

18.2.6. Allied Health Professionals

In addition to Occupational Therapy, other allied health professions can also have a role in supporting a sustainable workforce across Mental Health, whether from within AHP services or from within the mental health team:-

Physiotherapy can deliver improvement in physical health / wellbeing that correlates to a reduction in depression and anxiety and better patient outcomes. Demographic data for Scotland highlights that the prevalence of mental health complaints can directly relate to a reduction in physical health and wellbeing.

Art Therapists can offer equitable access to psychological interventions for those who struggle to engage in talking therapies.

Mental Health Dietitians offer interventions to correct dietary inadequacies, address increased nutritional requirements, address special dietary requirements, to provide health improvement and education and to address where physical or mental health conditions impact on dietary intake or nutritional status.

The efficacy of Podiatry treatment could be enhanced for patients with mental health conditions such as anxiety and depression, which would help improve overall health outcomes for these patients.

Speech and Language Therapy can have a positive impact across several areas. These include: Identifying and ensure appropriate response to speech, language, communication and swallowing needs, providing a differential diagnosis, providing (targeted) training for staff to ensuring the links between speech, language, communication and swallowing needs are addressed, supporting people with Speech , Language & Communication Needs (SLCN) who are neurodiverse during periods of crisis and increasing the understanding of the links between speech, language and literacy and mental ill health and social potential.

18.2.7. CAMHS

Our workforce is key to the delivery of service to Children and Young People. The Pandemic and the MHRR funding has created significant movement in staff, some retiring, some moving to promoted posts and some joining CAMHS at the start of their career. Ensuring our workforce feels welcomed, supported and developed will lead to better sustainability of our services.

Example development: CAMHS Pharmacy trials

A CAMHS pharmacist would bridge a current gap in pharmacy services to the CAMHS teams and bring GGC in line with government strategy in expanding and diversifying the CAMHS workforce to meet service pressures. A trial is beginning where a pharmacist will provide both a clinical service and develop a pharmacy and medication strategy for CAMHS.

18.2.8. OPMH

The workforce supporting patients and families in the community should reflect the wide range of services required to meet their needs. The workforce within Older People Community Mental Health Teams has developed over time with investment in services and staffing resource including Care Home Liaison, Acute Hospital Liaison and intensive / crises support services.

Whilst the framework recognises the need for HSCP's to develop services and teams in a way that best fits their local population and services, it has been agreed that there should be consistency and equity in the roles and skills present. This should also reflect the integrated nature of Health and Social Care Partnerships.

Work is required to revisit and refresh the role, function and skills within the teams, ensuring that as we move forward our teams are fully integrated and include a wide range of health and social care professionals.

In common with many other services there are a number of workforce pressures within the Mental Health System. A number of actions require identifying to alleviate these pressures including considering how we become an "employer of choice", supporting our staff to utilise the full extent of their knowledge, skills and expertise, whilst also develop new roles to address the needs of the population, and offer opportunities for progression for staff. These include:

- Access to a broader range of Allied Health Professionals
- Development of Advanced Practitioner Roles (e.g. Advanced Nurse Practitioners / Allied Health Professionals)
- Addressing vacancies in Consultant Psychiatry Staffing and achieving a sustainable workforce
- Addressing vacancies in the nursing workforce, and considering how we attract newly qualified nurses into the range of mental health services
- Reviewing the current level of Psychology staffing
- Embedding Social Work and Social Care staff in all Community Mental Health Services/Teams

Further engagement is also likely to be required for educational bodies to attract sufficient applicants to fill available training places as well as expand them to meet current and future staffing needs.

18.2.9. ADRS

Similar to the wider workforce, all ADRS teams report increasing levels of staff vacancies. This in turn leads to increased demands on existing staff, with increased caseloads, which in turn is resulting in difficulty to retain staff in post. Issues relating to staff recruitment are experienced at all levels and in all posts within ADRS.

Staff have identified that, due to increasing patient caseloads and during the COVID-19 pandemic, it is increasing difficult / there is a lack of opportunity to undertake development or participate in

existing training programs. The GADRS Review and thematic analysis of SAEs has evidenced that a Training Needs Analysis is required within an implementation of a workforce development plan.

19. Digital and eHealth

Before the pandemic, mental health services were already evolving to make better use of data and digital tools. The importance of these were evidenced through the COVID-19 pandemic which also demanded we move further and faster with our plans. This section, specifically focusing on digital and eHealth, was included in the strategy as a result.

19.1. Recommendations

1. Develop a data Strategy for Mental Health Services
2. Expand and ensure widespread access to Clinical Informatics
3. Continued investment in Mental Health Digital Team to support the progression of digital technologies within mental health services
4. Develop a patient facing application which allows patients to self-refer to services (where appropriate), choose appropriate assessment/treatment appointment slots and be able to complete information relating to equality
5. Continue IT investment in systems that improve delivery and quality such as Hospital Electronic Prescribing Medicines Administration and a full Electronic Paper Record (EPR)
6. Align EPR development with the data strategy to ensure the appropriate clinical and performance measures are captured to support quality improvement
7. Identify clinical 'champions' and develop forums that encourage staff engagement and ownership
8. Continue to engage actively with citizens and patients to inform service improvements
9. Replace paper processes with digital alternatives
10. Modernise and enhance existing systems to be fit for the future
11. Maintain our ability to respond to future challenges such as another pandemic
12. Increase the use of technology to support patient care, including virtual consultations
13. Provide the digital developments that support hybrid / blended working for our staff

19.2. Progress

During the COVID-19 epidemic Strategy recommendations have accelerated the rapid pace of development and the importance of 'digital' in terms of both advances in technology and clinical applications.

19.2.1. Access and Choice for Patients

Virtual Patient Management (VPM) includes telephone consultations and video conferencing. This has become a new way of working within mental health services since the onset of the COVID-19 pandemic. Mental health services implemented these solutions to ensure that where appropriate, consultations could continue while not all being face to face. Supporting guidance was developed for both staff and patients in relation to engaging with remote consultations. Virtual appointments will continue post-pandemic with clinical staff, in partnership with patients, continuing to assess suitability as per clinical guidance, utilising these appropriately.

19.2.2. Virtual Front Door and direct patient access.

Work is currently being undertaken to utilise patient facing applications that support patients within mental health services to receive results and appointments.

19.2.3. Self-Management

Mental Health will be part of a patient-facing Self-Management mega support app being developed in collaboration with four other specialties and the NHS Scotland DHI Right Decision System.

19.2.4. Safe And Secure Clinical Applications And Systems Which Support Patient Care And Information Sharing

The process to migrate from paper to digital records continues. There are four cornerstone applications which form the electronic patient record (EPR) within mental health services, these being; EMIS Web, TrakCare Order Comms, Clinical Portal and HEPMA. Considerable work has been carried out to ensure that each of these applications have had a planned and structured rollout within both inpatient and community services. This work is ongoing with current rollout of HEPMA to all mental health inpatient wards during the summer of 2022 and the further development of inpatient electronic record on EMIS which is due to be completed by summer of 2023.

Digital Champions Forums across community and inpatient services promote the use of digital applications within clinical areas, provide an opportunity to share learning, highlight challenges and input into future developments/functionality within these applications.

19.2.5. Evidence Based Reliable Data Driven Decision Making, Clinical Informatics

The value of high quality accurate clinical data in the ongoing provision of clinical care, operational decisions, future planning and scientific developments needs to be acknowledged and facilitated. Work is required to; improve data quality, improve the consistency of information recorded, support availability of accurate reports on service activity.

19.2.6. Digital Literacy

Digital literacy is defined as, “those capabilities that fit someone for living, learning, working, participating, and thriving in a digital society". These capabilities extend beyond just technical proficiency in using specific clinical systems, but include more conceptual knowledge such as data use, digital safety. It is the broad nature of these capabilities that make digital literacy foundational for all staff working in modern healthcare settings. Knowing which tools to use, and when, can support the delivery of care.

Our vision for digital literacy of the workforce in NHSGGC is to:

- Not assume staff are digitally literate
- Define a framework of recommended core and area specific digital skills for all staff.
- Evaluate the digital literacy of staff to enable a conversation on learning for digital success
- Adopt digital skills in the induction, and the learning and development process for mental health staff
- Provide the tools and technologies required for staff to work at their best digital capacity
- Promote an “I need digital to do…” approach to discovery and curiosity

For service users and carers, there can be both benefits and disadvantages of ‘digital’. These will need to be weighed against each other when deciding on the most appropriate type of appointment. It will be essential to avoid exacerbating or creating inequality among people seeking and accessing health care.

Challenges include the level of digital literacy, access for people experiencing digital barriers and others who may find this type of interaction difficult.

Benefits include where increased use of video consulting could improve access to services for those with barriers related to travel.

The Scottish national strategy, A Changing Nation: How Scotland will Thrive in a Digital World[20], looks to address digital exclusion. Digital mental health services will be developed and delivered with 'no one left behind'.

19.2.7. Telehealth / Telecare and Digital Solutions

In addition to universal/general challenges, the challenges faced by Older People with Mental Health issues and specifically cognitive decline has resulted in limited use and proved to be an additional barrier. As we move forward we need to continue to maximise opportunities for Older People to engage with technology that enables and improves access to a broad range of health, wellbeing and community resources.

19.2.8. CAMHS

Have also embraced a range of digital developments: Near Me, SMS text messaging, Order Comms and winvoice pro. In addition to the digital innovation we are working to extend our relationships with Universities and our Research agenda

[20] A Changing Nation: How Scotland will Thrive in a Digital World

20. Finance

20.1. Recommendation

1. Complete a forward financial framework for GGC to support implementation and delivery of the strategy based on the financial assumptions

20.2. Progress

20.2.1. Financial Context

Mental Health Services currently operates within a budget of £185m across Greater Glasgow and Clyde. This budget is made up of a number of funding streams:-

- Core service budgets
- 'Action 15' funding which was secured from the government's national mental health strategy to increase the workforce, giving greater access to mental health services to A&Es, GPs, the police and prisons.
- The Mental Health Recovery and Renewal Fund (established 2021) focuses on four overarching themes:-
    - Promoting and supporting the conditions for good mental health and wellbeing at a population level.
    - Providing accessible signposting to help, advice and support.
    - Providing a rapid and easily accessible response to those in distress.
    - Ensuring safe, effective treatment and care of people living with mental illness.
- Winter Planning for Health and Social Care (Oct 2021) was initially provided to help protect health and social care services over the winter period and has also been provided on a recurring basis to support longer term improvement in service capacity across our health and social care systems. Within mental health services this has been used to:-
    - Increased capacity OPMH and AMH discharge teams
    - Increased Mental Health Officer capacity
    - Testing an increase in psychological support for commissioned care homes.
    - Complex Care Discharges which require purchasing enhanced packages of care to support discharge from mental health adult and OP wards
    - Commissioned LD and MH purchased placements including Housing First (in Glasgow City)
- Other dedicated funding from Scottish Government which gives guidance in how it is to be utilised. For example, perinatal and infant mental health

The Scottish Government had provided a clear commitment to Mental Health as part of its Programme for Government 2021-22, which commits to "Increase direct mental health investment by at least 25% over this Parliament, ensuring that at least 10% of frontline NHS spend goes towards mental health and 1% goes on child and adolescent services." However, the Scottish Government has also subsequently recognised the challenging fiscal environment which it currently operates within the Resources Spending Review. This document outlines the Scottish Government approach which seeks to hold the total public sector pay bill at the same value as 2022-23, with staffing levels in total terms returning to pre-pandemic levels. It also highlights the need for the delivery of at least 3% savings each year. This context and the impact on funding specifically for Mental Health Services will be required to be considered when developing the financial framework to support delivery of this strategy.

20.2.2. Financial Framework

A new financial framework is being developed to support the implementation of this strategy. As a result of the financial context outlined above, the Mental Health Strategy will require a phased approach to implementation, with implementation being phased as funding becomes available.

The 2018 strategy financial framework identified the potential for a release of funding from disinvestment in services which could be used to further develop community services and deliver on the objectives of the strategy. The COVID-19 Pandemic and currently increased demand for mental health services will impact on the ability to deliver to the level originally planned by the 2018 strategy. A new approach will be required in order to continue supporting the Strategy from 2023 onwards.

In some cases, the change programme required to engineer and deliver a significant shift in the balance of care will need to be enabled by access to transitional funding or bridging finance. It is critical that new alternative services are able to be put in place in advance of any existing services being reduced and before any current mainstream resources can be released.

The financial framework will indicate the priorities, phasing of investment and where funded from existing budgets / funding or requiring new investment. This will help identify from where new investment can be sourced.

Developments will be fully costed as part of future updates to this strategy.

20.2.3. Capital Funding

The extant capital proposals to realign the inpatient estate to the service strategy utilised a mixed approach to sources of funding and was designed as a pragmatic response to enable immediate implementation of the more urgent service imperatives whilst rephrasing implementation of less urgent areas that are to be linked to the projected timing of treasury capital and capital receipts. The phasing of implementation was as follows:

- Phases 1 & 2 – A two stage process to reconfigure mental health services in North Glasgow that saw the withdrawal of the final 2 AMH acute wards from Parkhead Hospital reprovided on the Stobhill site, and 2 wards of Older People Mental Health complex care beds from the Birdston Complex Care facility reprovided on the Stobhill & Gartnavel inpatient sites.
- Phase 3 – The consolidation of Alcohol and Drugs Addiction inpatient services at Gartnavel Royal.
- Phase 4 – The consolidation of acute adult mental health beds for South Glasgow and Renfrewshire on the Leverndale site.

Capital monies are already committed for Phases 1 and 2 outlined above.

More detailed plans for the implementation of phases 3 and 4 above are to be developed through the site impact process as the number of potential location of services in future evolves along with HSCP and NHSGGC capital planning processes. Implementation timescales will depend on the availability of inpatient accommodation, future fixed term revenue costs for some inpatient wards that were not built using one off capital money and existing accommodation that will be retained for future inpatient use. Agreement to engaging on the site impact process now requires HSCP and NHSGGC signoff.

21. Managing Risk

21.1. Recommendation

1. The implementation plan should include the development of a risk management framework to identify, pre-empt and mitigate risks to the system of care to inform each phase of change.

21.1.1. Risk Management Framework

This will aim to provide robust service user and service indicators to inform of how the system of care is responding to the stepped changes in provision as each ward change occurs. The consensus of professional opinion from those involved in developing strategy remains that the scale and timing of the proposed changes to inpatient care, results in a gradation of risk that can be broadly split into three categories;

- delivering the first 1/3 of the inpatient redesign carries a low-to-medium level of risk.
- delivering the second 1/3 of the inpatient redesign carries a medium-to-high risk.
- delivering the last 1/3 represents a stretched target and therefore carries a higher risk.

This gradation of risk is summarised below.

Estimated service risk at different levels of change

Ward Type	**LOW to MEDIUM RISK**		**MEDIUM to HIGH RISK**		**HIGH RISK**
Mental Health Acute Short Stay specialties	Reduction of	1 ward	Reduction of	2 wards	Reduction of 3 wards
Mental Health Rehabilitation & Long Stay specialties	Reduction of 1	to 2 wards	Reduction of	3 wards	Reduction of 4 wards
Other Specialist Mental Health Services	Increase of 1	to 2 wards	Increase of	3 wards	Increase of 4 wards

Therefore, while the strategies demonstrate that it will be possible to make on-going transformational changes with system redesign in the next few years, it also shows the vulnerability of a system that can become destabilised by relatively minor changes in its component parts.

It is proposed that the risk management framework includes a prospective 'dashboard' of potential warning signs to inform each phase of implementation. An example of a suite if indicators to help estimate risk at different stages of change is set out below;

Risk	Early warning signs
Lack of bed availability when needed	• Bed occupancy persistently >95% • Boarding rates persistently >1% • increase in suicide rate • Increased detentions under the Mental Health Act • Increased / unusual rates of readmission
Recruitment and retention problems across the service tiers, both in statutory and non-statutory services	• % shifts covered by agency/locum/bank staff • Number of vacancies unfilled despite advert • Staff turnover • Sickness absence rates
Demand exceeds capacity for community teams and commissioned community services, both statutory and non-statutory services	• Rising waiting lists • Failure Demand • Conditions becoming more chronic and then requiring greater levels of intervention at higher cost • Lack of suitable accommodations or funding to move people through the system of care – people become 'stuck' in the wrong service tier for their needs • Increasing Delayed Discharge rates
Community Care becomes more episodic and fragmented	• A tightening of eligibility criteria • Increases in referrals to crisis services
Adverse impacts for other interdependent services or plans	• 'cost-shunting' or evidence of significant pressure on other parts of the care system • Delays in implementation plan timescales due to lack of co-ordination
Feedback from service users and carers	• Perceived reductions in the quality of care or service experience • Increase in formal complaints

22. Management and Governance

22.1. Recommendations

1. HSCPs and NHSGGC should maintain a whole-system approach to the strategic planning of Mental Health Services.
2. The remit of the Programme Board should be extended to include closer coordination with Older People's Mental Health and other care groups.
3. The implementation of the 5 year Strategy should be aligned with the Moving Forward Together transformational plans set out by NHS GG&C Board.
4. The scope and responsibilities of the whole-system "coordinating" role for adult mental health held by the Chief Officer of Glasgow City HSCP should continue.
5. Consideration is required on the governance and engagement arrangements surrounding the development and progression of an Implementation Plan, following approval of the 5 year strategy.

22.2. Progress

An Adult Mental Health Strategy Programme Board was established to provide overall coordination with membership from HSCP management, professional leadership, staff partners, and representation from the mental health network on behalf of users / carers. Implementation of the mental health strategies continues to be aligned with the Moving Forward Together transformational plans as set out by NHSGGC.

Multiple work streams have been established under the programme board to progress implementation:

- Prevention, Early Intervention and Health Improvement
- Recovery
- Effective and Efficient Community Services
- Commissioning
- Communications and engagement
- Workforce
- Unscheduled Care
- Digital / eHealth
- Rehabilitation
- Inpatients and bed modelling

Strategies have tended to focus on a single system approach to mental health across the board area but less so across services. The remit and membership of the programme board has been expanded to ensure greater connection across the wider mental health complex, including Older People's Mental Health, Adult Mental Health, Learning Disabilities, Child and Adolescent Services and Addictions which will require closer working across the different governance and strategy delivery structures.

Some HSCP Chief Officers hold responsibility for co-ordinating the strategic planning of mental health services on behalf of other HSCPs within NHSGGC (e.g. Adults, OPMH, LD) and this continues to be recognised. NHSGGC-wide professional leaders are in place and have a strong connection with NHSGGC Board responsibilities for governance and public health. These function alongside the collegiate management responsibility across HSCPs and NHSGGC.

A Learning Disability Programme Board, led by the East Renfrewshire Chief Officer, has been established to plan inpatient redesign and increase the resilience of community teams and commissioned services to improve pathways and sustain community placements for services users. This Learning Disability programme board reports into the Mental Health Strategy board and covers two key work streams: Community and Inpatient redesign and multi-agency collaborative commissioning.

Older People's Mental Health services have a board-wide strategy group to ensure a shared approach.

The governance and engagement arrangements surrounding the development and progression of implementation continues to be considered on an on-going basis.

System-wide clinical governance is co-ordinated e.g. by a Mental Health Quality and Care Governance Committee, chaired by the Associate Medical Director for Mental Health, and reported through the Board Quality and Governance Committee to the NHS GG&C Medical Director and ultimately to the NHSGG&C Chief Executive.

SUPPLEMENT

to

A Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde: 2023 – 2028

25 05 2023

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This supplement adds to the 2017-2023 Adult Mental Health Strategy and the subsequent 2023-2028 Refresh in providing additional or new information on the roles and functions of the wider mental health complex and the additional focus on Digital / eHealth.

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1. Introduction

This supplement to the 'Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde: 2023 – 2028' provides, or adds to, information on services not included in the original strategy for adult mental health services 2018-2023, reflecting the expanded scope that now takes account of the wider complex of mental health services.

The following table shows how the chapters in the Supplement map across to the Strategy Refresh.

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2. Public Mental Health

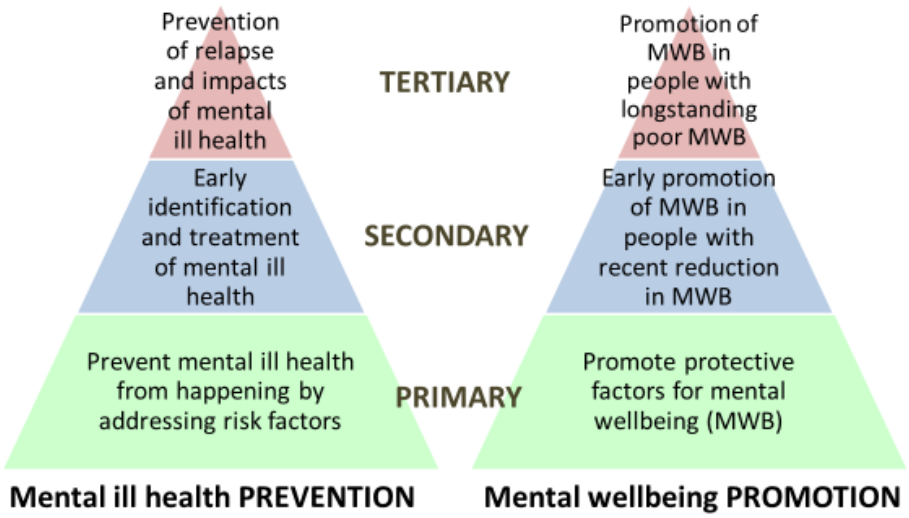
The term 'public mental health' means taking a systematic approach to working towards the best mental health possible for the whole population. This includes addressing both the root causes of poor mental health and strengthening the factors that boost positive mental wellbeing, in active partnership with relevant communities.

It seeks to address the social, environmental and individual determinants of mental health and:

- improves population mental health through the promotion of mental wellbeing, prevention of mental health problems and improving the quality of life of those experiencing mental ill health
- reduces inequalities in mental health
- reduces the health inequalities of those experiencing mental health problems

This should be done using a proportionate universalism approach, which addresses whole population mental wellbeing promotion and provides additional targeted support for high risk groups proportionate to the level of need.

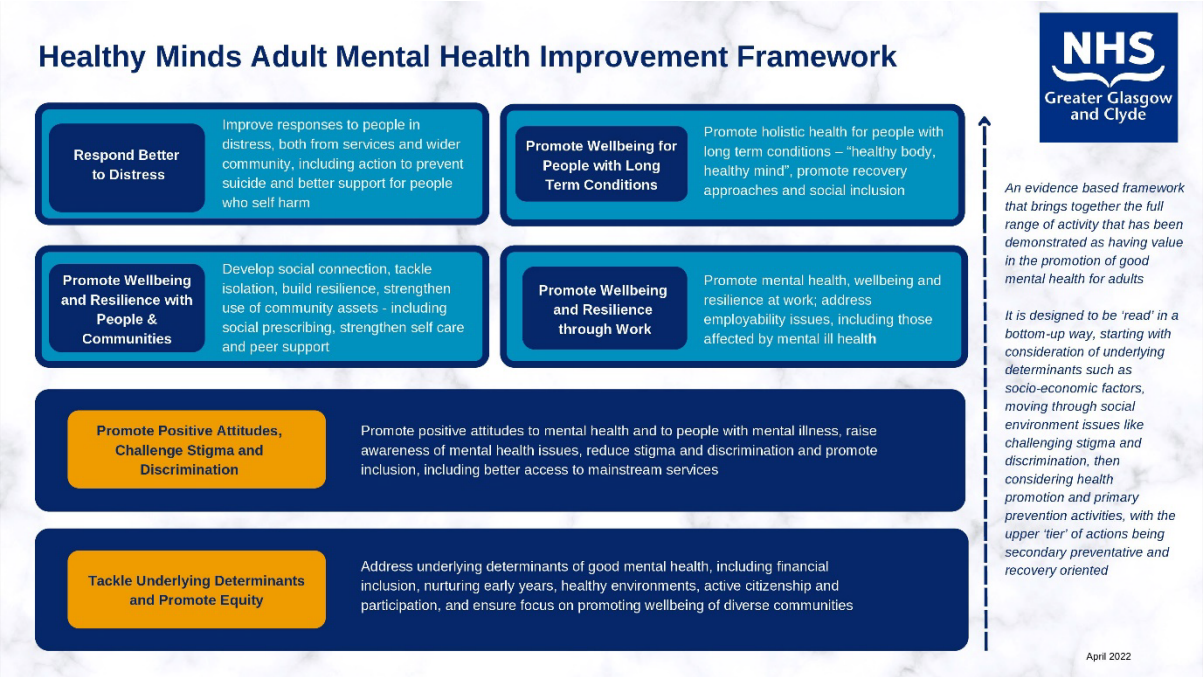
Splitting action into prevention and promotion, including primary, secondary and tertiary, helps to map out existing work and priorities for future focus.

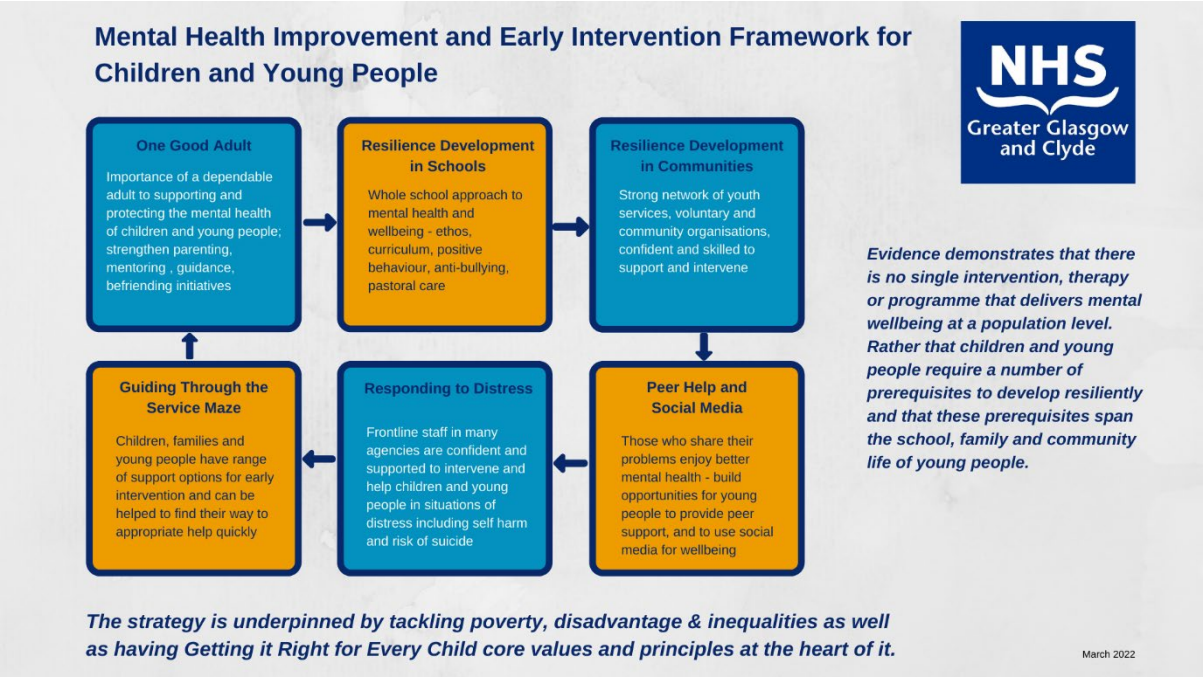


Mental wellbeing promotion and mental ill health prevention are considered and described across the life course, examining the main protective and risk factors at different stages of life and what can bolster or mitigate these factors.

2.1. Frameworks for action

The key elements of a public mental health approach are summarised both for adults and children and young people in separate evidence based strategic frameworks[1,2].





2.2. Children and Young People

The majority of mental health problems will develop before age 24 with 50% of mental health difficulties established by age 14. Mental health and wellbeing is declining in children and young people, with the COVID-19 pandemic having a disproportionately negative impact on this group, especially older young people.

2.3. Inequalities

Mental health is not experienced equally across the population, with higher risk of poor mental health in specific groups. These inequalities are driven by the wider determinants of mental health: poverty, employment, education, housing, social capital etc. Groups who experience stigma and discrimination such as BAME, LGBTQ+ and people with disabilities, are also more likely to experience poor mental health. The pandemic has had a disproportionately negative impact on those who already had higher risk of poor mental health.

2.4. Finding the right help at the right time

There is a wide spectrum of mental health support needed from preventative to acute distress response. Finding and accessing the right support at the right time is imperative to supporting good mental health and early or acute intervention when needed.

2.5. Training

Raising awareness and developing skills within the workforce and wider society around mental health continues to be a priority.

2.6. Partnership Working

Many of the opportunities and mechanisms for action and change sit out-with the NHS's direct control: e.g. in communities, Local Authorities and Third Sector and it is important to influence change through encouraging partners to view and consider issues through a public mental health lens.

3. Older People's Mental Health

Older Peoples Mental Health Services provide services and support to Older People (typically aged over 65), with moderate to severe mental health illness. Support and services are provided in a variety of settings including in the Community, Care Homes, Acute Hospital Liaison Service (Secondary Care) and In Patient Services in specialist Older People's Mental Health Beds.

Service users primarily access services via referral to an Older People's Community Mental Health Team by their General Practitioner. The Older People's Community Mental Health teams are well established multi-disciplinary teams, with a range of health and social professionals within the teams. These include medical, nursing allied health professionals, (for example Psychology/Psychological Therapists and Occupational Therapy), social work and social care colleagues.

Patients may present with a variety of issues including Functional Mental Health which includes support for conditions such as depression, anxiety, psychosis, or Organic Mental Health needs, which would include people with a potential or diagnosed dementia or cognitive impairment.

3.1. In- Patient Beds

In – Patient Beds fall into two categories; Acute Admission and Hospital Based Complex Care Beds and within this to Organic (i.e. for patients with a potential or actual diagnoses of Dementia or Cognitive Impairment) and Functional (i.e. for patients with conditions such as depression, anxiety, psychosis).

3.1.1. Acute Admission

Patients are admitted to an Acute Admission bed when they are in crises and require the full range of support available in a hospital in patient setting. Patients are admitted to these beds when their illness cannot be managed in the community, and where the situation is so severe that specialist care is required in a safe and therapeutic space.

Patients remain in these beds for a short period of time**.** As patients move through their treatment journey, discharge planning will commence and will include an assessment both of their mental health and social care needs.

3.1.2. Hospital Based Complex Clinical Care

The Scottish Government's national guidance for Hospital Based Complex Clinical Care (2015) set out a vision to disinvest from long stay beds by finding alternative strategic commissioning solutions in the community, stating "as far as possible, hospitals should not be places where people live – even for people with on-going clinical needs".

Patients admitted to a Hospital Based Complex Care Bed require care that **cannot be provided in any other setting**, these patients are reviewed every three months and as their care needs change may be discharged from HBCC to another care setting.

3.2. Liaison Services & Support

Our liaison services are aligned with our OPMH Community Teams. There are two different liaison responses; Secondary Care (Acute Hospital Liaison) Care and Care Home Liaison.

3.2.1. Care Home Liaison

The Glasgow City HSCP Care Home Liaison Service offers an effective and time limited response to the challenges associated with increasing demands for complex care beds for residents living with dementia. The service aims to promote a model of person-centred care that takes into account patients' needs, preferences, strengths, drives consistency of service delivery processes; as well as setting out a framework of key performance measures. It also aims to ensure care is delivered in the least restrictive manner. This is achieved through undertaking comprehensive mental health assessments, developing care/interventions plans with the emphasis on preventing and reducing acute admissions to hospitals, and through the reduction of anti-psychotic prescribing. The service also promotes proactive and preventative strategies to managing distressed behaviour through the promotion of non-pharmacological interventions. The service supports care home staff to develop their skills and competencies in mental health and in managing stress & distress behaviour through the delivery of training, which is matched to their skill level of expertise as outlined in the Promoting Excellence Framework. The service is delivered by Community Health Liaison CPNs, Psychiatrists with some resourcing for Clinical Psychology.

3.2.2. People's Mental Health Acute Hospital Liaison Service

The strategic priority of the Older People's Acute Hospital Liaison Service is to improve integration between physical and mental health care in the acute hospital context. A collaborative, multidisciplinary approach is adopted to care and discharge planning with the following aims:

- to improve the overall quality of care;
- reduce barriers to discharge and unnecessary re-admissions;
- to provide smooth transition to appropriate HSCP and third sector services; and
- to increase access to mental health care in underserved groups with high level of need (e.g. older adults with multi-morbidities, long term conditions, cognitive impairment).

Acute Liaison Services have been shown to offer excellent value for money, with improved health outcomes for patients and significant cost-savings for the NHS, namely due to more timely discharges and fewer unnecessary re-admissions, particularly among older patients (see Parsonage and Fossey, 2011).

The Glasgow City HSCP OPMH Acute Hospital Liaison service is a multidisciplinary team comprising of Psychiatry, Clinical Psychology and Nursing staff. Teams are attached to North East, North West Glasgow and Glasgow South localities. Clinical Psychologists within the team provide assessment, formulation & intervention for older people during their admission to acute or rehabilitation hospital wards. They also provide consultation and training to multi-disciplinary colleagues on supporting psychological aspects of patient care (e.g. Psychological interventions in response to Stress and Distress in Dementia and trauma-informed care). The service will assess and treat older people aged 65 years and above who are within an inpatient acute hospital ward; where there is a concern that the individual's mental health needs are impacting their physical health care/treatment or causing a delay to their discharge from hospital.

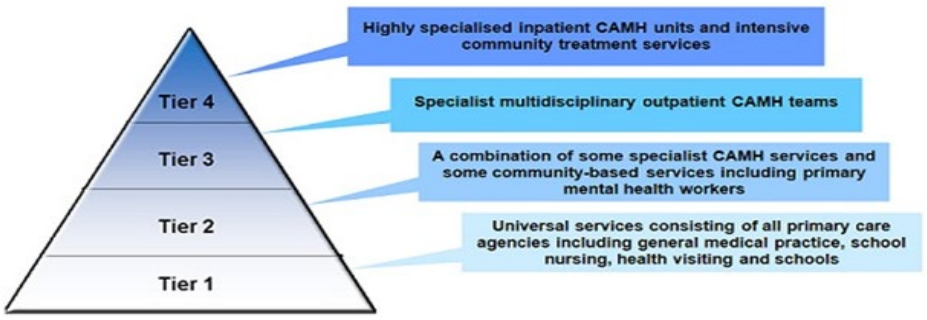
4. Children and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) are multi-disciplinary teams that provide (i) assessment and treatment/interventions in the context of emotional, developmental, environmental and social factors for children and young people experiencing mental health problems, and (ii) training, consultation, advice and support to professionals working with children, young people and their families. CAMHS supports children up to age 18yrs and for targeted group up to age 25yrs.

All children and families should receive support and services that are appropriate to their needs. For many children and young people, such support is likely to be community based, and should be easily and quickly accessible.

Children, young people and their families should also be able to access additional support which targets emotional distress through Community Mental Health and Wellbeing Supports and Services. Community supports and services should work closely with CAMHS and relevant health and social care partners, children's services and educational establishments to ensure that there are clear and streamlined pathways to support where that is more appropriately delivered by these services.

Mental Health supports for Children and Young People are delivered through a Tiered approached



There are eight Tier 3 Community CAMHS teams within NHSGGC spanning the six Health and Social Care Partnerships. These services are supported by a range of Tier 4 Board wide services: Intensive and Unscheduled CAMHS, Forensic CAMHS, Connect Eating Disorders team, and a range of mental health services delivered in to Women and Children's Directorate. GGC hosts the national Child Psychiatry Inpatient unit and the West of Scotland Adolescent Psychiatric inpatient unit.

5. Perinatal Mother and Infant Mental Health

Perinatal refers to the period during pregnancy and up to one year after the baby is born. During this period new and expectant parents (mums, dads, partners) can experience issues with their mental health also known as perinatal mental health problems. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period. These illnesses can be mild, moderate or severe, requiring different kinds of care or treatment.

Around 1 in 10 women will experience postnatal depression after having a baby. Depression and anxiety are equally as common during pregnancy. Most women recover with help from their GP, health visitor, midwife and with support from family and friends. However severe depression requires additional help from mental health services.

The symptoms of postnatal depression are similar to those in depression at other times. These include low mood, sleep and appetite problems, poor motivation and pessimistic or negative thinking.

Two in 1000 women will experience postpartum psychosis. The symptoms of this illness can come on quite rapidly, often within the first few days or weeks after delivery, and can include high mood (mania), depression, confusion, hallucinations (odd experiences) and delusions (unusual beliefs). Admission to a MBU is advised for most women, accompanied by their baby. Women usually make a full recovery but treatment is urgently necessary if symptoms of postpartum psychosis develop.

5.1. Perinatal Mental Health Service

Scotland's first specialist perinatal mental health inpatient and community service for mothers, babies and their families provides a comprehensive service which consists of:

The West of Scotland Mother and Baby Unit (MBU) is situated in purpose-designed facilities at Leverndale Hospital and is staffed by a multi-disciplinary team of professionals admits women who are experiencing severe mental illness in the later stages of pregnancy or if their baby is under 12 months old. It allows for the joint admission of mothers accompanied by their babies, where the woman requires acute inpatient mental health care and enables mothers to be supported in caring for their baby whilst having care and treatment for a range of mental illnesses including:

- postnatal depression
- postpartum psychosis
- severe anxiety disorders
- eating disorders

The unit offers a wide range of therapies including biological, psychological and psychosocial interventions including interventions to enhance the mother-infant relationship.

The Community Perinatal Mental Health Team (CPMHT) are a specialist multi-disciplinary team service providing care and treatment to women who are pregnant or postnatal and are at risk of, or are affected by, significant mental illness in pregnancy or the postnatal period. They also offer expert advice to women considering pregnancy if they are at risk of a serious mental illness on risk and medication management, and provide a maternity liaison service to all NHSGGC Maternity hospitals.

The service will work in partnership with partners and families, maternity services, primary care (including health visiting and Family Nurse Partnership), adult social services, children & families social services and other agencies, to design, implement and oversee comprehensive packages of health and social care to support people with complex mental health needs.

The Infant Mental Health Service is a specialist community multidisciplinary team who can draw on a range of expertise and experience to offer needs-led support for infants and families. A key aim of the service is to ensure that the voice and experience of the infant is held at the centre of work with families across the health board.

The multi-disciplinary Maternity & Neonatal Psychological Interventions (MNPI) Team will address the common and/or mild to moderate psychological needs of the maternity and neonatal populations by providing in-patient and out-patient assessments and a range of evidence based psychological interventions. The central focus in all of these interventions is to enhance the parent-infant relationship, improve parental and infant mental health and to prevent a range of psychological difficulties (emotional and cognitive) in childhood and later life.

6. Learning Disability

"We believe that people with learning disabilities should be given the right support so that they can live fulfilling lives in the community. This support should always be person centred, preventative, flexible and responsive. People should only be admitted to inpatient assessment and treatment services when there is a clear clinical need which will benefit from hospital based therapeutic intervention. Challenging behaviour, with no identified clinical need, is not an appropriate reason to admit people to inpatient assessment and treatment services."[1]

A learning disability is a significant, lifelong, condition that starts before adulthood. It affects a person's development and means they need help to:

- Understand information
- Learn skills
- Cope independently

Learning difficulties, such as dyslexia, ADHD, dyspraxia and speech & language difficulties are not defined as a learning disability due to the specific nature of their developmental delay.

Policy and practice guidance commonly distinguishes between two reasons why people with learning disabilities may require or be at risk of admission to inpatient assessment and treatment services:

- people who have mental health problems may need assessment and treatment for an acute episode of ill health or, for example, to manage a change in medication under close supervision
- people who have a history of behaviour that challenges (or an unexplained change in behaviour) may need admission for very detailed investigation; sometimes admission is seen as the only option for people who need time away from their usual home

East Renfrewshire is host HSCP for managing specialist inpatient learning disability services with community services directly managed by each HSCP.

7. Alcohol and Drug Recovery Services

The Alcohol and Drug Recovery Service (ADRS) comprises integrated multi-disciplinary teams of health, social care workers, qualified social workers and administrative staff, providing a Recovery Orientated System of Care to adults and young people with drug or alcohol dependency and significant problem substance use.

Services include: alcohol in-patient and community detoxification and supportive medications, opiate replacement therapy, psychosocial support, harm reduction advice and interventions, needle replacement, blood borne virus testing and treatment, access to alcohol and drug Tier 4 services, psychiatry, psychology, occupational therapy, specialist inpatient and outpatient services. ADRS also provides access to a range of commissioned services delivered by third sector partners such as residential, crisis, rehabilitation and stabilization services and community Recovery Hubs, and recovery communities.

[1] Designing an Effective Assessment and Treatment Model, NHS Greater Glasgow and Clyde 2018

ADRS staffing comprises NHS and local authority comprising: health, qualified social worker, social care and admin.

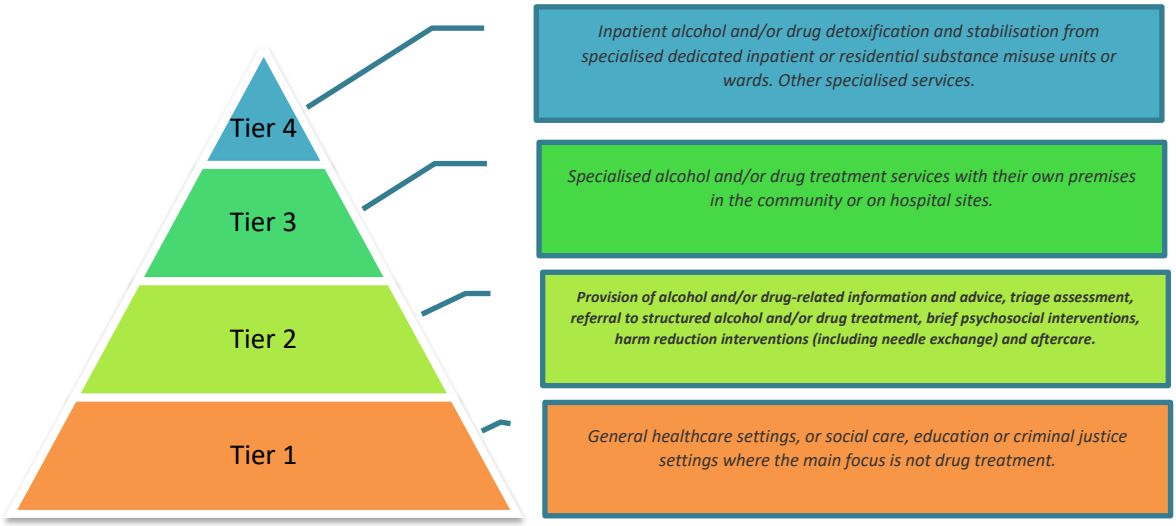


Figure 1 ADRS Tiers

7.1. NHSGGC Service Tiers

7.1.1. Tier 1

Information regarding ADRS services, and pathways into treatment including self-referral, are available from a variety of sources including GP practices and community pharmacies, and in a variety

7.1.2. Tier 2

Injecting Equipment Provision (IEP)

WAND (Wound Care, Assessment of injecting Risk, Naloxone and Dried Blood Spot Testing) Initiative (Glasgow City)

Naloxone Supply - Supply may be made from GP shared care, Police Custody, Acute Addiction Liaison team, Prisons, Scottish Ambulance Service and SFAD in addition to ADRS.

7.1.3. Tier 3

Community alcohol and drug teams are delivered from 16 sites

7.1.4. Tier 4

There are a number of tier 4 services delivered by GGC ADRS: Inpatients, Occupational Therapy, Psychology, Dietetics, Alcohol Related Brain Damage (ARBD) Team, Enhanced Drug Treatment Service (EDTS), Glasgow City Centre Outreach Team, Glasgow Crisis Outreach Service, Acute Addiction Liaison Teams.

Glasgow City hosts board wide ADRS services such as in-patient wards at Stobhill and Gartnavel, however most ADRS services are delivered and managed in each HSCP area. Heads of Service for each locality manage locality multi-disciplinary teams. Board wide systems exist to ensure governance and sharing of best practice and information. Clinical and Care Governance is via the

relevant HSCP and NHS GG&C governance leads and groups. Incidents and complaints are managed through HSCP processes utilising the NHS GG&C Significant Adverse Event Policy.

In addition to the local HSCP specific roles, there are a range of roles with a board wide responsibility e.g. the Associate Medical Director, lead nurse, lead psychologist, and lead pharmacist.

There is a heavy burden of drug harms in GGC. In 2020, there were 444 drug-related deaths in GGC, and the age-standardised rate of drug-related deaths was 30.8 per 100,000 population (95% confidence interval 29.4-32.3), higher than any other large NHS Board area and nearly 50% higher than the rate in Scotland as a whole. Since 2015, there has also been an outbreak of HIV amongst people who inject drugs in GGC, and the estimated prevalence of chronic active hepatitis C infection amongst this population is 19%. Alcohol prevalence data is not readily available, however previous research has demonstrated that the vast majority of dependent drinkers are not engaged in treatment. In recent years alcohol referrals tend to dominate presentations to the ADRS teams**.**

7.2. Alcohol and Drug Partnerships

The ADPs act as the strategic and planning group for alcohol and drugs in their locality. In the six localities, the ADP is hosted by the local authority and involves a range of relevant partners including ADRS.

The ADPs are tasked by the Scottish Government with tackling alcohol and drug issues through partnership working, membership includes health boards, local authorities, police and voluntary agencies. They are responsible for commissioning and developing local strategies for tackling problem alcohol and drug use and promoting recovery, based on an assessment of local needs. The ADPs work to the framework 'Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs (2019)'. ADPs also have action plans in relation to the national Drugs Deaths Task Force (DDTF) priorities. The ADPs deliver annual reports and other reports to government as requested. ADP action plans are approved by local IJBs.

8. Forensic Mental Health & Learning Disabilities

Forensic mental health services specialise in the assessment, treatment and risk management of people with a mental disorder who are currently undergoing, or have previously undergone, legal or court proceedings. Some other people are managed by forensic mental health services because they are deemed to be at a high risk of harming others or, rarely, themselves under civil legislation.

The Directorate of Forensic Mental Health and Learning Disabilities provide services to the NHS Greater Glasgow Clyde area (NHSGGC). There are both national and regional services located within the medium secure service at Rowanbank Clinic, which forms a key component of the Scottish Forensic Estate.

Multi-disciplinary forensic teams include, Forensic Psychiatrists, Clinical Psychologists, Occupational Therapists, a Speech and Language therapist, a Dietician, a Pharmacist, and Nursing Staff.

Central to management of forensic patients is the Care Programme Approach and all our patients are subject to enhanced CPA as set out in national guidance for Forensic Services. Risk management is a key feature of the forensic service, and all patients case-managed by the service will have a risk assessment, formulation and risk management plan to inform the individualised care-plan.

8.1. Medium Security

The service provides medium secure care for male mental illness patients from the West of Scotland region (NHSGGC, NHS Lanarkshire, NHS Ayrshire & Arran, NHS Dumfries & Galloway and the "Argyll part of NHS Highland"). Rowanbank Clinic provides a female medium secure service for NHSGGC patients, occasionally taking female patients from across the regions on a case by case basis. It also hosts the National Medium Secure Intellectual Disability service for Scotland.

8.2. Low Security

Low secure in-patient services for NHSGGC are based at Leverndale Hospital serving male mental illness (MMI), male learning disability beds (LD), male pre-discharge beds (MMI & LD) and Low Secure Women Beds.

8.3. Forensic Community Services

There are 2 Forensic Community Mental Health Teams covering NHSGGC. Both teams have a caseload comprising mainly patients subject to compulsory measures. Within NHSGGC all restricted patients are managed within forensic services (with the exception of pre-trial remand patients who may also be managed in IPCUs, depending on the level of offending and presentation). The service does look after some informal patients, particularly complex cases with significant risk issues, but will aim to move patients back to general psychiatry community teams when appropriate.

8.4. Forensic Intellectual Disability Services

There are both medium and low secure Intellectual Disability beds as noted above. The medium secure beds are provided as a National service on a risk share basis through the National Services Division (NSD) of NHS National Services Scotland. Low secure male LD beds are provided for NHSGGC patients, although out of area referrals are accepted if capacity allows. There is no specialist provision for female LD patients. In terms of community forensic Intellectual Disability services, a small team covers the NHS Greater Glasgow & Clyde area for those patients who require ongoing forensic input (including restricted patients) in the community.

8.5. Forensic Liaison Services

8.5.1. Prison

The Forensic Directorate provides consultant forensic psychiatry support 3 prisons and although not managed by forensic services, each prison has a specialist mental health team which includes RMN input and psychology. Prisoners can be referred by the prison GP and may also self-refer. Referrals are assessed by a nurse and may then be seen by the visiting psychiatrist.

8.5.2. Sheriff Court Diversion Schemes

The Forensic Directorate provides 5 day per week cover to one court diversion scheme covering Glasgow Sheriff Court and Clyde Sheriff Courts (Greenock, Paisley and Dumbarton). A Forensic CPN is on call each morning to receive and assess referrals of individuals who are having their first appearance in court. If a psychiatric assessment is required then there is an on-call psychiatrist (specialist trainee), supervised by an on call forensic consultant. There is no additional funding from the court to provide this service.

8.5.3. Forensic Opinion Work

The Directorate frequently receives requests for forensic opinions and risk assessments and attempts to respond as quickly as possible. Requests may be refused because they do not seem appropriate at the outset. It would only be in exceptional circumstances that formalised risk assessment work would be undertaken, often in liaison with the STAR service.

8.5.4. Psychiatric Reports for Procurator Fiscal

Requests for psychiatric reports may be allocated to a trainee under the supervision of a Consultant Forensic Psychiatrist. Consultant Psychiatrists may also provide psychiatric reports for patients known to them, especially if this is integral to their ongoing care however, there is no agreement to provide court reports routinely.

8.6. STAR Service

The Specialist Treatments Addressing Risk (STAR) service accepts referrals from secondary and higher level services. Individuals can be referred to the service if they have a presentation consistent with a major mental disorder, present a risk of harm to others and there appears to be a functional link between the client's mental disorder the risk of harm. In addition to providing consultations, assessments and interventions regarding risk and mental disorder the STAR service also offers specialist assessments regarding and a prescribing service for anti-libidinal medication and a specialist assessment service for autistic patients.

8.7. Forensic Service Governance Structure - Nationally, Regionally and Locally

The core function of the forensic governance groups are to monitor and provide assurance. Groups monitor all aspects of the service and provide regular reporting under the headings of the six dimensions of healthcare quality (Institute of Medicine) proposed in the Healthcare Quality Strategy for NHS Scotland: Person Centred, Safe, Effective, Efficient, Equitable and Timely.

The other main functions of the Groups are to share good practice and to support each NHS Board area in delivering services to a consistent and high quality level.

8.8. Multi-Agency Public Protection Arrangements (MAPPA)

Multi-Agency Public Protection Arrangements (MAPPA) are the way in which legislation is implemented. The approach to implementing MAPPA, supported by National policy and guidance, has been to develop local Implementation Groups, comprising all relevant agencies. MAPPA are organised within the structures and boundaries of Community Justice Scotland and for NHSGGC this involves three Authorities covering nine local authorities, one police force and three NHS Boards. NHSGGC are represented on all steering groups. The Strategic Groups are supported by MAPPA Operational Groups. The MAPPA Strategic Groups report to the Chief Officer's Group which has been established in each local authority area and on which the Health Board's Chief Executive sits. These Chief Officers' Groups regularly receive reports on operational, strategic and performance issues related to MAPPA and other public protection matters such as Adult Support and Protection and Child Protection.

NHSGGC Nurse Director is NHSGGC board lead for MAPPA. This role is strategically and Operationally supported on a day to day basis by the General Manager and Service Manager from the Forensic Service who provide oversight, approval of protocols and procedures so as to ensure the NHS Board fulfils its duty as Responsible Authority in respect to Restricted Patients and its duty to co-operate role with other agencies where any individual comes within the MAPPA process.

In addition the NHSGGC Board has a designated MAPPA manager who is the single point of contact (SPOC) for all communications relating to MAPPA from and to MAPPA Co-ordinators within the Authorities regarding Registered Sex Offenders and MAPPA extension cases in or who are about to be placed in the community.

9. Mental Health Rehabilitation (Service)

The 2018 iteration of the mental health strategy provided a brief description on mental health rehabilitation. This section provides additional information:

In NHSGGC, rehabilitation services specialise in supporting people who typically have a long-term primary diagnosis of schizophrenia, other psychosis (e.g. delusional disorder), or bipolar disorder. However, on a case-by-case basis, it may be that an inpatient rehabilitation need may be justified on an individualised case conceptualisation for people who do not have the above presentations. Typical difficulties may include:

- Ongoing (e.g. positive and negative syndromes) psychotic features (sometimes referred to as "treatment resistant" from a medication perspective, leading to high dose anti-psychotic medications)
- Difficulties or a high likelihood of difficulties sustaining community residence (recent extended duration of hospital admission, high frequency admissions, recent loss of a supported living environment). Low prospect of successful and safe living in the community without specialist rehabilitation.
- Vulnerabilities due to cognitive impairment, difficulties engaging with services, risk of harm to self/others, self-neglect, difficulties with motivation & daily life skills, risk of exploitation, and/or complex physical health problems.
- Experience of severe 'negative' symptoms that impair motivation, organisational skills and ability to manage everyday activities (self-care, shopping, budgeting, cooking etc.) and placing and individual at risk of serious self-neglect.

Most require an extended admission to inpatient rehabilitation services and ongoing support from specialist community rehabilitation services over many years.

Although some users of rehabilitation services may be subject to Mental Health or Incapacity legislation it is imperative to gain consent and work towards mutual goals wherever possible. Consequently matching the goals of an individual with the service best placed to empower them to achieve this is the most important consideration.

Maintaining a positive and therapeutic environment and culture within inpatient rehabilitation units is very important.

The social and individual functioning and engagement of an individual is a key consideration. Significant deficits in functioning and engagement should not be a barrier to accessing rehabilitation care but may influence decisions about when an individual is most likely to benefit or which type of unit is most suitable.

The physical health and intellectual capacity of the individual again may influence their ability to engage in rehabilitation however intellectual disability or physical health should not by itself preclude the opportunity of rehabilitative care.

Diagnosis alone should not be a barrier to accessing rehabilitation services in those with a primary functional mental disorder.

10. Digital and eHealth

Mental health services have a dedicated structure responsible for delivering and implementing IT / eHealth systems across mental health services. This involves close working with corporate eHealth services to deliver on the digital agenda and to manage practice change required with clinical services.

Before the pandemic, mental health services were already evolving to make better use of data and digital tools. COVID-19 demanded that we move further and faster with our plans, by providing the ability for people to connect face-to-face without being in the same room, or to enable clinicians to monitor a patient's health in their own home. These demands created an increasing requirement to deliver more consultations remotely and to have a more agile work force who can meet the increased demand.

Data and digital technologies impact on every element of our lives and this applies to mental health and mental health services, including:

- Existing and emerging people and patient facing technologies, extending beyond virtual consultations (e.g.cCBT)
- The use of digital to support decision making and provide clinical informatics
- Systems development to support electronic patient records for better patient care and information sharing
- By necessity, the need for digital literacy for people to learn and develop alongside digital

A dedicated work stream, directly reporting to the programme board, has been established to ensure the focus that is warranted in order to support the progression of digital technologies within mental health services.

Glossary

to

A Refresh of the Strategy for Mental Health Services in Greater Glasgow & Clyde: 2023 – 2028

Document Version Control

Date	Author	Rationale
25/05/23		

Glossary

ACE	Adverse Childhood Experience
acute	Sharp / severe / sudden
Acute sector	The hospital sector where patients receive active, short-term treatment for a physical health condition
ADHD	Attention Deficit and Hyperactivity Disorder
ADP	Alcohol Drug Partnership
ADRS	Alcohol and Drugs Recovery Services
ARBD	Alcohol Related Brain Damage
BPD	Borderline Personality Disorder
CAMHS	Child and Adolescent Mental Health Services
CDRS	Compassionate Distress Response Service
chronic	Persisting for a long time or constantly recurring, contrasting with 'acute'
CLW	Community Links Worker
CMHACS	Community Mental Health Acute Care Service
CMHT	Community Mental Health Team
College	an organized body of persons engaged in a common pursuit or having common interests or duties
Collegiate	of, relating to, or comprising a college
CPMHT	Community Perinatal mental Health Team
DDTF	Drugs Deaths Taskforce
Dyspraxia	Difficulty in performing coordinated movements
EDTS	Enhances Drug Treatment Service
GP	General Practice
HSCP	Health and Social Care Partnership
IEP	Injecting Equipment Provision
IPCU	Intensive Psychiatric Care Unit
LD	Learning Disability
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer (or questioning)
MAT	Medication Assisted Treatment
MBU	Mother and Baby Inpatient Unit
MDT	Multi-Disciplinary Team
MH	Mental Health
MHO	Mental Health Officer
MHWPCS	Mental Health and Wellbeing in Primary Care Services
MNPI	Maternity & Neonatal Psychological Interventions
NHSGGC	NHS Greater Glasgow and Clyde

Non-statutory Services	Not, or only, partially government funded, supported by the public, and generally registered as a charity
NSD	National Services Division
OPCMHT	Older People Community Mental Health Team
OPMH	Older People Mental Health
PCMHT	Primary Care Community Mental Health Team
PIFU	Patient Initiated Follow Up
PsyCIS	Psychosis Clinical Information System
SAS	Specialty and Specialist Grade (Doctor)
SMI	Severe Mental Illness
Statutory Services	Services paid for through taxation, funded by the government and established in law.
Third Sector	Non-governmental and non-profit-making organizations or associations, including charities, voluntary and community groups, cooperatives, etc.
WAND	Wound Care, Assessment of injecting Risk, Naloxone and Dried Blood Spot Testing Initiative