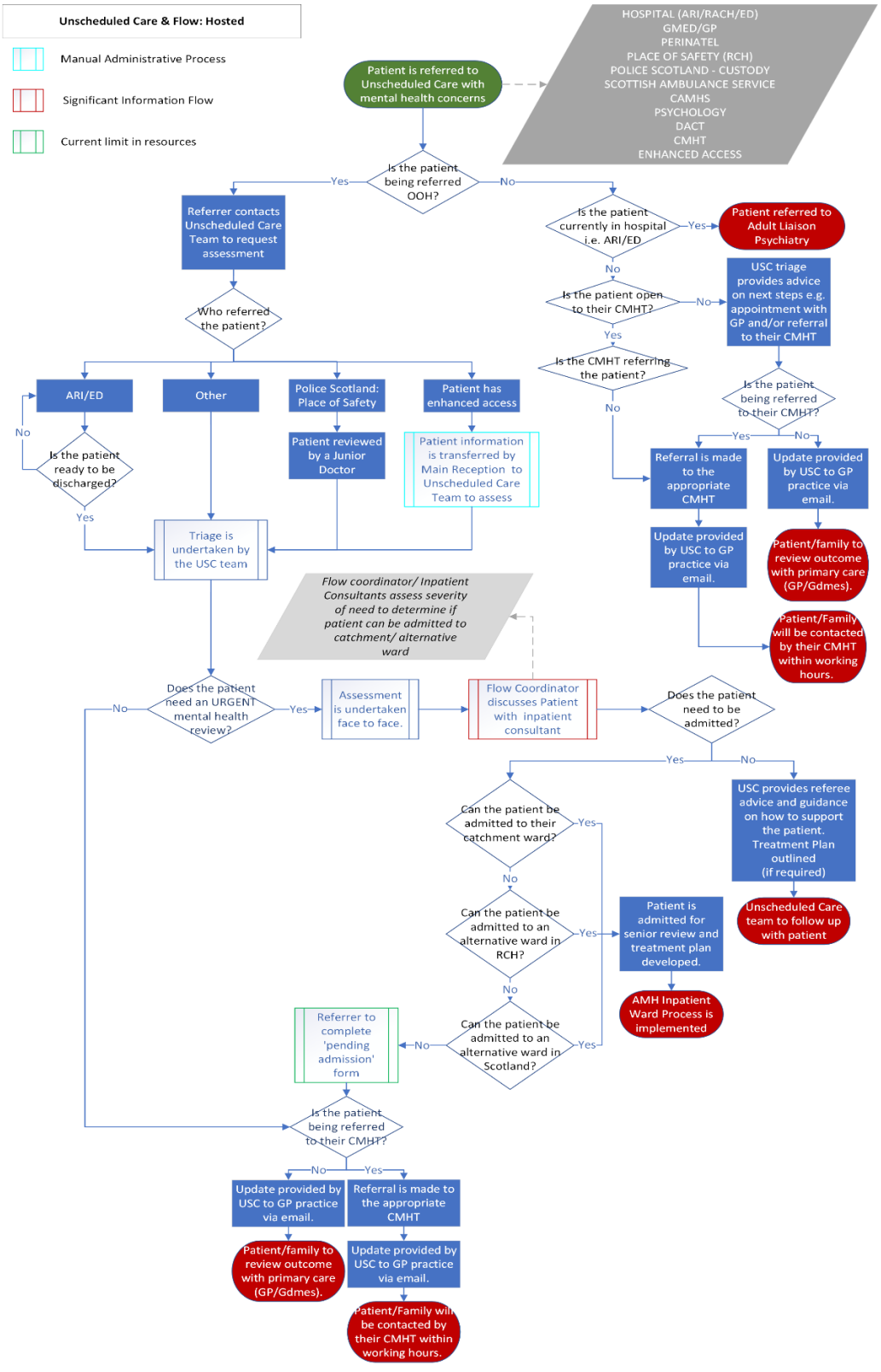
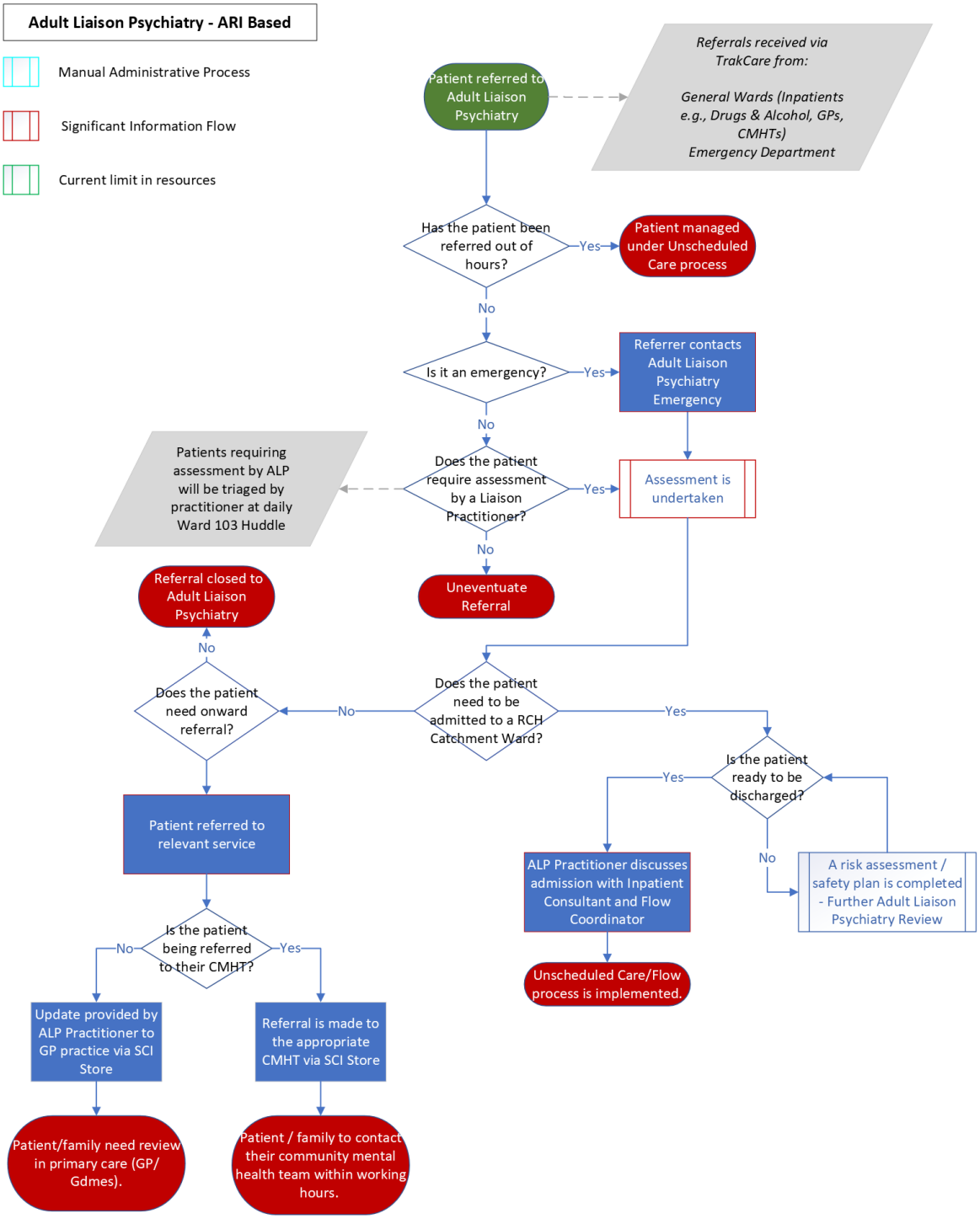
General Adult Mental Health Secondary Care Pathway Review

Appendices

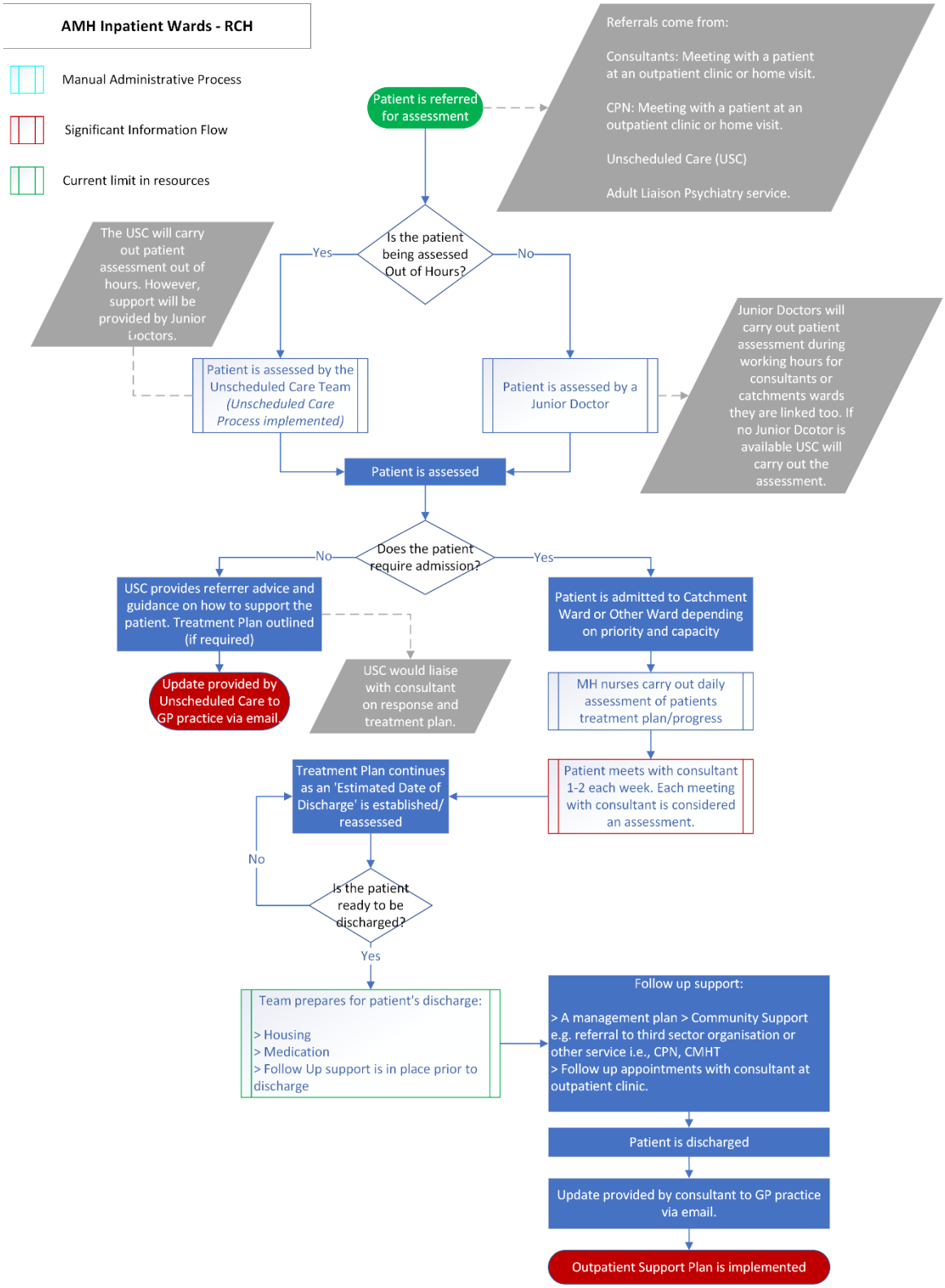
Appendix A: Unscheduled Care & Flow (Aberdeen City & Aberdeenshire)



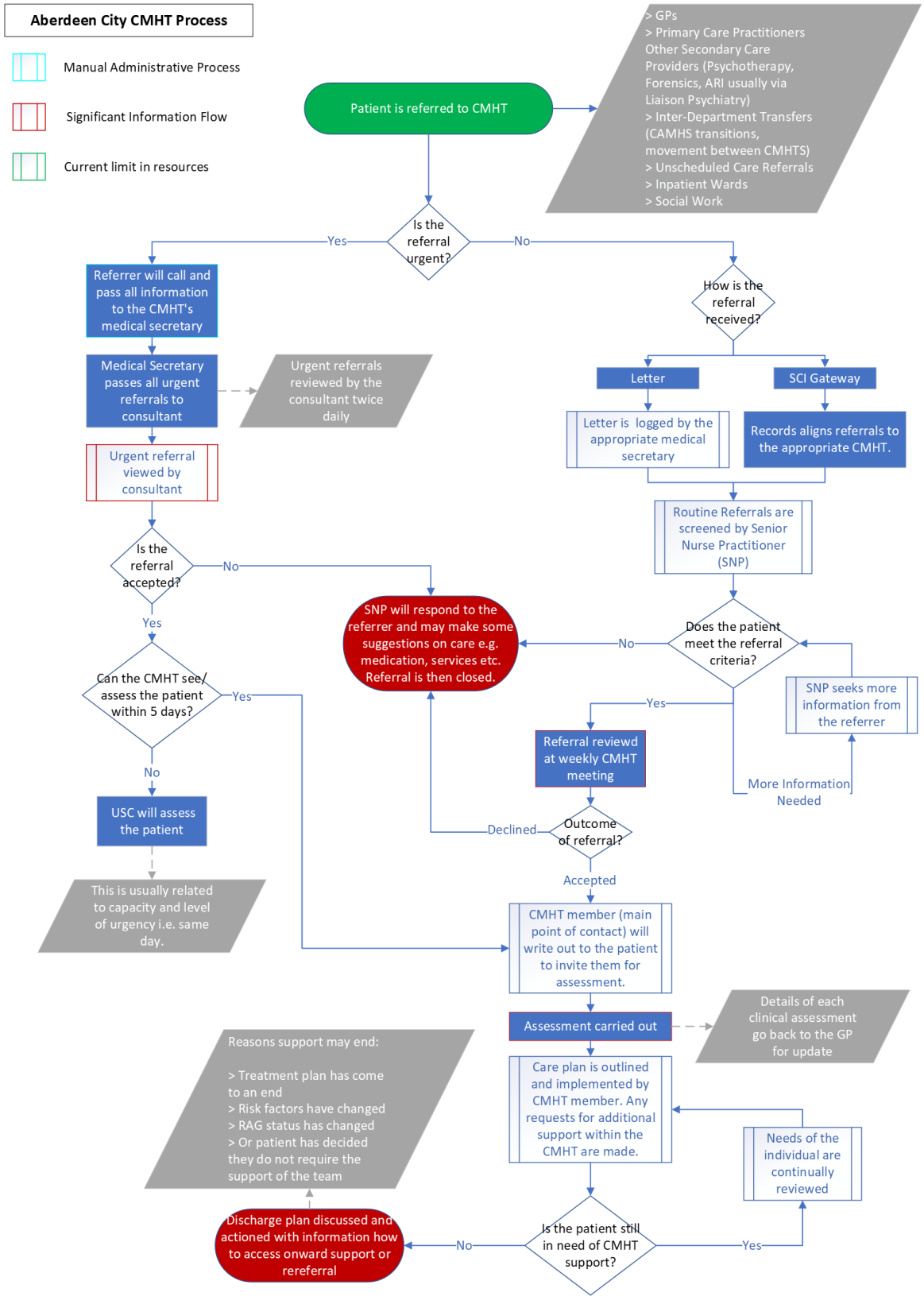
Appendix B: Adult Liaison Psychiatry (Aberdeen City & Aberdeenshire)



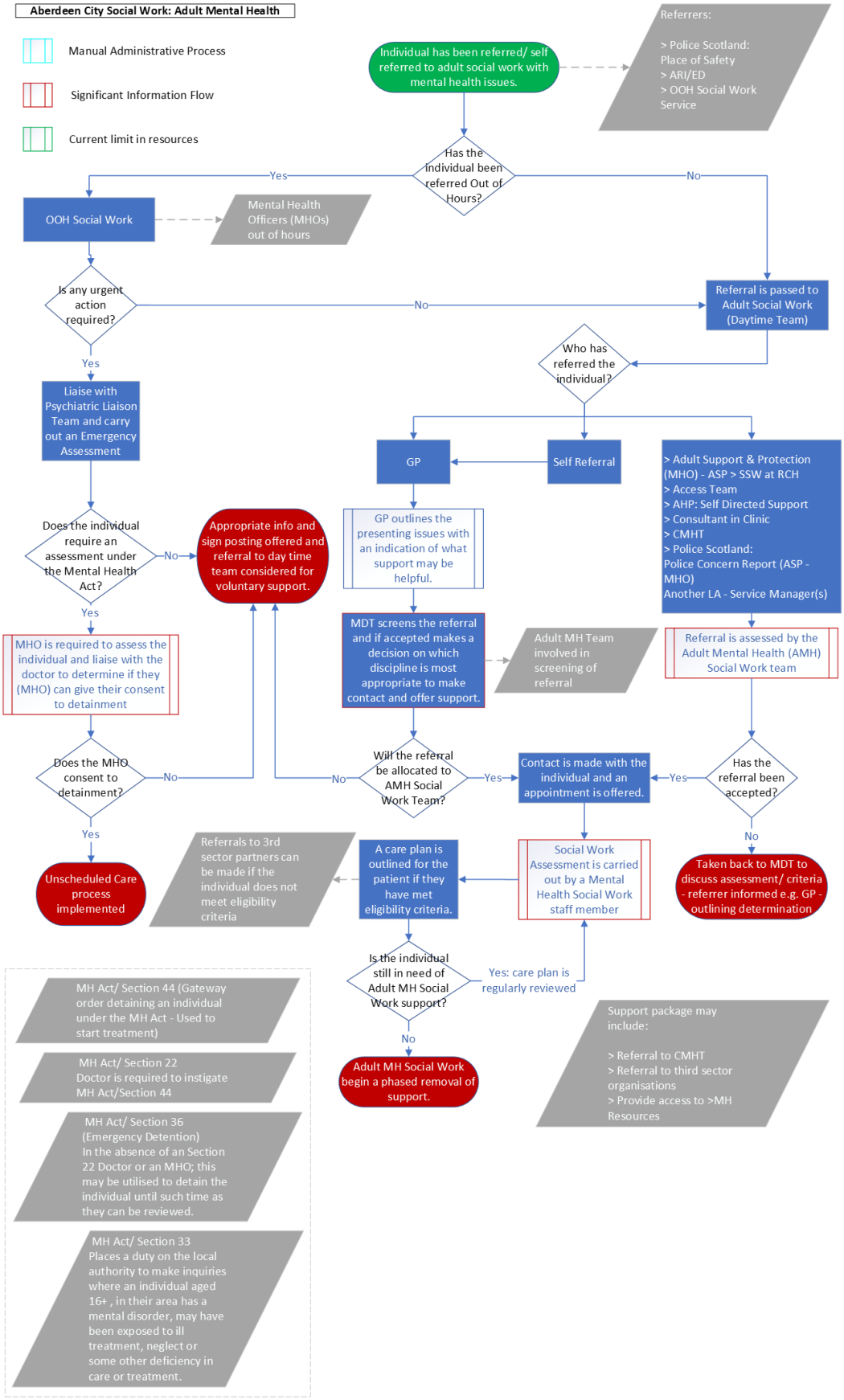
Appendix C: AMH Inpatient Wards (Aberdeen City & Aberdeenshire)



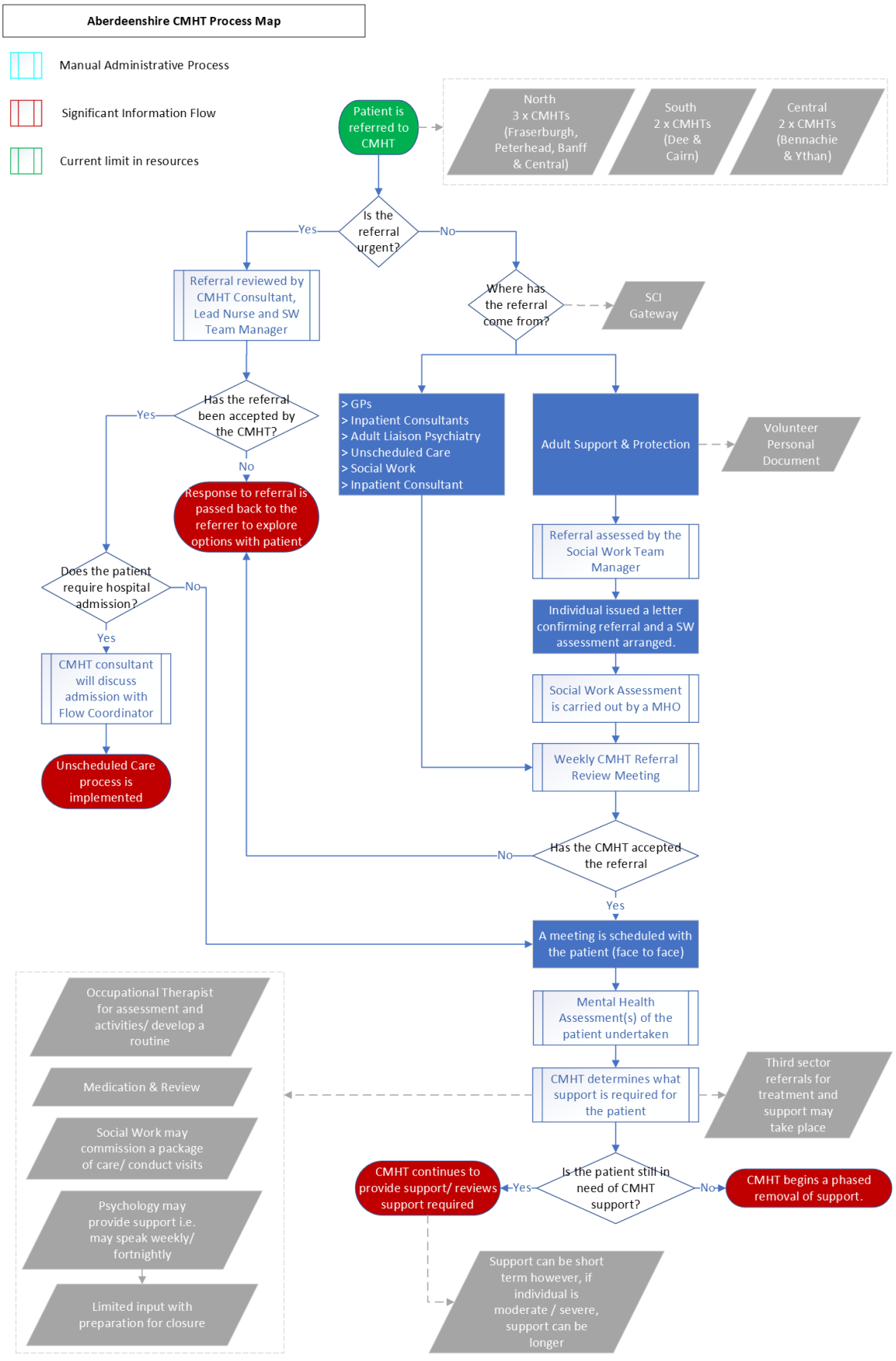
Appendix D: Community Mental Health Teams (Aberdeen City)



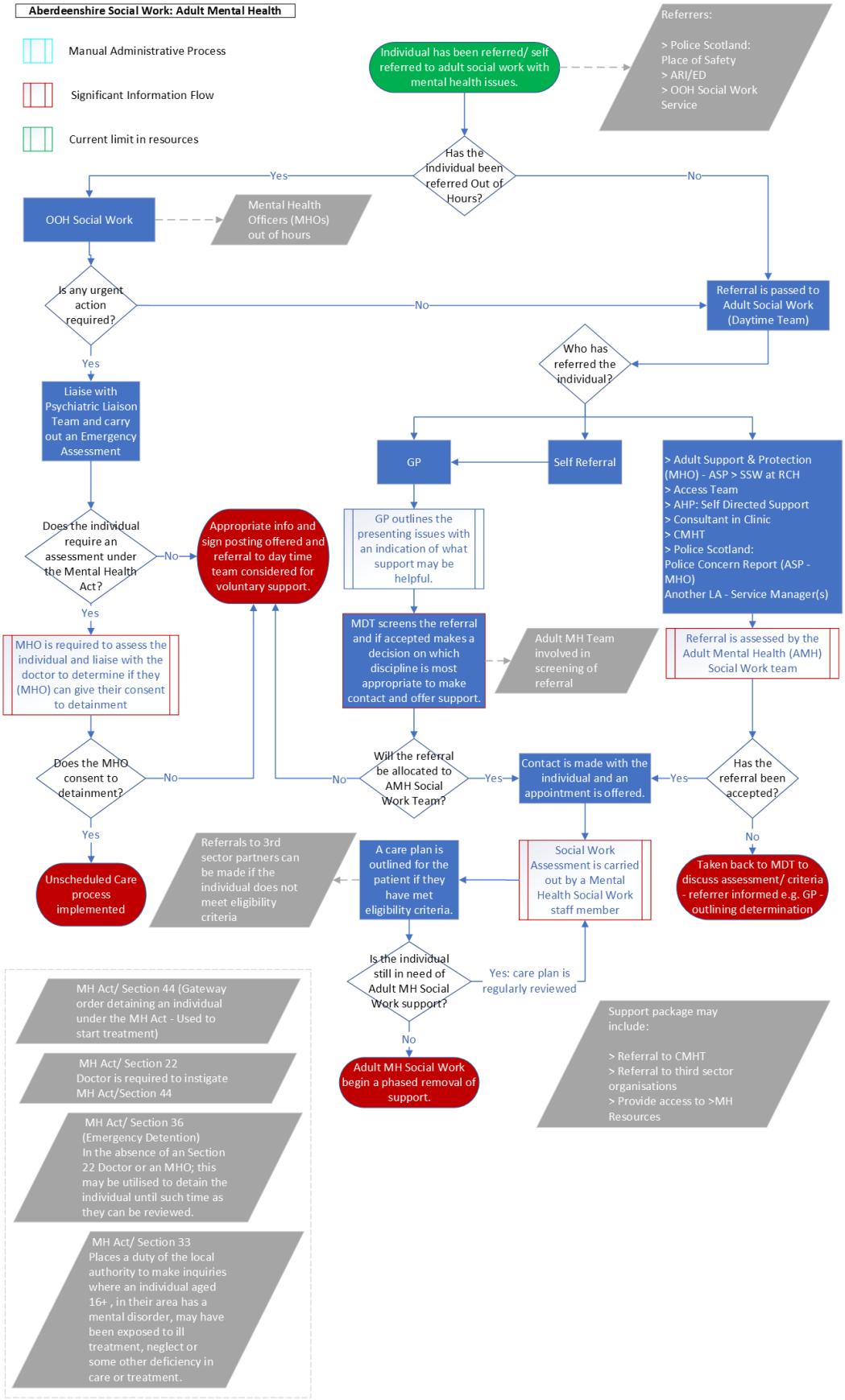
Appendix E: Adult Mental Health Social Work (Aberdeen City)



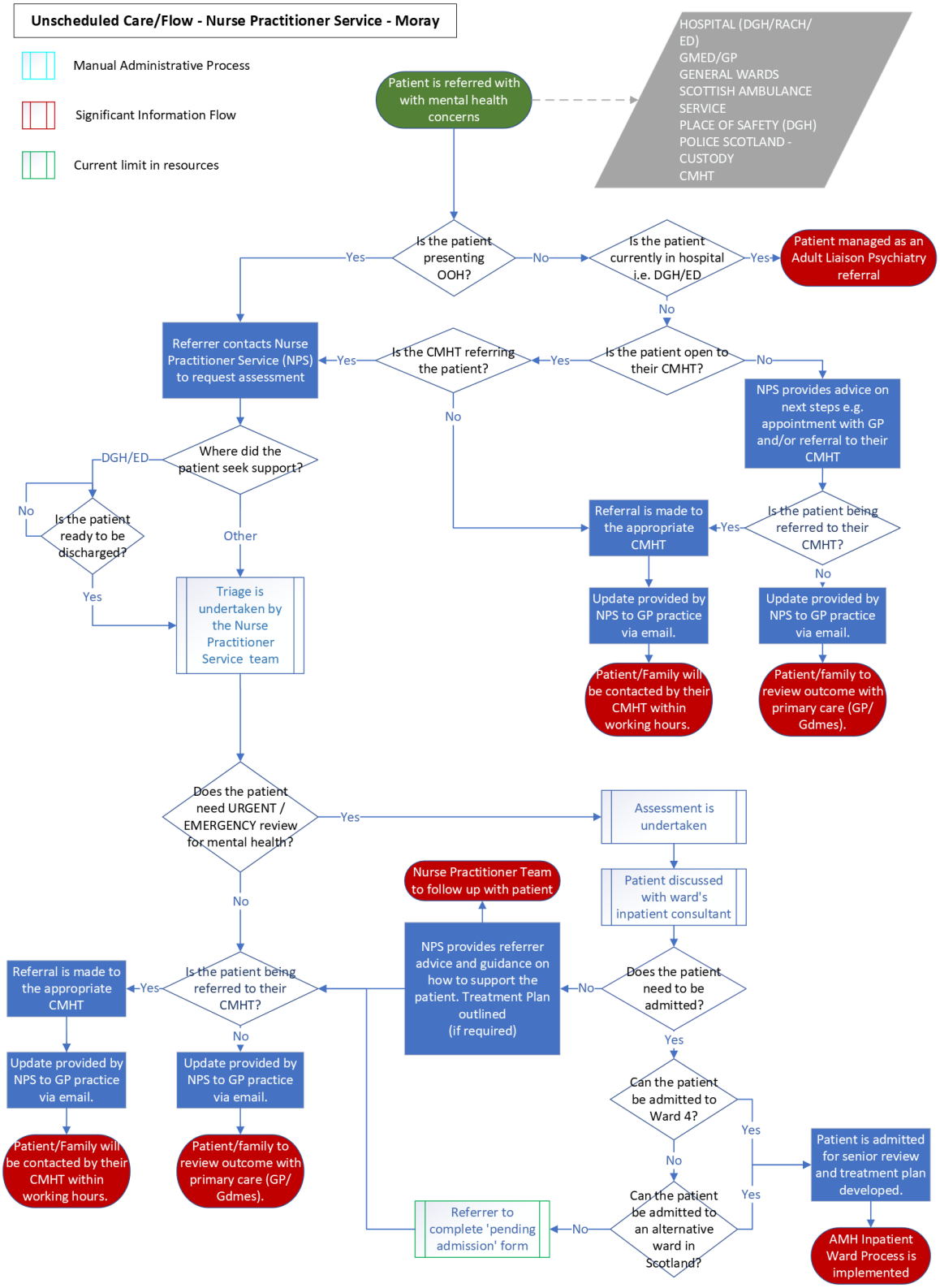
Appendix F: Community Mental Health Teams (Aberdeenshire)



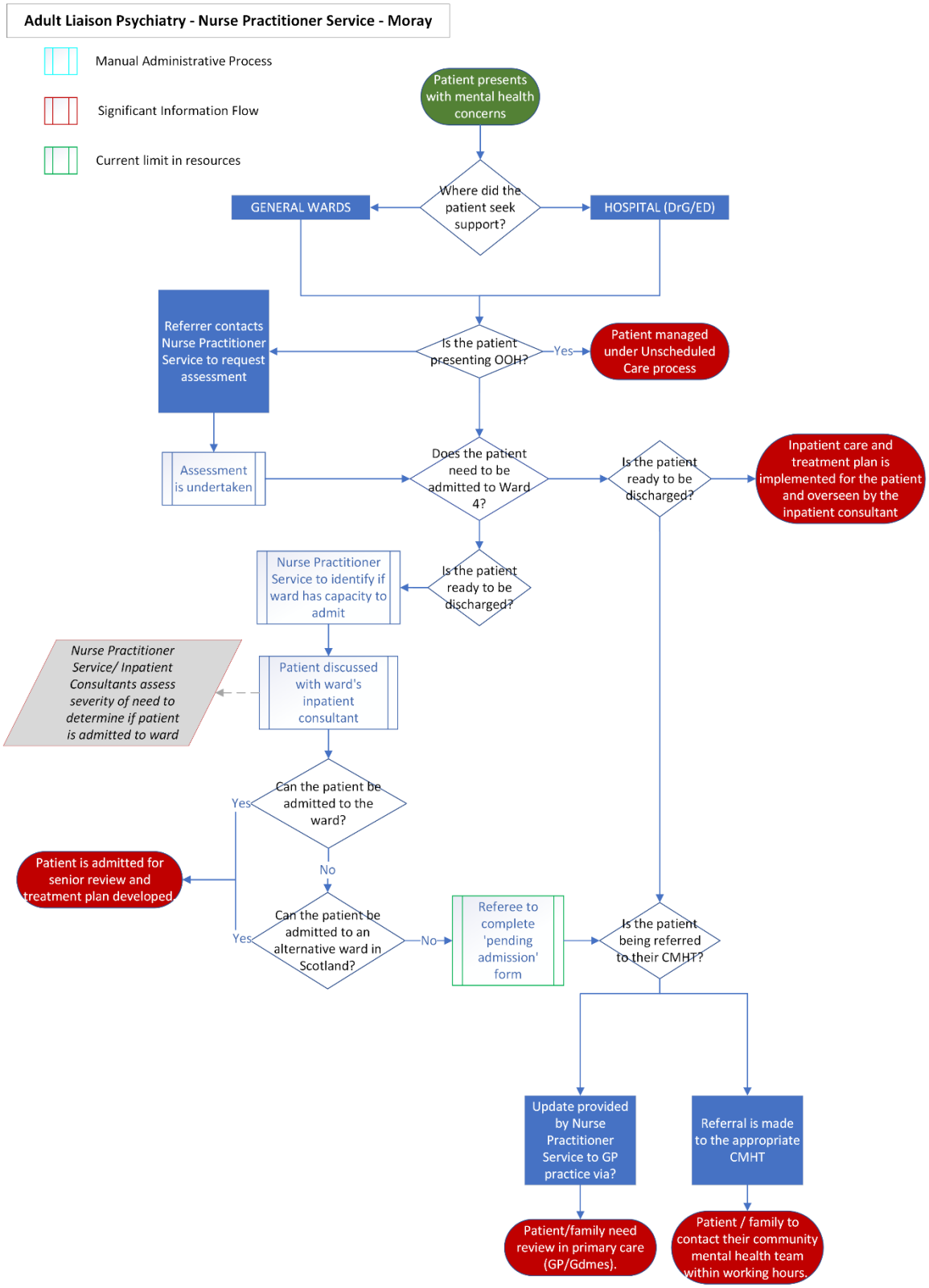
Appendix G: Adult Mental Health Social Work (Aberdeenshire)



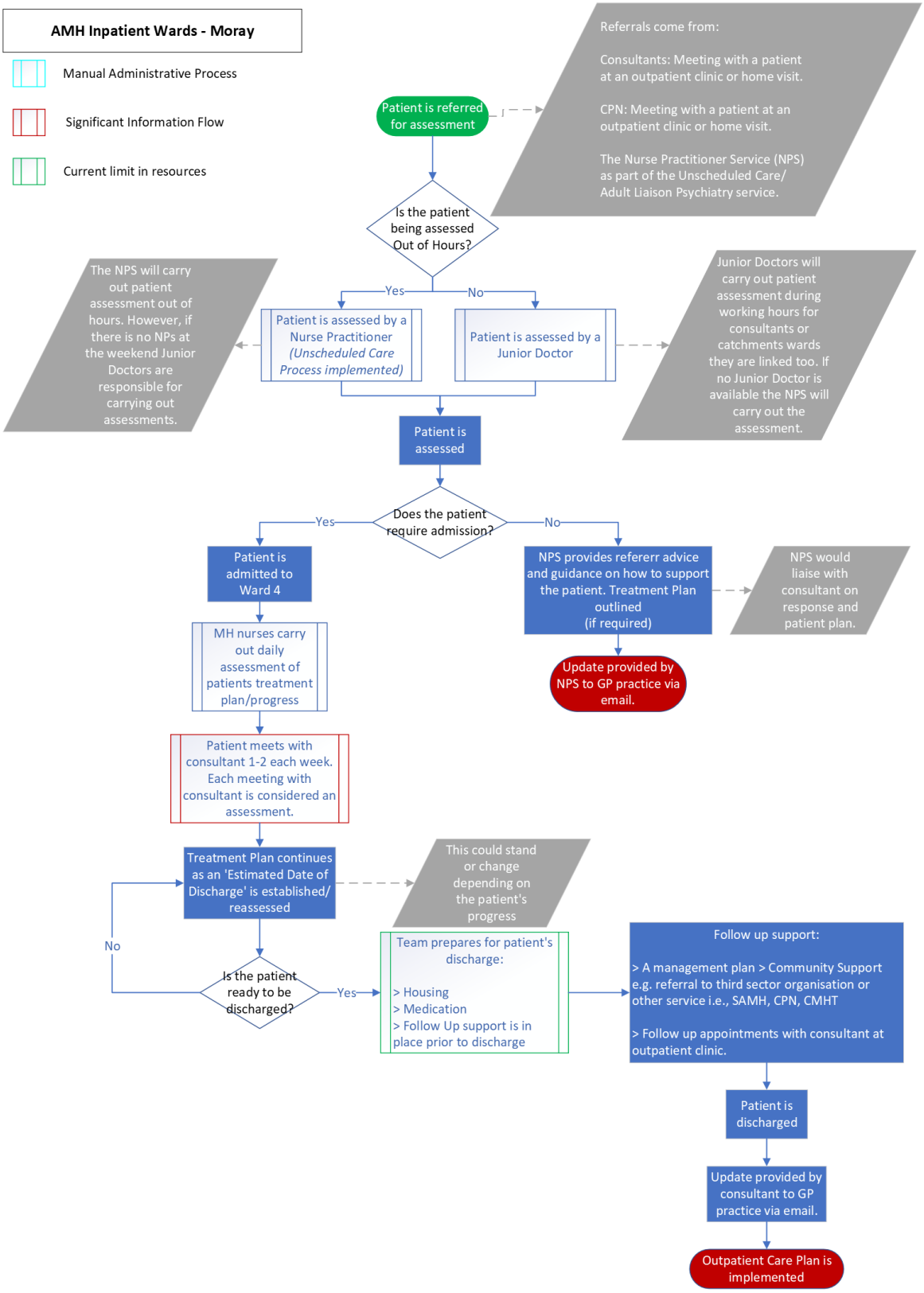
Appendix H: Unscheduled Care & Flow – Nurse Practitioner Service (Moray)



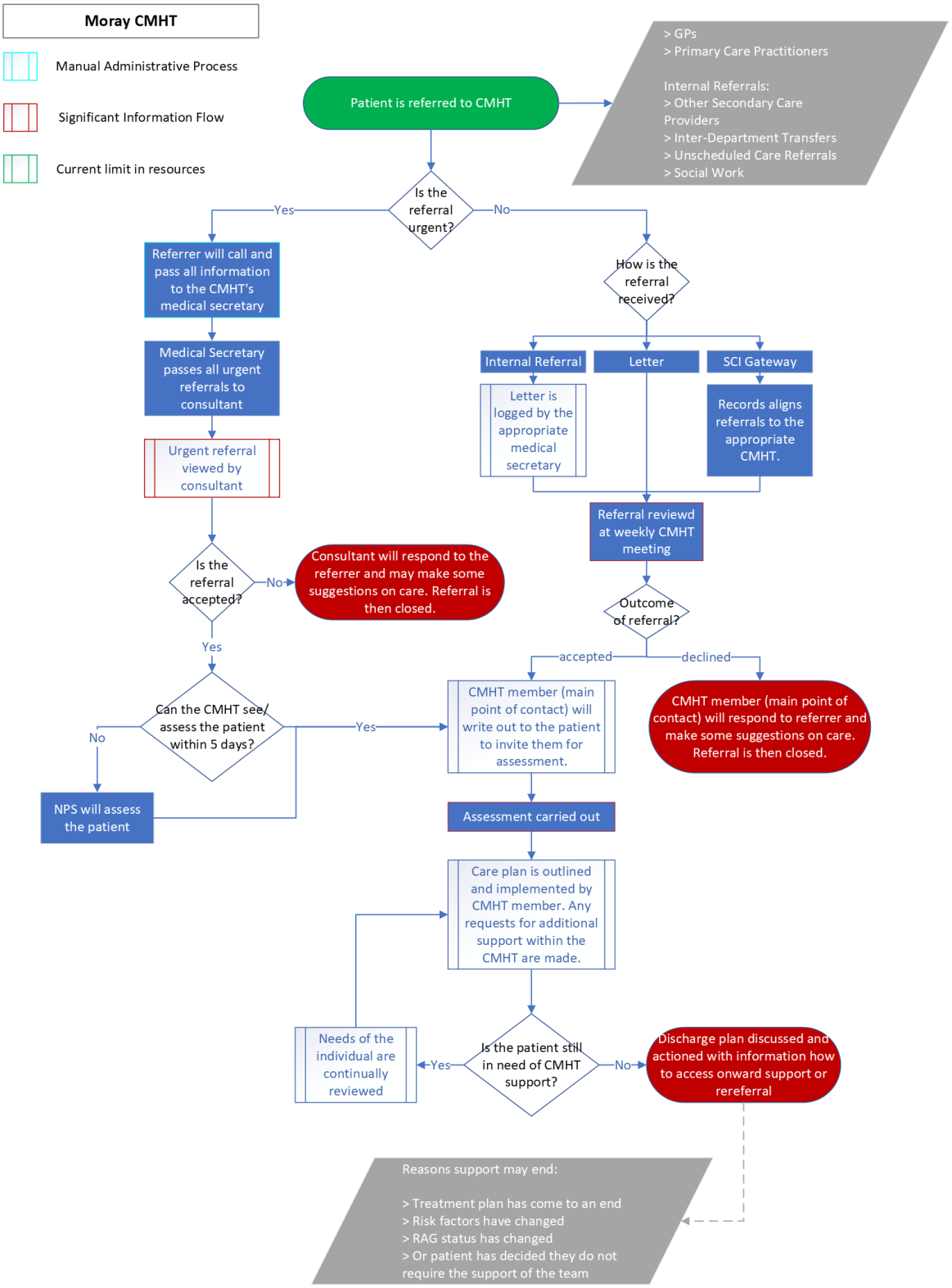
Appendix I : Adult Liaison Psychiatry – Nurse Practitioner Service (Moray)



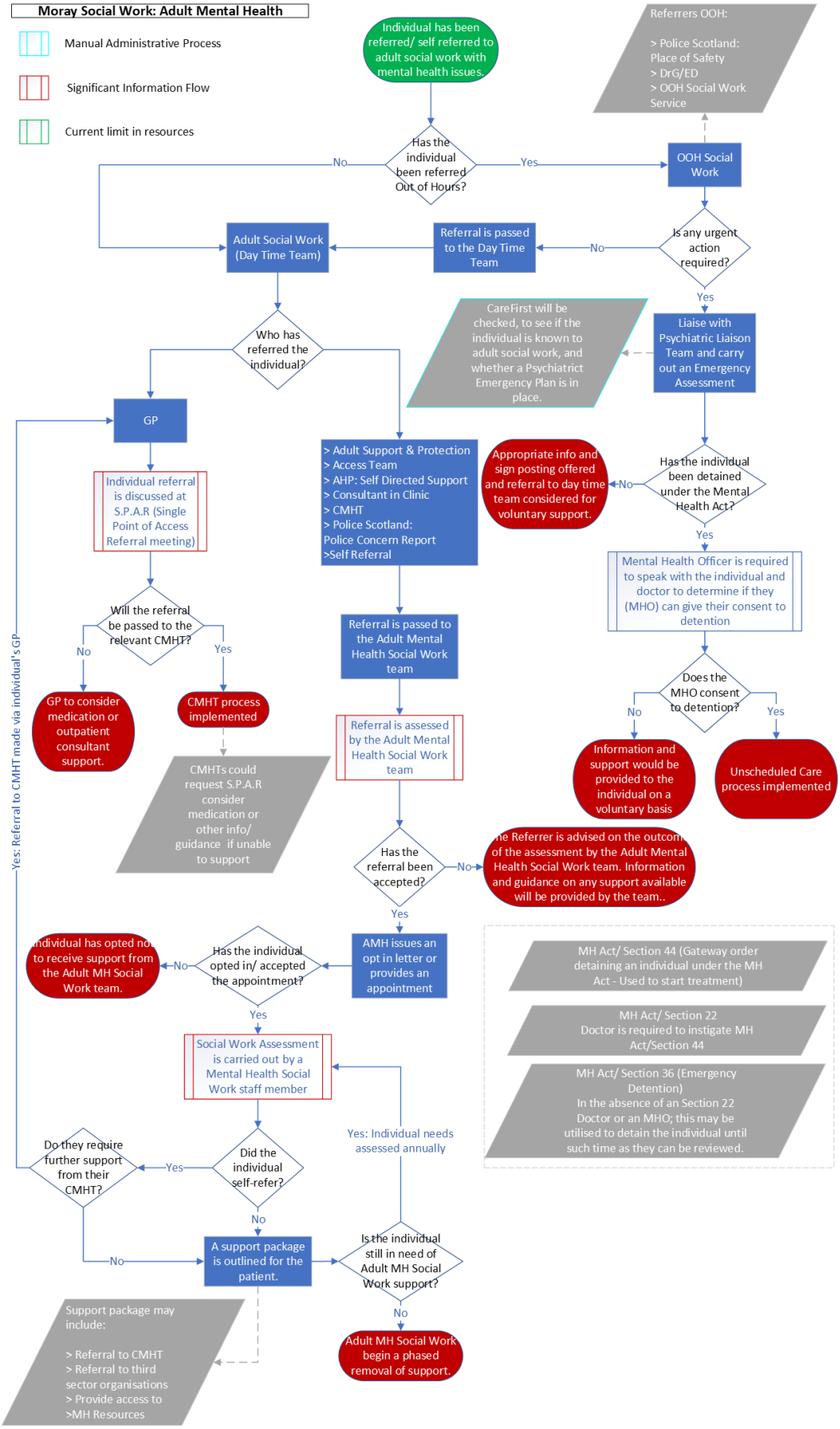
Appendix J: Adult Mental Health Inpatient Wards (Moray)



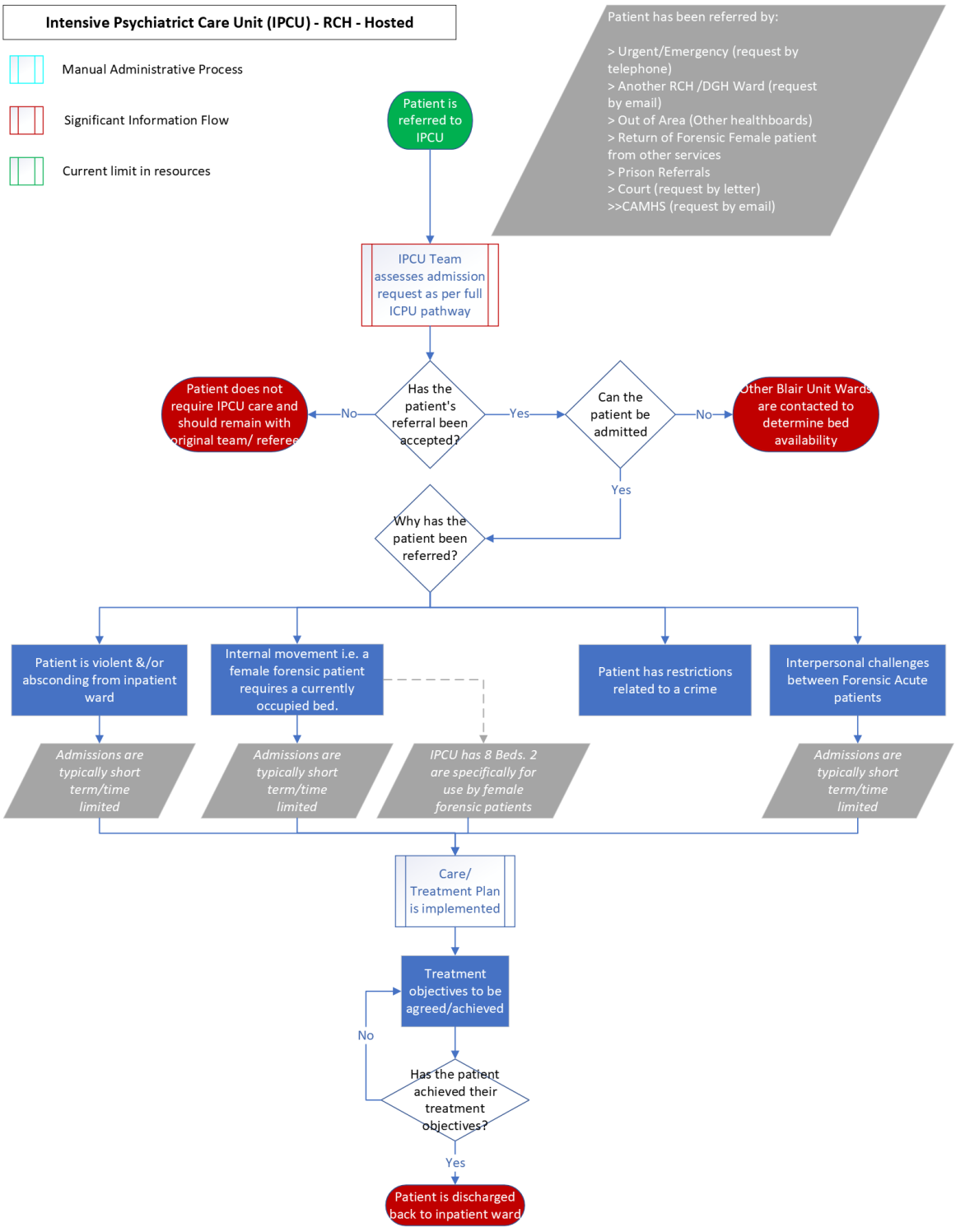
Appendix K: Community Mental Health Teams (Moray)



Appendix L: Adult Mental Health Social Work (Moray)



Appendix M: Intensive Psychiatric Care Unit (Hosted)



Appendix N: Problem Statements/How Might We Statements

Key:

How (Medium to High Difficulty/ Medium to High Innovation)

Wow (Medium to High Difficulty/ Low to Medium Innovation)

Now (Low to Medium Difficulty/ Low to Medium Innovation)

Mental Health Standard	Problem Statement	How Might We Statement	Ideas	Theme	Summary Outcome
Access	Aberdeenshire CMHTs often work differently and separately to each other which can make working together/delivering a consistent service very difficult.	How might we bring consistency to CMHT working, incorporating AMH, OAMH and LD, across Grampian?	Fully Integrating teams (not relying on professional silos) so there is one referral into CMHT that could be picked up by any CMHT. Ensure that SOP's/Referral Criteria are consistent across all CMHTs whether Aberdeenshire, City or Moray. Promote team sense of ownership of the eligibility criteria and if not in place develop SOP that is shire wide. Ensure that SOP's/Referral Criteria are consistent across Teams Appreciative enquiry - assess the effectiveness of these different ways of working, draw out the best practice(s) from each and consolidate	Process	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.

Access	HSCPs do not provide exactly the same services or prioritise funding exactly the same way. Depending on which area you reside within, you may have easier access to a particular service than others. This is more apparent in areas where there is a larger geographical area to cover and higher chances of patient isolation.	How might we ensure fair access to in-demand MH services, across Grampian, to ensure all individuals with a need for assessment are seen based on priority/urgency of need?	Create a SLWG that will explore opportunities for fairer use of resources within MH secondary care services, across Grampian, and determine whether these opportunities are viable.	Funding	Improved overall mental wellbeing and reduced inequalities
Access	If patients had easier access to MH support in their communities in the lead up to, or following a diagnosis, it may prevent patients progressing to moderate/severe MH issues that require more resource and time to resolve/ balance	How might we ensure fair access to in-demand MH services, across Grampian, to ensure all individuals with a need for assessment are seen based on priority/urgency of need?	Invest in peer led recovery focused support systems and social movements. These types of approaches can have big impact with small resources (funding) Correlates with some other 'How Might We' statements about having consistency in governance of access, care planning treatment & support. MH Portfolio Board to lead strategic direction for Grampian. Also need review and agree there will be local based decisions by IJBs in line with Integration agenda.	Resources	Better equipped communities to support people's mental health and wellbeing and provide opportunities to connect with others.

Access	Patients whose needs could be met through a community provision can find it difficult to access these resources in an emergency which can often result in hospital admission. Psychology patients will only have access to secondary care services if this is where their current care originated, and this is not the care for other services e.g. OT	How might we ensure fair access to in-demand MH services, across Grampian, to ensure all individuals with a need for assessment are seen based on priority/ urgency of need?	Review then adhere to eligibility criteria Ensure a matched care model that is fluent across services. One could postulate that if in hours mental health support in place, there would be patient involvement in assessment, care planning, treatment and support in developing Advance Statements, Crisis Plans and Anticipatory Care Plans which would reduce burden on urgent and emergency services. Appropriate and regular use of Care Program Approach. If this is the case for Psychology services, I am happy to look at improvements to ensure a matched care model that is fluent across services. Lived experience advisory group with clear structures in place for participants	Relationships	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
Access	Patients open to secondary care that don't qualify for specific support (e.g. within CMHT) cannot then access primary care services	How might we ensure that patients have clear and easy access to necessary MH services/support, regardless of where their MH care originated i.e. primary or secondary?	Pathway to be reviewed to incorporate a need for patients open to mental health social work, but no other secondary care discipline, being able to access primary care services, i.e. psychology. Clarity about service referral criteria, which the process mapping should present.	Relationships	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
Access	The public has a differing perception of mental health	How might we improve public understanding of	Create a Grampian wide communication plan, using existing	Change Management	Improved quality of life for people with mental health

	services that doesn't necessarily match with need, demand, and MH strategies.	MH services, including but not limited to purpose, priorities, access, and support, to guide the public on how it functions and the resources available?	resources/ mediums, with minimal cost implications, that share agreed and consistent messages about MH services and resources across the region.		conditions, free from stigma and discrimination.
Access	The public lack understanding around secondary care services and what these services aim to deliver, which may prevent them seeking support form secondary care services which is not necessary/ can be provided elsewhere.	How might we improve public understanding of MH services, including but not limited to purpose, priorities, access, and support, to guide the public on how it functions and the resources available?	Public Engagement Group, IJB and NHS Executive Team can drive narrative of engagement with public. Relevant communication strategy adapted where needed (in terms of messaging and channels) to reach all demographics and look for collaboration and synergies with third sector. Public Engagement: engage with groups and organisations with a vested interested in MH services. Enter in honest conversations with people about the stress on HC systems; describe how MH systems link together; outline what they (currently) can and cannot do for people. Capture people's concerns and try to establish what they feel are priorities within the secondary MH system.	Communication	Improved knowledge and understanding of mental health and wellbeing and how to access appropriate support.

Access	The public has a differing perception of mental health services that doesn't necessarily match with need, demand, and MH strategies.	How might we improve public understanding of MH services, including but not limited to purpose, priorities, access, and support, to guide the public on how it functions and the resources available?	Public Engagement Group, IJB and NHS Executive Team can drive narrative of engagement with public. Relevant communication strategy adapted where needed (in terms of messaging and channels) to reach all demographics and look for collaboration and synergies with third sector. Public Engagement: engage with groups and organisations with a vested interested in MH services. Enter in honest conversations with people about the stress on HC systems; describe how MH systems link together; outline what they (currently) can and cannot do for people. Capture people's concerns and try to establish what they feel are priorities within the secondary MH system.	Resources	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
Moving between and out of Services	Providing care in the community using resources from RCH, often leaves RCH without the resources it needs to maintain a safe? / necessary staffing level	How might we improve the process, for assessing patients at acute sites, so that the time impact on RCH staff is reduced/ minimal/ removed?	Having separate inpatient / outpatient medical model Can current level of bed numbers be sustained if staff are simultaneously covering both inpatient and community patients? Is the inpatient/outpatient model the correct course for the future of service delivery? Should we modernise, consider new models, and learn from previous good working across the pathway for the patient	Resources	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.

			Are there any existing tools for quick, effective assessment of someone mental health to triage appropriately? This from the SCIE, for England and Wales at least, https://www.scie.org.uk/mca/dols/practice/assessments/mental-health) seems to suggest it is a highly specialised area. Is there a tool that could be used to assess the risks of not immediately addressing a person's mental health difficulties?		
Access	Pilots which have proven successful or could have a significant impact on delayed discharges, cannot go ahead due to the absence of funding.	How might we provide easy access, either physically or digitally, to appropriate community resources for patients who could live independently; together with fellow public sector organisations?	In order for something new to be done something old has to stop. Need to be pragmatic and see where the priorities are and focus the limited resources, we have on that Financial austerity is real. Communication about limitations upon all public sectors could be explored	Funding	Improved quality of life for people with mental health conditions, free from stigma and discrimination. Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
Access	Patients are unable to reside within their communities safely, and with easy access to necessary services, which can often lead to delayed discharges or patients discharged into inappropriate environments (isolation/injury).	How might we provide easy access, either physically or digitally, to appropriate community resources for patients who could live independently; together with fellow public sector organisations?	The issue is there is often a lack of appropriate community resources to support patients, however improved discharge planning meetings, coordinated earlier in the patient's admission journey, may assist.	Resources	Better equipped communities to support people's mental health and wellbeing and provide opportunities to connect with others.

Access	Patients cannot receive timely access to their CMHT's secondary care psychological services which places pressures on the CMHT MH nursing and social work to provide appropriate interim support and increasing the pressure elsewhere.	How might we reduce wait times to access secondary care services, so that patients can receive appropriate care more timely, and ease pressures on other MH services/roles?	Consider models of working, triage app and 'homework' meantime Consider criteria and SOP's for primary/secondary care Psychology Interested again to look at this and consider criteria and SOP's for primary/secondary care Psychology	Process	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
Access	Partner organisations such as SAMH can often be used to provide interim support to patients waiting to access secondary care services. However, this leaves their resource strained and unable to provide support to those who perhaps do not require secondary care support.	How might we reduce wait times to access secondary care services, so that patients can receive appropriate care more timely, and ease pressures on other MH services/roles?	Contractual agreements? Clarifying mental health pathways with start and end point which then links with third sector might improve flow Clarifying mental health pathways with start and end point which then links with third sector might improve flow. Detail as to what service(s) this is referring to might help pinpoint direction to explore support	Resources	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
Access	There are more people in need of the IPCU service, than there is capacity to provide.	How might we understand the demand for hospital care, treatment, and rehabilitation, so that our secondary care services are structured appropriately, to ensure access to inpatient care is accessible to those that need it?	Forensic Services Programme Board likely to be established to support the implementation of actions outlined within the Forensic Services Review (response to the Barron Report).	Resources	

Access	There is no established national pathway for forensic female admissions.	How might we participate in national discussions regarding forensic pathways for females so that we can respond to the need of female forensic patients?	Forensic Services Programme Board likely to be established to support the implementation of actions outlined within the Forensic Services Review (response to the Barron Report).	Process	Improved overall mental wellbeing and reduced inequalities
Access Assessment, Care Planning, Treatment and Support	Hours of operation are inadequate for patient need and population served Outpatient waiting list is greater than 5 months (well over 1 year for psychology) Limited hours preclude timely OOH assessments.	How might we expand or change how we support individuals experiencing MH distress, so their MH condition/ distress does not worsen, while directing care and support to the most appropriate services?	Develop wrap around services to include peer support from those with lived experience Are we still maximising opportunities for near me and group-based interventions? Whole system move towards extended hours, 7-day working would need modelling upon demand, workforce resource, and capacity. Disparity in some specialist services and pathways having longer waiting times than others, particularly psychological based treatments. Review of out of hours resource for liaison psychiatry (adult and older adult), and capacity in USC resource.	Operational	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
Access Assessment, Care Planning, Treatment and Support	There is no Psychology Crisis Service/ Early Intervention team that can support patients early in their crisis, to prevent it from becoming a larger issue.	How might we expand or change how we support individuals experiencing MH distress, to ensure that their condition/ distress does not worsen during wait periods, requiring secondary care intervention?	Develop robust referral screening pathways and for consideration to be given as to whether there is a role for other disciplines to support the patient whilst they are on a waiting list for psychological supports. Development of standardised letters with contact details for supports and what the patient should do if their health	Resources	Improved overall mental wellbeing and reduced inequalities

			deteriorates (escalation protocol) Moray model of working with third sector partners as integral CMHT members allows for flexibility of service and responsiveness to emergent need Home Treatment Team with Psychology involved would be one model to address this issue. Early Intervention is Psychosis Teams are another very effective model but require significant resource. Can review hosted services (Assertive Outreach Team) function, resource, demand, and capacity. Well-resourced community-based MH services which can give people support and interventions that are proven to help alleviate psychological distress and risk - DBI's and ASIST for e.g. Also, to adopt an ethos similar to Housing First - the support is open ended/ ongoing as per an individual's needs.		
Access Assessment, Care Planning, Treatment and Support	Individuals experiencing MH distress, who cannot access secondary care services, often see their condition/ distress worsen with them engaging with a number of different services without	How might we expand or change how we support individuals experiencing MH distress, to ensure that their condition/ distress does not worsen during wait periods,	Develop robust referral screening pathways and for consideration to be given as to whether there is a role for other disciplines to support the patient whilst they are on a waiting list for psychological supports. Development of standardised letters with contact	Resources	Improved knowledge and understanding of mental health and wellbeing and how to access appropriate support.

	receive clear or consistent support.	requiring secondary care intervention?	details for supports and what the patient should do if their health deteriorates (escalation protocol) Power of peer support or life skills training and facilitation e.g. WRAPS etc. Engagement with third sector who can appropriately respond to distress. Improved connections between sectors are important, but pressure on third sector also makes it difficult to address people in distress in a timely manner. CMHTs working effectively and consistently in developing Advance Statements, Anticipatory Care Plans, Crisis Plans, and or use of Care Program Approach		
Access Assessment, Care Planning, Treatment and Support	There is pressure on other public sector services such as Police Scotland to respond and manage MH distress/episodes in the community because patients cannot yet access a service or are not yet considered in need of a service, while the MH continues to worsen.	How might we expand or change how we support individuals experiencing MH distress, to ensure that their condition/ distress does not worsen during wait periods, requiring secondary care intervention?	Further invest in DBI and explore models of extended DBI timeframes Need representation from social care, welfare, housing and alcohol and drug services, and third sector. Shouldn't medicalise all mental health distress when underlying social factor might be issue	Relationships	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.
Assessment, Care Planning, Treatment and Support	Currently care planning does not cover likely escalation/crisis processes so that there is a clear step in and step out of	How might we assess our care planning process, to incorporate likely patient escalations/crisis, so that it is clear where	Models exist to support anticipatory care planning such as the WRAP model and this has been used within CMHT's in the past. Promote use of Advanced Statements as per MWC guidance.	Resources	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.

	unscheduled care/acute care.	unscheduled care and acute care are needed?	Tap into lived experience resource to help support and empower patients to be motivated to develop anticipatory care plans. Use any pathways that exist e.g. EUPD pathways. Encourage the wider spread use of the WRAP planning tool - involve people in thinking about what they might need in future on 'not so good days'.		
Assessment, Care Planning, Treatment and Support	Staff feel bound to the hospital. Due to a lack of resource, they are unable to visit patients in the community. Meaning patients then have to come into travel to hospital, where a community setting would have been more appropriate.	How might we build capacity into secondary care teams, to be able to follow up with their patients in their community, without impacting inpatient experiences?	Separate inpatient and outpatient medical cover? In some areas of Aberdeenshire, this is the model and whilst this should make community presence / follow up easier this is not always the case. Perhaps something about cultural norms that needs addressing? Moray model of working in close partnership with third sector commissioned service for community-based resource. Audit activity of community-based facilities that could be available to host CHMT drop ins? Coordination with community-based or third sector support opportunities/spaces. Resource mapping most relevant opportunities to then explore potential collaboration? Service Improvement and Service Planning to support teams achieve	Relationships	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.

			Target Operating Models would uncover opportunities to develop. Perhaps links to "Community Mental Health Interventions Review" (CMHIR) headed by Jenny Rae// Also, is there a linkage here with the TEC work Tracey M was involved in? I.e. using tech to overcome some of the geographical and time restraints.		
Assessment, Care Planning, Treatment and Support	Roles designed to prevent patient's mental health progressing to moderate/ severe, by addressing social issues impacting their mental health, are not continuing, and adding to an already stretched system.	How might we build on existing preventative/ proactive activities to ensure MH care, and support for impacting social issues, can be provided at the earliest opportunity?	Improve links with / awareness of the Mental Health Improvement & Wellbeing Service (Aberdeenshire) that sits under primary care. Linkage to third sector? Better coordination with and redesign of MH supports in primary care and third sector. The making recovery real in moray partnership offers an example of good co-productive work. This I think, requires really close working with third sector organisations to maximise community support for people when discharged from health. Also need include welfare, housing, addiction services. Create synergies with third sector where possible. Focus must be on real prevention before people need to access any mental support service. Extend inclusion and	Recruitment & Retention	Better equipped communities to support people's mental health and wellbeing and provide opportunities to connect with others.

			extension of work by public health and primary care to address mental health and wellbeing issues that are not in need of secondary care mental health services.		
Assessment, Care Planning, Treatment and Support	The lack of resource to carry out parallel assessments of MH need in Emergency Department prevents us improving acute flow.	How might we carry out MH assessment within Emergency Department, to improve patient experiences when also presenting with MH issues, which would improve acute flow?	Think there is a pilot whereby SAS can access Nurse Practitioners directly rather than needing to go via ED	Resources	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.
Moving between and out of Services	There is a lot of waiting around with no decisions on who is doing what. i.e. who is escorting and at what time.	How might we improve the process, together with [transportation services], for transporting patients to RCH for assessment/ admission, so that the time impact on RCH staff is reduced/ minimal/ removed?	Are there adverse event reviews or debriefs available to support shared learning approach to understanding this?	Process	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
Assessment, Care Planning, Treatment and Support	USC Decision makers do not have access to info from community-based support OOH which can make, making decisions OOH, much harder to do.	How might we provide access to important patient information, out of hours for key decision makers, so they can make better, more appropriate decisions for patient care?	EPR roll out this year. Data Information Governance Procedures are being explored with Caldicott Guardian	Resources	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.

Assessment, Care Planning, Treatment and Support	Individuals requiring admission to hospital are unable to because there is no suitable place for them to be accommodated safely i.e. bed/ staffing.	How might we understand the demand for hospital care, treatment, and rehabilitation, so that our secondary care services are structured appropriately, to ensure access to inpatient care is accessible to those that need it?		Process	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
Assessment, Care Planning, Treatment and Support	RCH IPCU does not meet appropriate accommodation standards for its function, in terms of the national standards documents.	How might we identify the necessary maintenance and changes required to the IPCU so that an appropriate action plan to address these changes can be implemented?	Forensic Services Programme Board likely to be established to support the implementation of actions outlined within the Forensic Services Review (response to the Barron Report), which will incorporate a Forensic Services Accommodation Project Board, of which its role will be to support actions to address inpatient and outpatient accommodation.	Resources	Improved overall mental wellbeing and reduced inequalities
Assessment, Care Planning, Treatment and Support	IPCU patients cannot easily access time with Allied Health Professionals.	How might we understand the challenges regarding access to AHP for IPCU patients so that we may remove any barriers to their support?	Forensic Services Programme Board likely to be established to support the implementation of actions outlined within the Forensic Services Review (response to the Barron Report).	Resources	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.

Assessment, Care Planning, Treatment and Support	Consultants do not have enough time and capacity to contribute effectively to the care and wellbeing of IPCU patients.	How might we build interest in, or develop our MH vocations, to develop a quality recruitment pool, on which to build the MH workforce.	Forensic Services Programme Board likely to be established to support the implementation of actions outlined within the Forensic Services Review (response to the Barron Report).	Process	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
Governance and Accountability	There is project work taking place in HSCPs that is not shared with Hosted services. Staff are unfamiliar with governance structures responsible for MH secondary care or projects taking place across MH secondary care.	How might we clarify the governance structures across Grampian, which support MH services and any projects impacting secondary care services, for staff to become familiar with these activities and where to find information about these activities?	There is a Cross System Strategic Delivery Team (CSSDT) which incorporates senior managers and professional leads for MH cross Grampian. This team reports into Mental Health Portfolio Board and new strategic service developments should be discussed there if impacts wider system	Communication	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.
Moving between and out of Services	The duty doctor system and how this rotates can cause issues within admin and data collection.	How might we discover what issues are arising in relation to the duty doctor system, which would improve the quality of admin and data being collected?	Review process also with external support to provide a more overarching view of what could be improved and most importantly connect with other NHSG areas working to improve the same issue (data collection should be reviewed and improved across the organisation)	Process	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.

Governance and Accountability	We are providing services to a changing demographic within a system that is still dependent on medical leadership.	How might we explore alternative models of practice, so that we can determine whether our secondary care services are structured and delivered in a way that best meets the needs/demand of the current population?	We need to consider alternative models of practise Develop a strategy that makes best use of the clinical recourses available to us Train more medical staff Create a SLWG that will explore alternative models of practice and determine whether other models are viable. Psychology/Nursing/AHP's are often well placed to support MDT decision making if welcomed to do so, it may take a change in SOP where appropriate to progress. Lived experience advisory group.	Resources	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
Governance and Accountability	There is no visibility of clinical pathways.	How might we improve the documentation of clinical pathways, and make these visible to staff who are supporting their implementation, so that they can provide a high standard of care?	Not sure what this means - Grampian Guidance, SIGN Guidelines, Royal College Guidelines, National and Local Delivery Plans Pathways, National Policy and Standards and Service Specification	Process	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.

Governance and Accountability	Services such as social work are seeing a significant increase in referrals in areas such as Autism Spectrum Disorder and co-morbidities which services are not necessarily prepared to manage/support.	How might we make better preparations, when forecasting suggests impending issues or a significant increase in MH diagnoses and any related co-morbidities impacting patients, to ensure that services are fit to meet the demand.	Need strategic decision making around whether autism and ADHD needs can or should be met within adult mental health services. Are there other teams or parts of the system in social work that can pick this up. Can third sector offer anything Should we invest in training to increase skills and knowledge in NDD, autism, ADHD	Resources	Better access and use of evidence and data in policy and practice.
Governance and Accountability	Staff do not understand the current or proposed strategy for change or improvements to MH services.	How might we review MH strategies, which outline the current situation for MH services and what needs to be done to deliver improvements to these services, so this is clear for staff of all levels?		Communication	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
Governance and Accountability	The upper age boundary for acute hospital e.g. separate older adult liaison team, with a different site, which is poorly resourced, isn't an effective use of resources and isn't patient centred.	How might we understand the demand for hospital care, treatment, and rehabilitation, so that our secondary care services are structured appropriately, to ensure access to inpatient care is accessible to those that need it?	Liaison has three teams almost, CAMHS crisis service, Adult Liaison and Older Adult Liaison, who work across different hospital sites and departments. Perhaps workshop could be arranged to review overlaps and potential opportunities. Adult Liaison challenged in supporting ED 4hr target due to limited hours of operation. All teams handover to USC MH team and On Call team out of hours weekends where consistency of assessment, care planning and treatment may be impacted	Resources	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.

Governance and Accountability	Individuals requiring admission to hospital are unable to because there is no suitable place for them to be accommodated safely i.e. bed/ staffing.	How might we understand the demand for hospital care, treatment, and rehabilitation, so that our secondary care services are structured appropriately, to ensure access to inpatient care is accessible to those that need it?	Review of MH Bed Base in line with Executive Team commitment to consider RCH as next phase to ARI Bed Base Review	Resources	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
Moving between and out of Services	Interface issues with AMH.	How might we understand the challenges regarding IPCU interface with AMH so that we may remove any barriers preventing an effectively relationship?	Forensic Services Programme Board likely to be established to support the implementation of actions outlined within the Forensic Services Review (response to the Barron Report).	Relationships	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.

Governance and Accountability	There is limited access for primary care/secondary care to refer to 3rd sector i.e. DBI. These patients are then followed up internally when perhaps a non-clinical option may have been better.	How might we determine a suitable process, which would allow for primary/secondary care, to refer to third sector organisations, where their care and resources are more appropriate for the patient?	This happens successfully in some areas, usually referral discussed at MDT and if rejected to secondary care, social work will usually make contact with the referrer (usually GP) and the patient to signpost to third sector (social work usually best placed to identify / be familiar with what is available within the community) The third sector needs to be funded appropriately to create the capacity to accept higher number of referrals and contract to deliver the support should be closely monitored for efficiency and retendered if need be. Resource with community-based or third sector-led services, and provision of support for third sector services considered more relevant (e.g., training). Can the access be reviewed and extended to MH & ED USC? Perhaps links to "Community Mental Health Interventions Review" (CMHIR) headed by Jenny Rae// Also, is there a linkage here with the TEC work Tracey M was involved in? I.e. using tech to overcome some of the geographical and time restraints.	Process	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.

Moving between and out of Services	Patients are discharged too early, this may be as a result of admission pressures/other pressures, which result in patients being readmitted at a later date.	How might we ensure patients are only discharged because they are ready, they have met their milestones and because an appropriate community care plan is in place?	Improved discharge planning and communication between inpatient and outpatient teams. Better use of the CPA framework where appropriate. Creative joint working with third sector partners to support early but safe discharges that offer continuity of support from ward to home and also in advance of admission Home Treatment Team approach could assist in early discharge/prevent admissions but only if properly MDT resourced. Need use readmission data as reference. Clarity over aims of admission and criteria for discharge. Improve Criteria Led Discharge practice by multi professional disciplines, as currently reliance upon medical model for discharge.	Operational	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.

Moving between and out of Services	There are challenges relating to the discharge of patients considered 'adults with incapacity' that cannot be resolved.	How might we identify patients impacted by delayed discharge, and the challenges relating to their discharge, so that appropriate planning and resources for their discharge can be identified and implemented timely?	Improved communication between inpatient and outpatient teams to ensure patients lacking capacity can be identified. Responsibility is on SW to chair AWICC's where this is needed. Improved use of delayed discharge recording. Two things here firstly to secure assessment by medical staff and MHO as a priority (dedicated time set aside) and secondly being aware of resource provision and limitations in the community i.e. lack of beds in care homes Could consider such cases as activating MDT case conference/team formulation taking a positive risk tasking approach to decision making-may be a training need here|??/ Use of CPA (care Program Approach) consistently across system. Additional level of external review of all patients delayed over 60 days (in line with Acute and Community Hospitals) Engage with people who have, or may have, been affected by delayed discharge to assess what the impact has been. Ask what might have helped to alleviate some of those impacts at any stage in their patient journey.	Process	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.

Governance and Accountability	There are no documented, overarching policies across Grampian services to support and guide joint service delivery e.g. responding to complaints, and where partnerships policies and systems often conflict.	How might we identify processes or activities, which require Grampian-wide alignment, to ensure patient experiences are consistent are far as possible?	There are national policies and procedures for managing complaints for public bodies. Quality, Safety and Assurance Clinical and Care Governance Group starts end February to bring cross Grampian issues	Process	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
Governance and Accountability	There is not a consistent process for when patients are being discharged and this often results in staff not knowing that it is happening.	How might we implement a consistent discharge process that is visible and clear to all staff involved in the process, so that that it is easily understood?		Communication	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.
Moving between and out of Services	There is no clear out of area pathway for when a patient needs to go to an out of area bed. At this stage they tend to be extremely ill, and transporting the patient can be challenging.	How might we understand the challenges regarding the transfer of IPCU patients out of area so that those individuals can receive the right support and treatment in the most appropriate location?	Forensic Services Programme Board likely to be established to support the implementation of actions outlined within the Forensic Services Review (response to the Barron Report).	Process	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.

Workforce	Lack of Consultant Psychiatrist cover which impacts on continuity of the overall service Lack of in-patient staff (Moray) Inadequate provision of senior medical staff to cover statutory Mental Health Act work in general hospitals, can be reliant on duty medical teams.	How might we build interest in, or develop our MH vocations, to develop a quality recruitment pool, on which to build the MH workforce.	Work should link to the Workforce Plan, Aberdeenshire HSCP (and presumably each HSCP will have similar?) and specifically the Workforce and Training Group Cesar opportunities to train our own… redesign how existing consultants time is utilised and consider developing of a senior nurse practitioner role? Freeing up consultant time to be more of a consultative role. Routine review to be managed elsewhere in system Greater use of peer support, linking people to others who have the lived experience and who understand what the 'recovery journey' can look and feel like – how this could fit with specialised secondary pathways, I am not sure.	Recruitment & Retention	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
Workforce	There are not enough [consultants/nurses] to deliver an effective MH service. There are not enough [consultants/nurses] to deliver an effective MH service.	How might we build interest in, or develop our MH vocations, to develop a quality recruitment pool, on which to build the MH workforce.	Work should link to the Workforce Plan, Aberdeenshire HSCP (and presumably each HSCP will have similar?) and specifically the Workforce and Training Group Need to think about the opportunities of tapping into the value of lived experience. Grow the workforce by having a training plan and invest in third sector so the statutory resource can be highly focused on their particular	Recruitment & Retention	A diverse, skilled, supported, and sustainable workforce across all sectors.

			role. Potential to attract more Psychology graduates into mental health nursing, especially if PT pathways for career development were developed. Also potential to use EPP's to add to the skill mix in nursing which, if appropriate, could free up nursing time to focus on specific nursing duties Greater use of peer support, linking people to others who have the lived experience and who understand what the 'recovery journey' can look and feel like – how this could fit with specialised secondary pathways, I am not sure.		
Workforce	There is a lack of service provision which prevents services undertaking self-directed support with patients/individuals.	How might we build interest in, or develop our MH vocations, to develop a quality recruitment pool, on which to build the MH workforce.	Work should link to the Workforce Plan, Aberdeenshire HSCP (and presumably each HSCP will have similar?) and specifically the Workforce and Training Group Need to think more creatively about service provision and see whole community as a resource pool that can be tapped into - move away from traditional commissioned provider model. Education within adult services about eligibility criteria for SDS Potential to attract ore Psychology graduates into mental health	Resources	Better informed policy, support, care, and treatment, shaped by people with lived experience and practitioners, with a focus on quality and recovery.

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Workforce	There are not enough [consultants/nurses] to deliver an effective MH service.	How might we build interest in, or develop our MH vocations, to develop a quality recruitment pool, on which to build the MH workforce.	Work should link to the Workforce Plan, Aberdeenshire HSCP (and presumably each HSCP will have similar?) and specifically the Workforce and Training Group	Resources	A diverse, skilled, supported, and sustainable workforce across all sectors.
Workforce	Lack of understanding around Scottish legislation - how legislation was applied Impact on patient care, relationships with GPs, pressure on teams to pick up if and when locums consultants are used, as well as the locum's commitment to the service Locum Consultant - diagnosis changing often along with treatment, with	How might we induct locum consultants, to geographical areas they are unfamiliar with, to help build strong peer relationships and maintain a high standard of patient care?	Locums should be community based with teams (at least part of the week) which may assist with this problem area. Working more directly with teams, including MHO's would help them have a better understanding of other roles within the team Redesign use of locums to cesar training programs and have nurse led clinics for consistency develop some social supports for locums from peers and colleagues	Recruitment & Retention	A diverse, skilled, supported, and sustainable workforce across all sectors.

	each locum, and impact on patient significant - further impact on patients mental health Locums - not embedded in the team and don't discuss changes with the wider team Locum medical cover is leading to inconsistency in quality of service.		(monthly social club) to allow them to feel welcomed and less isolated to areas alongside work, Try to emotionally invest the locums to want to join the service. This a trickier one. Limit how long locum contracts can be extended if there are long term locums not willing to apply for the vacant posts. (need some ideas on this). virtual tours of the locale? Structured induction, regular, quick catch ups with colleagues in the region		
Workforce	There are not enough [consultants/nurses] to deliver an effective MH service. There is an impact to patient care, relationships with GPs, pressure on teams to pick up, if and when locums consultants are used, due to disorganised handovers.	How might we induct locum consultants, to geographical areas they are unfamiliar with, to help build strong peer relationships and maintain a high standard of patient care?	Re: Nursing Workforce - as 5-8 above. Medical Workforce - as (14) above, additionally we need to work alongside public health strategies and primary care to ensure patients getting right care, etc, and prevent NHS G population needing the secondary care services. virtual tours of the locale? Structured induction, regular, quick catch ups with colleagues in the region	Process	A diverse, skilled, supported, and sustainable workforce across all sectors.

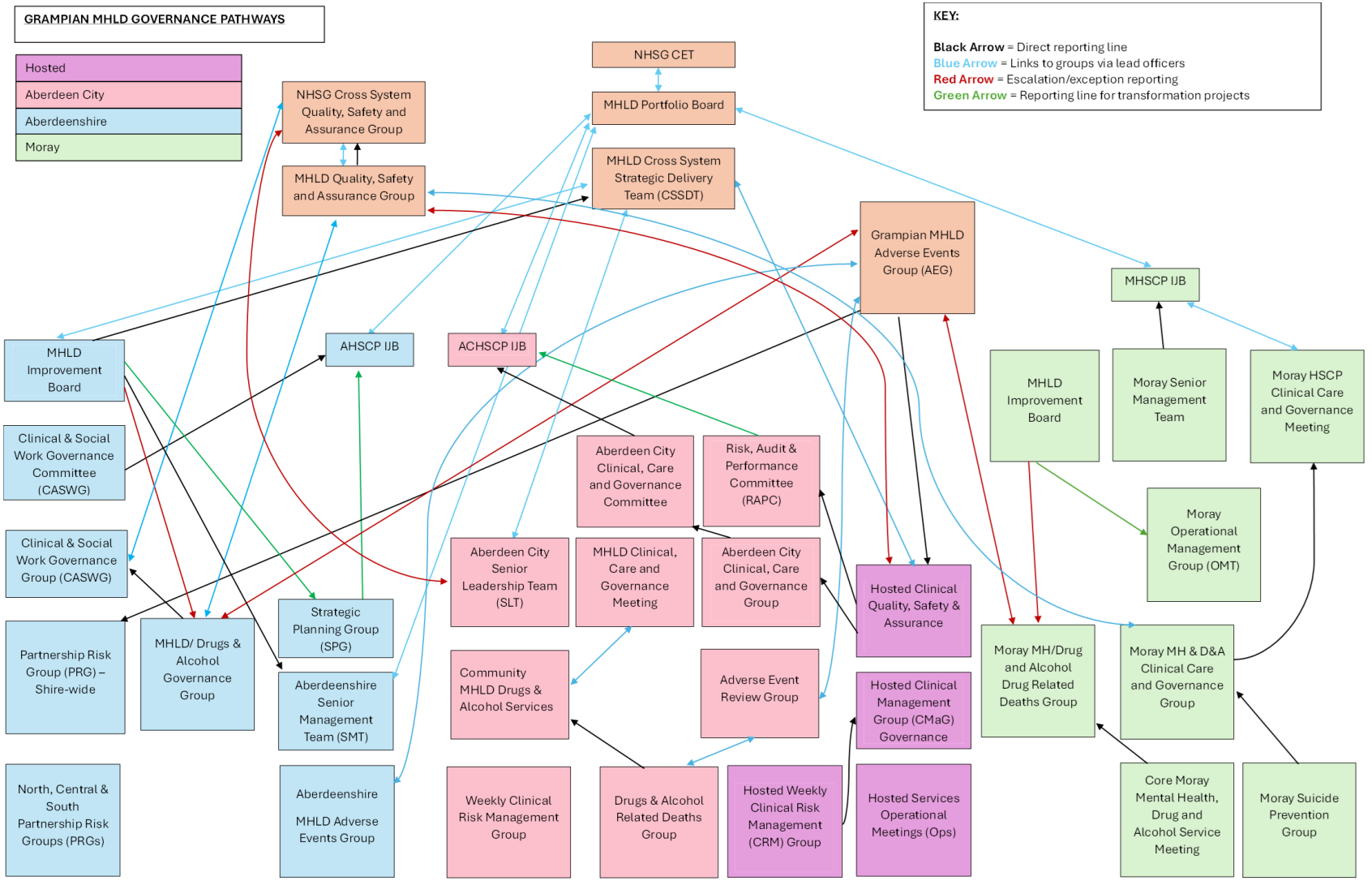
Workforce	There is a lack of funding to support continuous learning in the workplace which is impacting staff development, progression, and the ability to deliver best practice as this evolves.	How might we expand our in-house MH training opportunities to support continuous learning in the workplace?	CPD doesn't always have to be about workshops or training sessions but can include protected time for reflective writing and reading of free resources and materials. Identify and accurately describe the skills, knowledge and behaviours required for a particular post. Conduct a training needs analysis. Design training to focus on narrowing the gap between what is desired and what the current reality is. Develop and facilitate peer learning sessions – use of 'solution circles' for example.	Training	A diverse, skilled, supported, and sustainable workforce across all sectors.
Workforce	Communication between secondary care services and GPs not happening - GP not receiving communication or acting on information provided by secondary care, after patients have been provided support	How might we improve relationships and communication between fellow secondary care services/ teams and primary care, so that continuing patient care is not obstructed?	Aberdeenshire: Virtual Community Wards Are there regular practice meetings that secondary care staff attend at the GP? For discharge information, inpatient medical staff should adhere to PDD and full discharge summary recommendations. Clinical staff record keeping audits - are these conducted in all disciplines in community, what is record keeping standards by professional regulatory body - how is being measured and benchmarked?	Communication	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.

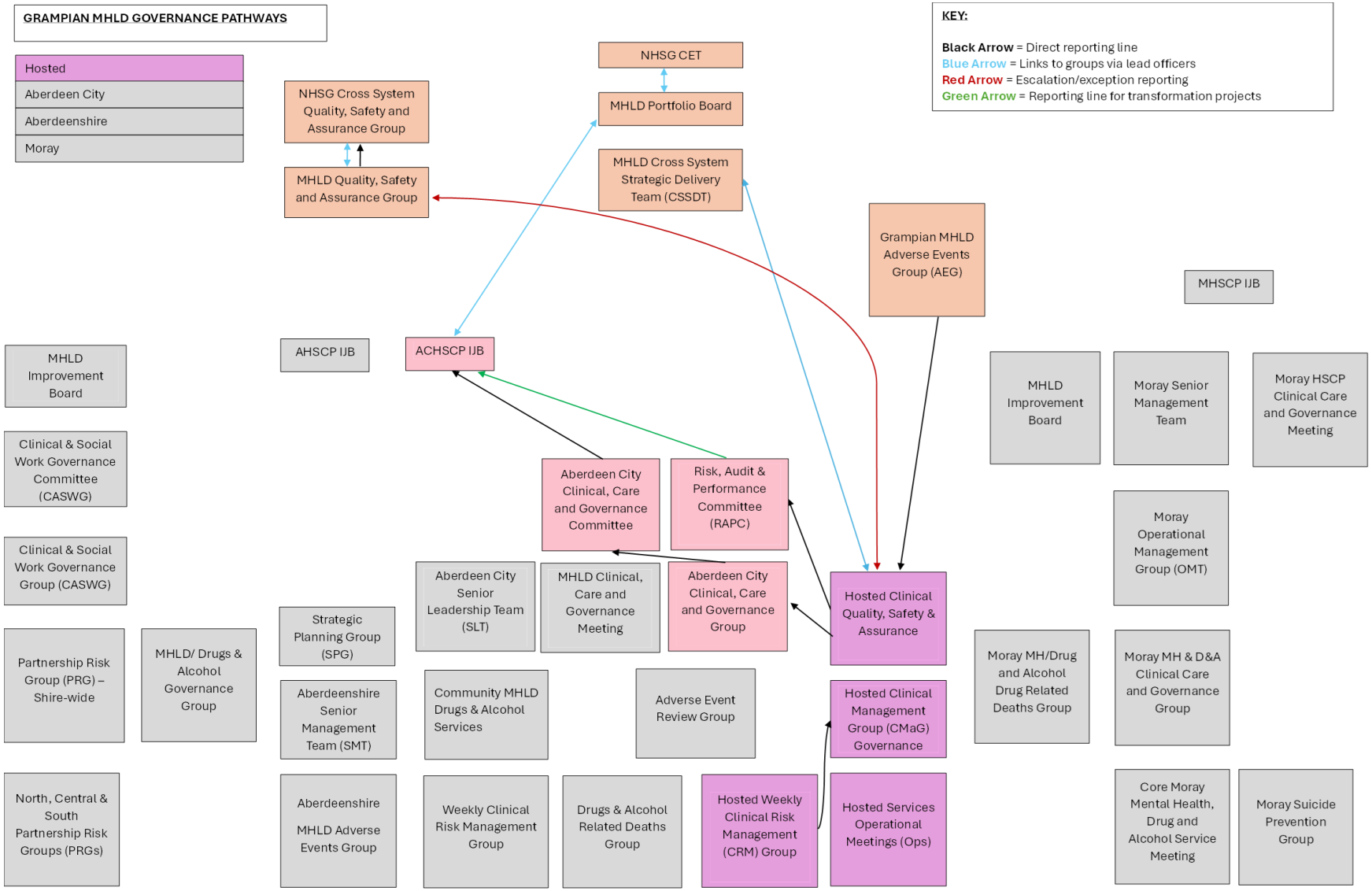
			Public Engagement: engage with groups and organisations with a vested interested in MH services. Enter in honest conversations with people about the stress on HC systems; describe how MH systems link together; outline what they (currently) can and cannot do for people. Capture people's concerns and try to establish what they feel are priorities within the secondary MH system.		
Workforce	The relationships between primary care and secondary care are not strong which impacts patient care. There is a lack of communication between secondary care and primary care psychology services which can result in patients fall between the cracks of these services and not receiving and care/support at all.	How might we improve relationships and communication between fellow secondary care services/ teams and primary care, so that continuing patient care is not obstructed?	Moray model of having interface meetings and contribution to referral discussions for psychological support between PC and SC staff Create a SLWG that would identify improvements to this situation.	Relationships	More effective cross-policy action to address the wide-ranging factors that impact people's mental health and wellbeing.
Workforce	There is a high financial pressure on partnerships through the use of locum medical cover. The disparity between locum medical cover and permanent staff is large and obvious which impacts moral amongst permanent staff.	How might we minimise the use of, or more effectively make use of, locum medical support to ease the funding pressure it presents to the HSCPs?		Funding	Better access and use of evidence and data in policy and practice.

Workforce	Staff are burnt out while they try to cover all roles and responsibilities within their team/service. There are not enough [consultants/nurses] to deliver an effective MH service.	How might we provide quality support and care to staff, to ensure they feel heard and valued, during periods of change.	Aberdeenshire: ensure there are service representatives on the Staff Health and Wellbeing Group (sits under the Workforce Plan 2022 - 2025). Make sure all staff support services are activated for staff at earliest opportunity, especially for those who are off sick with anxiety/depression where early access to PT's can keep people at work or allow them to return more quickly	Recruitment & Retention	Increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing, meeting individual needs.
Workforce	Staff are burnt out while they try to cover all roles and responsibilities within their team/service. There are not enough [consultants/nurses] to deliver an effective MH service.	How might we provide quality support and care to staff, to ensure they feel heard and valued, during periods of change.	Aberdeenshire: ensure there are service representatives on the Staff Health and Wellbeing Group (sits under the Workforce Plan 2022 - 2025). Communication channels to be established and support for workforce wellbeing. You said we did model within service How might we support staff during these pressurised times? Culture collaborative: We Care, good staff governance	Recruitment & Retention	A diverse, skilled, supported, and sustainable workforce across all sectors
Workforce	There is a high amount of clinical work to be undertaken, requiring significant resource which is lacking.	How might we provide quality support and care to staff, to ensure they feel heard and valued, during periods of change?	Values based 'supervision' or 1-to-1's. facilitated meetings, rather than one or two voices dominating. Basic good practice for change management - make people aware of the need for change, etc, etc,	Resources	A diverse, skilled, supported, and sustainable workforce across all sectors.

Workforce	The role that people have in teaching students, and training junior doctors aren't taken into account and there is often no space either in job plans or physically for this to be undertaken	How might we safeguard time within MH clinical roles, to ensure that any teaching requirements they have, can be met appropriately and without risk to patient care?	As a workforce we need to be pragmatic in evidencing what protected time is needed for such tasks in order to have a resilience sustainable workforce	Training	A diverse, skilled, supported, and sustainable workforce across all sectors.
Workforce	There is not an appropriate number of staff, with the required skills mix, within the IPCU service.	How might we build interest in, or develop our MH vocations, to develop a quality recruitment pool, on which to build the MH workforce.	Forensic Services Programme Board likely to be established to support the implementation of actions outlined within the Forensic Services Review (response to the Barron Report).	Recruitment & Retention	A diverse, skilled, supported, and sustainable workforce across all sectors.

Appendix O: MHLD Grampian Governance Pathways

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Aberdeenshire
Moray
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Blue Arrow = Links to groups via lead officers
Red Arrow = Escalation/exception reporting
Green Arrow = Reporting line for transformation projects
NHSG CET
MHLD Portfolio Board
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MHLD Quality, Safety and Assurance Group
MHLD Cross System Strategic Delivery Team (CSSDT)
Grampian MHLD Adverse Events Group (AEG)
MHSCP IJB
AHSCP IJB
ACHSCP IJB
MHLD Improvement Board
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Moray HSCP Clinical Care and Governance Meeting
Moray Operational Management Group (OMT)
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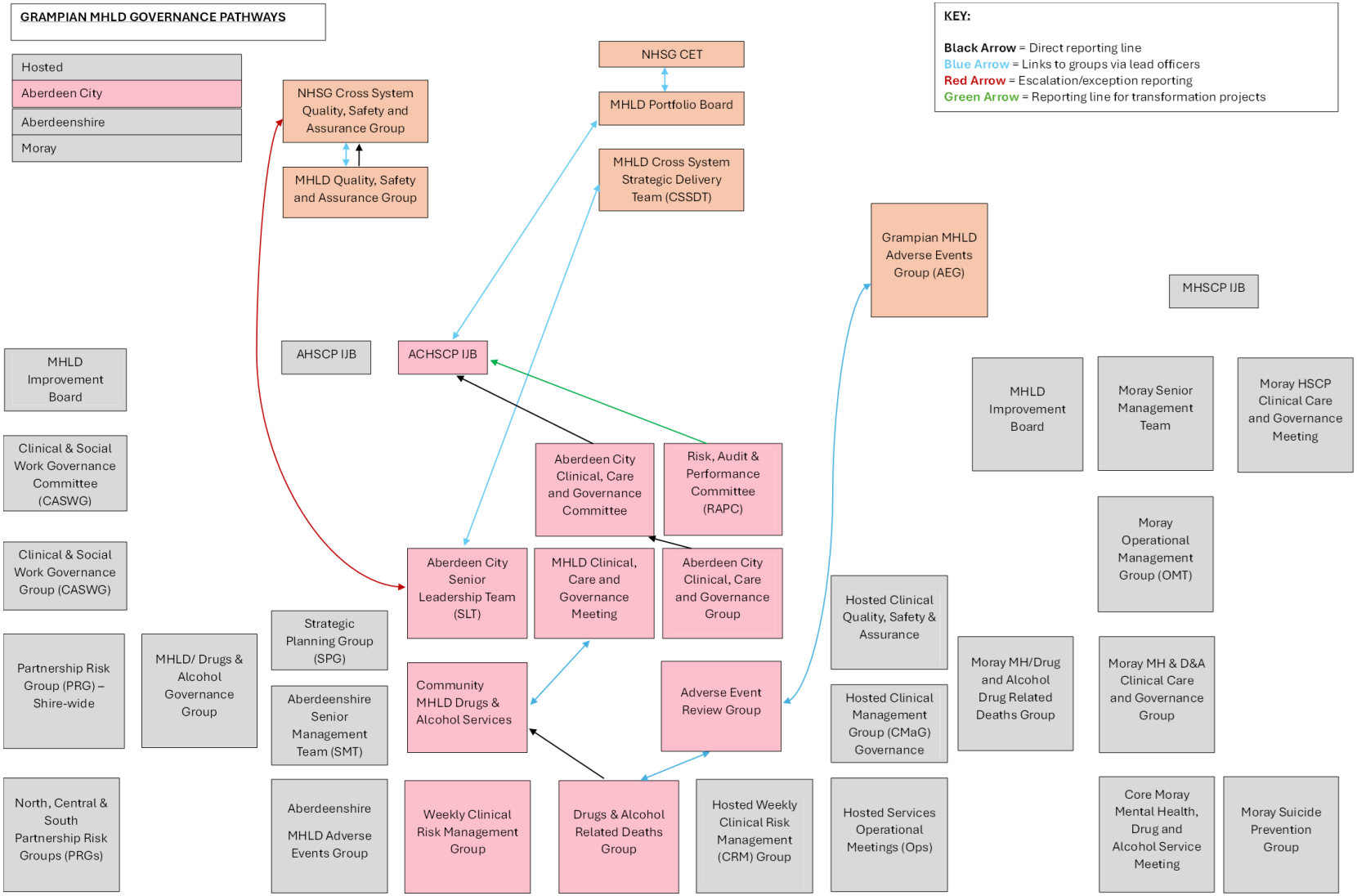
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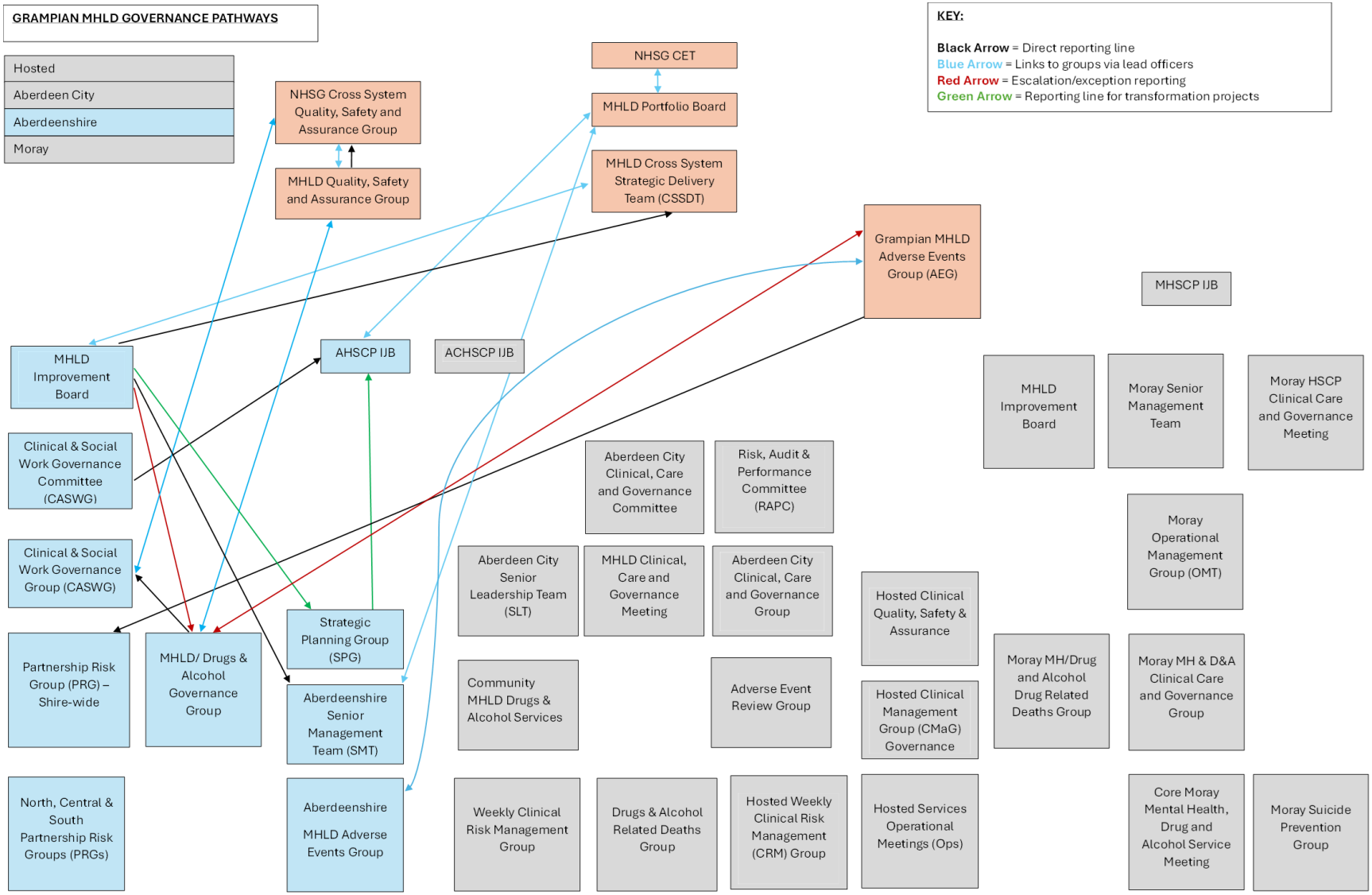
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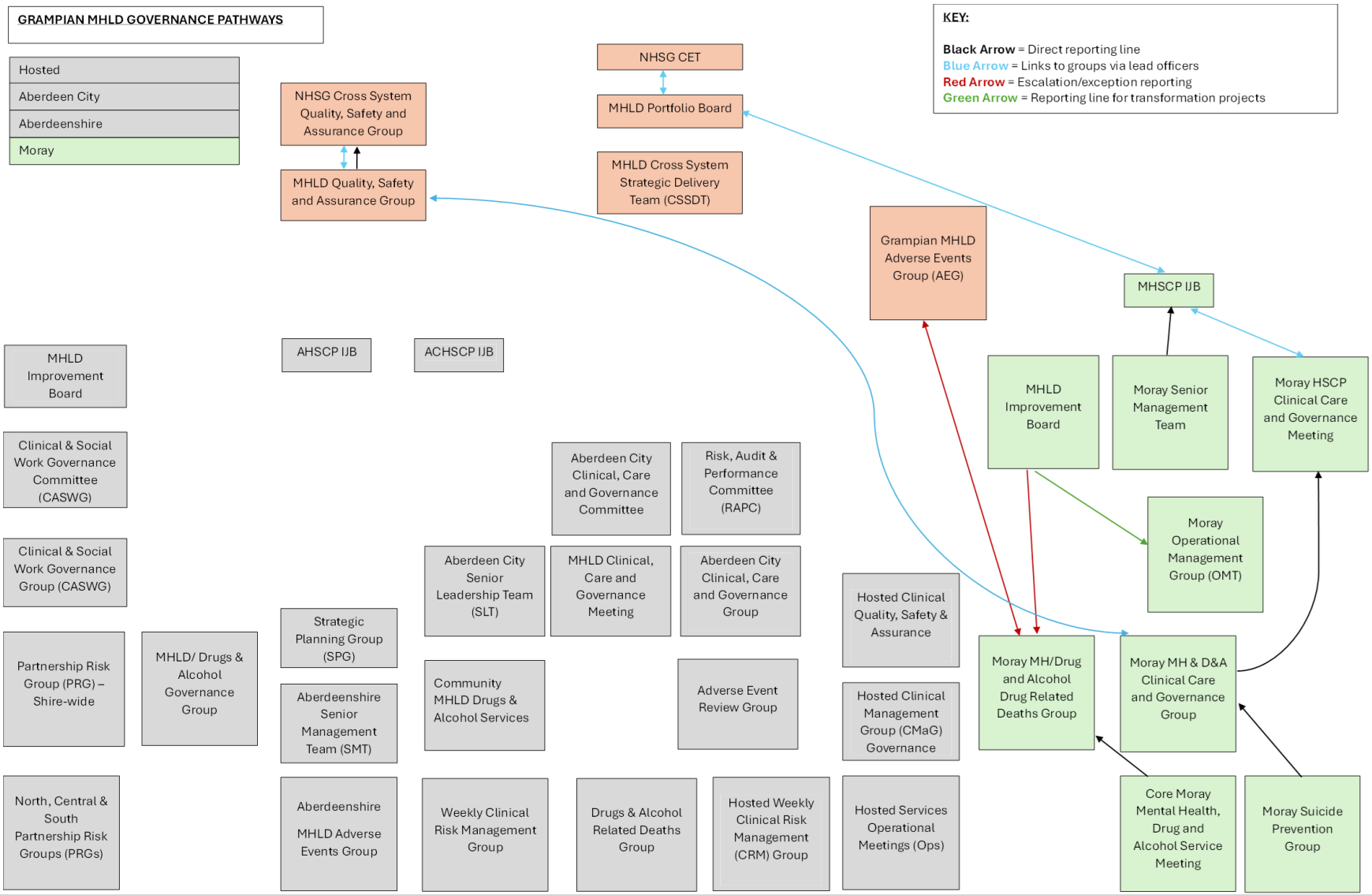
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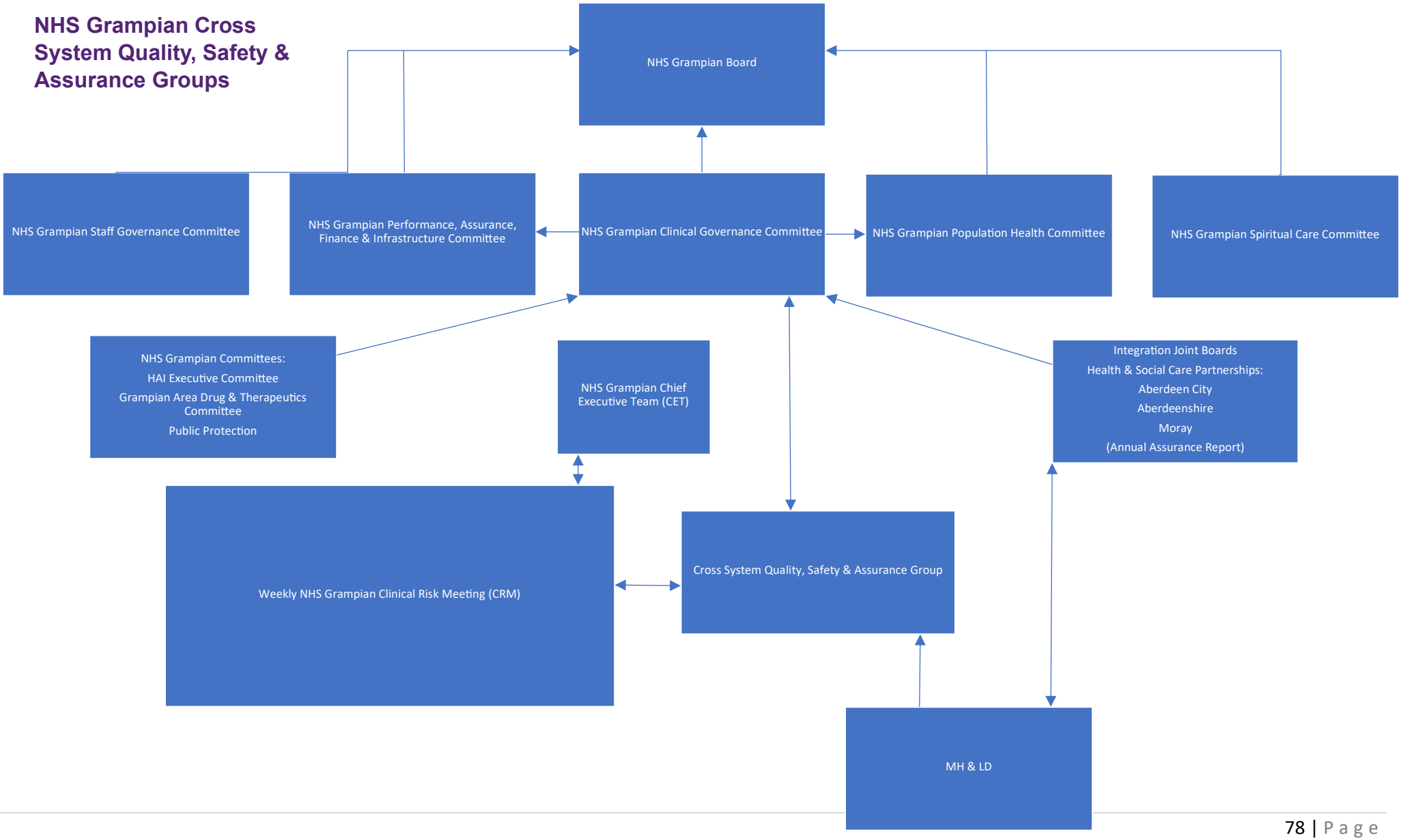
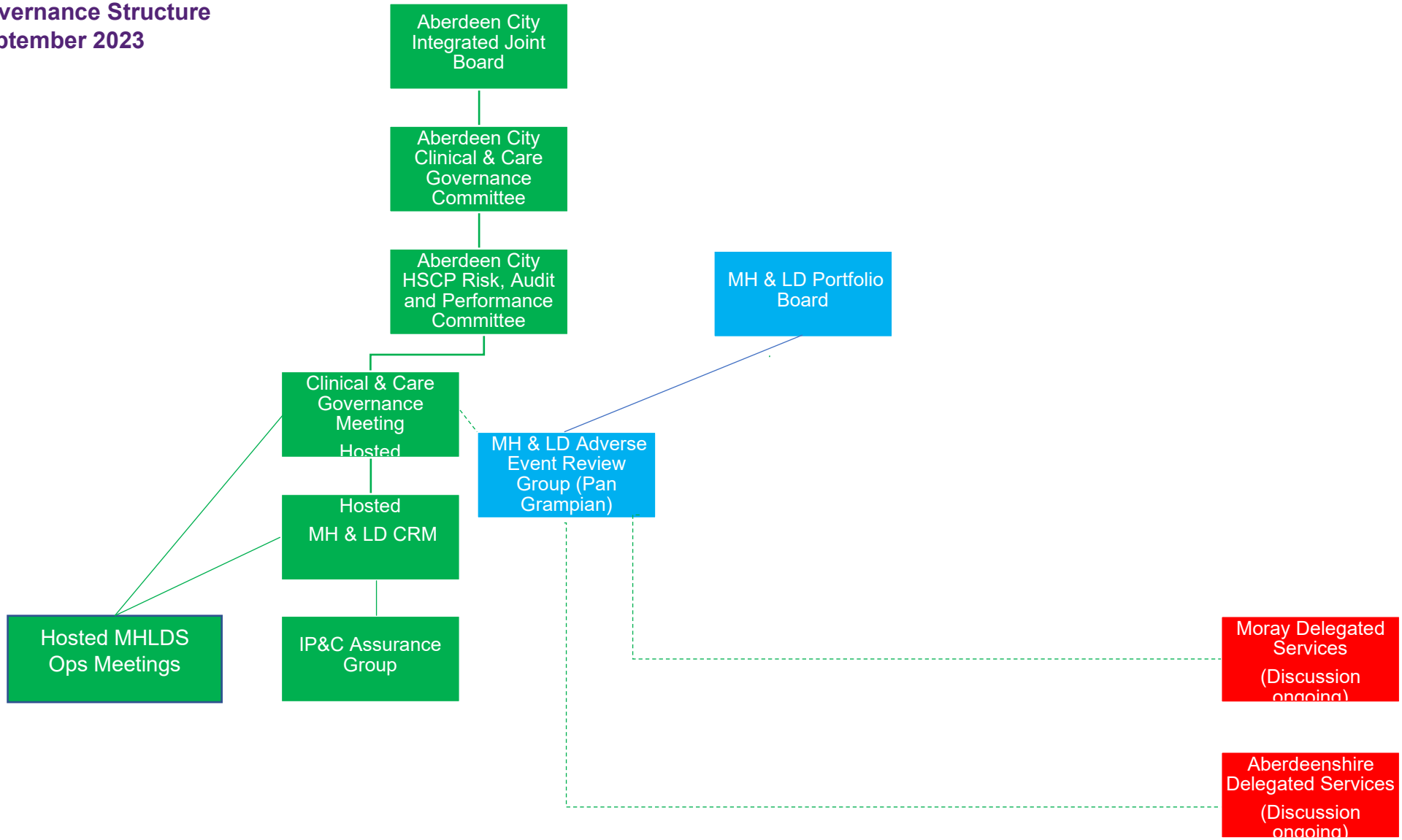


MHLDs Clinical & Care Governance Structure September 2023



Grampian MHLDs Cross System Strategic Delivery Team (CSSDT)