A Five Year Strategy for Adult Mental Health Services in Greater Glasgow & Clyde: 2018-23

Contents

1. Introduction: context, drivers and principles for change

1.1. Scope of this Strategy

This 5 year strategy has been commissioned by the Chief Officers of the 6 Health and Social Care Partnerships (HSCPs) within Greater Glasgow and Clyde, and in partnership with NHS Greater Glasgow & Clyde (NHS GG&C), who are committed to the need to take a whole-system approach to the strategic planning of Adult Mental Health Services, particularly given the interdependence and connectivity across HSCPs in relation to Mental Health Inpatient services. The rationale for developing a 5 year strategy at this stage is to:

- Maintain the momentum of the service change and improvements arising from the Clinical Service Review (CSR) led by NHS GG&C.
- Take early advantage of the benefits of integrated Health and Social Care Services and systems following the formal establishments of HSCPs.
- Respond to the challenges of increasing service demand and constrained finances by identifying transformational change solutions that ensure services are sustainable and targeted appropriately to meet need.
- Contribute to delivering the aspirations set out within national strategies, including the Scottish Government's Mental Health Strategy 2017-27[1].

While the focus of this strategy is Adult Mental Health Services, it is recognised that elements of it affect and rely on the wider 'Mental Health Family' (including Mental Health Social Care, Older People's Mental Health (OPMH), Child and Adolescent Mental Health (CAMHS), Alcohol and Drugs, Learning Disability and Forensic Services) as well as other services, including Acute hospital care and Primary Care.

It is also important to highlight that the production of this 5 year strategy document is very much the beginning of the change and improvement process. The document itself will be open to further modification as necessary as we develop an implementation plan to support delivery of the proposed recommendations. The implementation plan will be supported by workforce, financial and risk management frameworks and will be designed to reflect the dynamic nature of the proposed changes, with careful checks and balances at each major phase of implementation. It is anticipated that an initial, broad implementation plan will be developed by June 2018, with a commitment to engage further with key stakeholders to shape its final content.

1.2. Summary of the Proposed Service Changes and Improvements

Each section of the 5 year strategy document sets out the issues and recommended actions necessary to deliver the aims of the strategy. Particular attention is drawn to the following service changes proposed:

Prevention, Early Intervention and Health Improvement

[1] Scottish Government's Mental Health Strategy 2017-27

- 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).
- Support community planning partners to develop and implement strategies to address 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.

Physical Health

- On-going application of the Physical Healthcare and Mental Health Policy.
- 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 staff to ensure that the delivery of physical healthcare meets current standards.

Recovery Orientated and Trauma-aware services

- Collaboration with people with lived experience, local Mental Health networks and Scottish Recovery Network do develop co-production approaches to promoting recovery.
- Work with partners to pilot the introduction of Recovery Colleges in the Board area.
- Develop and implement a model of Peer Support Workers.

Primary Care

- To assess the implications of the new GP contract, particularly around the potential for additional Mental Health workers.
- The Mental Health Strategy should be considered as a contributing element of the Primary Care Improvement Plans.
- Work to manage and support those with long term physical conditions should be expanded and prioritised to ensure that effective communication of physical and mental health condition management requirements are shared between clinicians in both Primary Care and Mental Health settings.

Community and Specialist Teams

- A focus on maximising efficiency and effectiveness of our Community Mental Health Teams (CMHTs)in order to manage the current trend of 3% increases in demand each year and to manage additional demand as a consequence of proposed reductions to bed capacity.
- A review of eligibility criteria, length of contact and models of support in specialist teams to help create capacity within Adult Community Mental Health Teams.
- The introduction of a matched care approach to the provision of care and treatment for Borderline Personality Disorder.

Social Care

- Where necessary, a 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/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 reprovision programme.

Unscheduled Care

- Liaison/Out of Hours (OOH): provide 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 from 8am to 11pm, 7 days a week.
- OOH: provide a single phone number for all Unscheduled Care arising OOH. An experienced clinician could offer guidance to referrers, directing calls to local Crisis Resolution Home Treatment Teams (CRHTs) (or CMHTs and other daytime services) as needed.

Bed Modelling

- A combined reduction to Adult Mental Health Inpatient bed capacity of approximately 100 beds, in line with benchmarking analysis and proposed reinvestments in community services.
- Development and implementation of an Adult Acute Care Pathway across all adult acute inpatient sites; the application of more clearly defined standards and consistent practice within Intensive and High Dependency Rehabilitation wards; and an aim to move away from hospital based wards for people requiring long-term, 24/7 care.
- A greater focus on addressing delays in discharge and ensuring a proactive approach to discharge planning - this will include closer integration with community and social care services to ensure joint prioritisation of resources and a smoother patient flow across inpatient and community settings.

Not able to be captured in specific bullet points is 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 that will be necessary to ensure the overall system of care is designed in the best way it can to meet people's needs. This strategy aims to be a catalyst for such an approach. In doing so, it is also recognised that many of the solutions for improving the Mental Health of individuals and the population can only be achieved through effective, co-ordinated action with wider agencies and community planning partners.

1.3. Strategic Context: Shifting the Balance of Care

For decades, service development in Mental Health Services in Scotland has been characterised by a reduction in hospital beds, supported by improved community services. NHS Greater Glasgow led much of the UK in a large-scale psychiatric hospital closure programme from the 1980s, with beds reducing in Glasgow City from 4,370 in 1978 to 783 in 2017[2] Bed closures accelerated in the 1990s in Glasgow, and the process has continued ever since, albeit at a slower pace. "Modernising Mental Health" strategies (2001 for Greater Glasgow and 2006 for Clyde) set out frameworks for the development of comprehensive community services and the reconfiguration of Inpatient beds.

The closure of more than 3,500 beds across Greater Glasgow and Clyde during this period released significant levels of funding for reinvestment in community services, and allowed for major improvements in the quality of accommodation in the Inpatient estate. A recent review of Mental Health Services in Scotland concluded that the "conditions of inpatient facilities have been significantly improved".[3]

Figure 1 shows the reduction in absolute bed numbers that has taken place in NHS GG&C over the last decade. While beds have continued to reduce across Scotland, there was a levelling-off in GG&C from 2013/14.

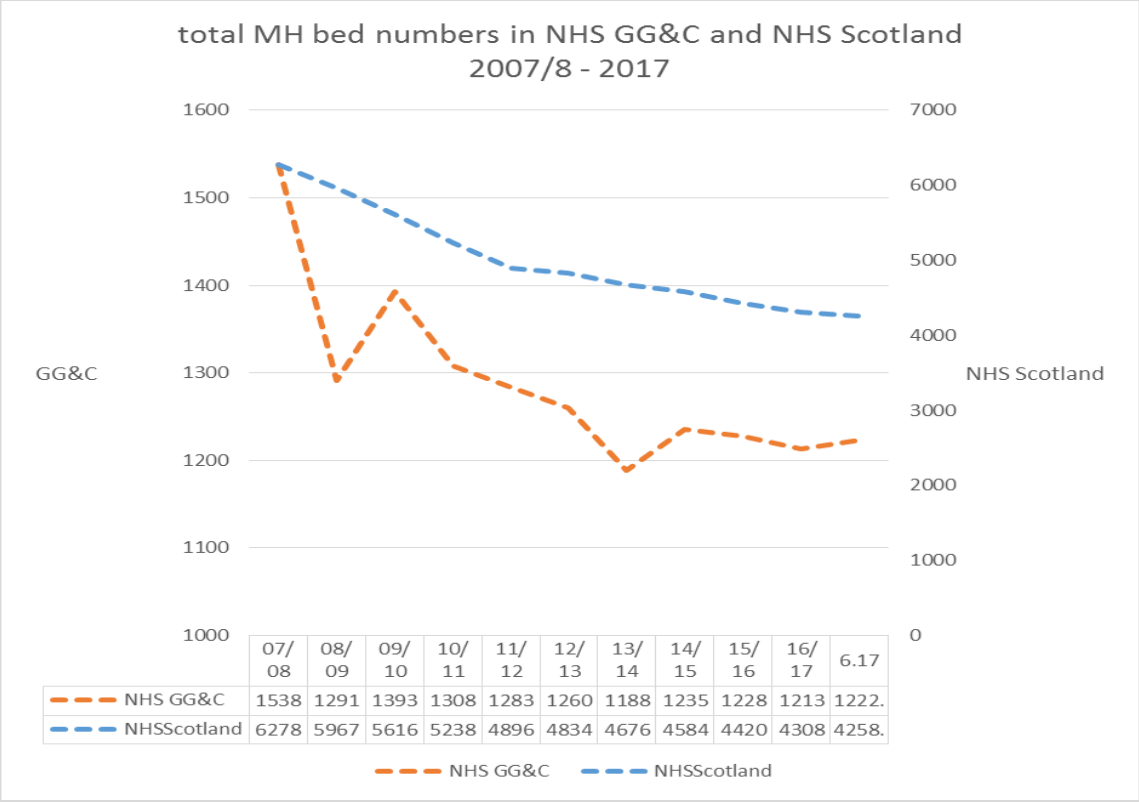


Figure 1: Changes in bed numbers in NHS GG&C (beds shown in red) and NHS Scotland (beds shown in blue)

Figure 2 shows the relative changes over the same period. The overall reduction in beds by 21% in NHS GG&C includes significant investment and increase in Forensic bed provision (linked to the

[2] Audit Scotland Adult Mental Health Bulletin, 1998 p5

[3] A Review of Mental Health Services in Scotland: Perspectives and Experiences of Service Users, Carers and Professionals: Report for Commitment One of the Mental Health Strategy for Scotland: 2012 - 2015

strategic change in care approach at the State Hospital and nationally across Scotland), offset by a large reduction in Adult beds of 32%.

The absolute number of beds required for a given population is very difficult to predict changes over time in relation to social and demographic changes, and also will depend on the overall system of care.[4] Reporting on the "State of Care in Mental Health Services" in 2017, the Quality Care Commission in England recognised that reducing the number of available beds increases the threshold for admission, the proportion of detained patients, the exposure to risk of violence for staff and patients, and the risk of inappropriate "out of area" placements.[5] Section 7, "Shifting the Balance of Care" recognises these risks and proposes a pragmatic approach to determining appropriate levels of inpatient provision.

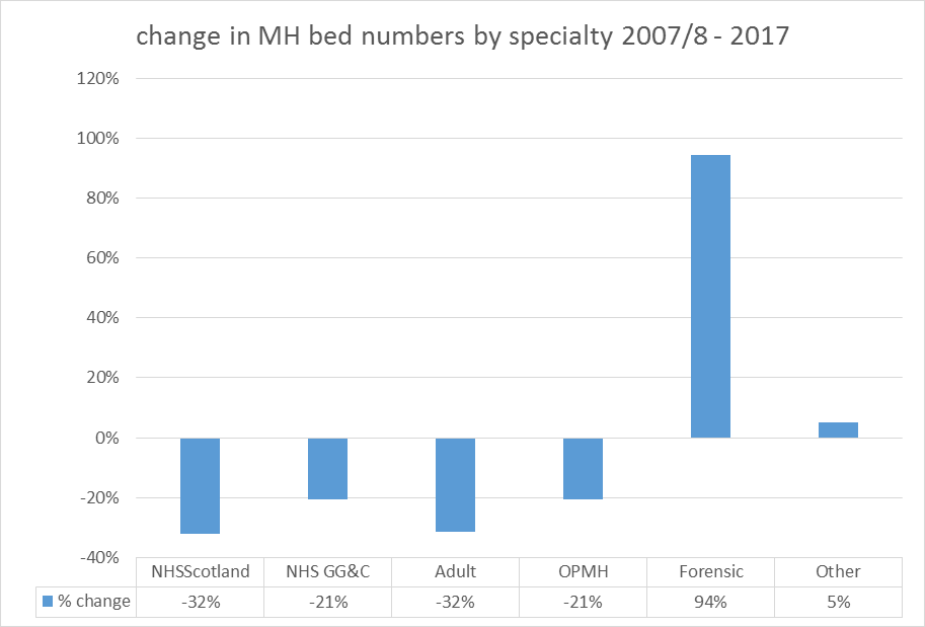


Figure 2: relative changes in bed numbers 07/08 to June 2017

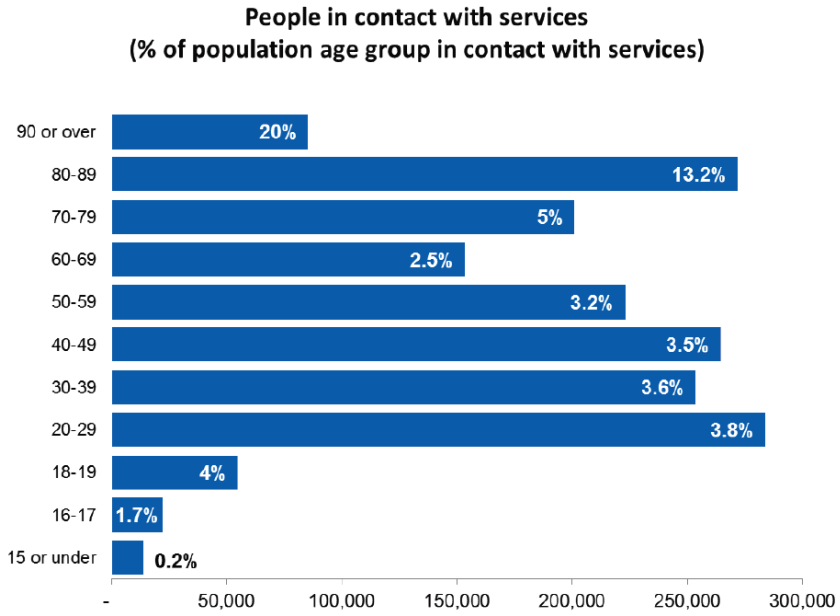
Community Service provision was initially based around the Community Mental Health Teams (CMHT) in Adult Services, with equivalents in Addictions, Forensic Mental Health, Child and Adolescent Mental Health (CAMHS) and Older Peoples' Mental Health (OPMH) services. In a suite of service developments through the early 2000s, those teams were complemented in NHS GG&C by Primary Care Community Mental Health Teams (PCMHTs) delivering "high volume, low intensity" care for common Mental Health problems and Crisis, Out of Hours and Home Treatment Teams providing emergency and unscheduled care.

A range of specialist teams were developed to meet particular needs, including the Adult Autism Team, the Perinatal Mental Health Team, the Adult Eating Disorder Team, provision for homeless people and Esteem, which provides early intervention for people with psychosis.

Such services have substantial population reach, with data from NHS England showing that about 3.4% of the adult population in England were in contact with Adult Mental Health and Learning Disability Services at some point in 2015/16. Only 6% of that group were admitted to inpatient

[4] Has the closure of psychiatric beds gone too far? British Medical Journal 2011
[5] The state of care in mental health services 2014 to 2017. Care Quality Commission, 2017.

Mental Health care. Contact with Mental Health Services rises significantly for the over-80s (13.2% of that age group).



Source: NHS Digital, Mental Health Bulletin 2015-16 Annual Report

Figure 3: People in contact with Mental Health services in England, 2015-16

Mental Health services in NHS GG&C supported the development and implementation of a range of national initiatives including the "see me" campaign against stigma (2002)[6], the Choose Life national strategy and action plan to reduce suicide (2002)[7], Doing Well by People with Depression (2003)[8], Breathing Space telephone help line (2004)[9], the Scottish Recovery Network (2004)[10], Implementation of the new Mental Health Act and associated Mental Health Tribunal (2005)[11], Getting it Right for Every Child (2006)[12], the Mental Health Collaborative (2008)[13], Equally Well (2009)[14], the Early Years Framework (2009)[15], Scotland's National Dementia Strategy (2010)[16], the Scottish Patient Safety Programme (2012)[17], and the integration of Health and Social Care from 2015[18].

NHS GG&C has implemented recommendations made by the Scottish Intercollegiate Guideline Network (SIGN) on the management of Bipolar Affective Disorder (2005)[19], Dementia (2006)[20], ADHD

[6] " See Me" campaign against stigma (2002)
[7] The Choose Life National Strategy & Action Plan to reduce Suicide (2002)
[8] Doing Well By People with Depression (2003)
[9] Breathing Space Telephone Help Line (2004)
[10] The Scottish Recovery Network (2004)
[11] Implementation of the New Mental Health Act & Associated Mental Health Tribunal
[12] Getting it Right for Every Child (2006)
[13] The Mental Health Collaborative (2008)
[14] Equally Well (2009)
[15] The Early Years Framework (2009)
[16] Scotland's National Dementia Strategy (2010)
[17] The Scottish Patient Safety Programme (2012)
[18] The Integration of Health and Social Care (2015)
[19] SIGN on the Management of Depression (2005)
[20] SIGN Dementia 2006

(2009)[21], Non-Pharmaceutical Management of Depression (2010)[22], Perinatal Mood Disorders (2012)[23] and Schizophrenia (2013)[24].

During the period 2003-14, NHS GG&C met or exceeded the HEAT targets for: reduced readmissions; an 18-week referral to treatment target for psychological services; 50% of frontline staff trained in suicide prevention; a 26-week target for referral to treatment in CAMHs; and improved rates of diagnosis for dementia. Two additional national targets were to reduce suicides by 20% in the decade to 2013 (with a reduction of 19.5% achieved) and a target to reduce the rate of increase in antidepressant use (withdrawn as considered to be inconsistent with the evidence base). Those HEAT targets have now been replaced by local delivery plan standards.

1.3.1. Future Delivery of Public Services

The 2011 Christie Commission on the Future Delivery of Public Services anticipated that public spending would not return to 2010 levels until 2026, while new demographic and social pressures would increase demand on public services. The Commission's report[25] set out a series of "urgent and sustained reforms" thought to be required to meet that unprecedented challenge.

Calling for a "radical change in the design and delivery of public services", the report estimated that up to 40% of all spending on public services is accounted for by interventions that could have been avoided by prioritising a preventative approach. It was critical of an unresponsive and "top-down" approach to service delivery which was often unresponsive to the needs of individuals and communities, emphasised the need for collaboration between public bodies and those who use them, the need to harness community assets and resilience, the need to prioritise preventative measures to reduce both demand and inequalities and to use data to drive a long-term programme of improvement.

1.3.2. Clinical Services Review

In 2012 NHS GG&C embarked on an extensive Clinical Services Review (CSR) in response to the Scottish Government's national vision that:

> *By 2020 everyone is able to live longer healthier lives at home or in a homely setting with a healthcare system that has integrated health and social care; a focus on prevention anticipation and supported self-management...*

The Board-wide CSR included Mental Health services. The core principles underpinning the CSR in Mental Health, and the main drivers for change are shown in Appendix A. Output from the CSR focused on the following actions:

- Developing Care Pathways to ensure availability of effective interventions.
- Reviewing the functioning and configuration of community services to deliver appropriate care.

[21] SIGN ADHD 2009
[22] SIGN Non Pharmaceutical Management of Depression (2010)
[23] SIGN Perinatal Mood Disorders (2012)
[24] SIGN Schizophrenia (2013)
[25] Report on the Future Delivery of Public Services by the Commission chaired by Dr Campbell Christie. Published on 29 June 2011.

- Reviewing the function and configuration of Inpatient services to deliver interventions consistent with a patient-centred and recovery-oriented focus.
- Reviewing the function and configuration of Out of Hours services to deliver urgent emergency and crisis interventions consistent with care pathways.
- Developing a range of Health Improvement and preventatives approaches, with an increased focus on the importance of prevention and early intervention for children and young people, particularly for those with Adverse Childhood Experiences (ACEs).

These actions were incorporated into a Community and Specialist Services Review (CSSR) in Mental Health, which endorsed the delivery of a model of "stepped" or "matched" care, in which patients would receive "all the care they need, but no more". The "care needed" means timely access to the full range of interventions recommended by NICE, SIGN, and other accepted care standards in Scotland, adapted through care pathways for delivery in NHS GG&C.

Using a "stepped" or "matched" care model, services tailor the intensity of care provided to meet patient needs, based on routine monitoring of clinical outcomes. Five levels of care were identified as part of the CSSR: public health interventions, "open access" services available without referral, "brief interventions", longer-term multidisciplinary care and intensive support. An "unscheduled care" element is also needed to respond to crises and emergency needs, across all conditions and settings. Figure 4 represents the levels of care that applies to prevention, treatment and care in Mental Health services.

Care level	**public**	**open access**	**ERBI: early response, brief intervention**	**longer-term, multi-disciplinary care**	**intensive treatment**
numbers					
type of Interventions	information, screening, self-help	education, self-help, peer support, group classes	"low intensity" work: brief interventions, psychological therapies, guided self-help	longer-term psychological therapies; community rehabilitation;	risk management , physical health care
access	everyone	open, self-referral	self-referral and GP referral	GP or secondary care referral	GP or secondary care referral

Figure 4: levels of care in Mental Health, with examples of interventions

1.3.3. *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[26] has enabled 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.

1.3.4. *The Five-Year Forward View for Mental Health in England (2016)*

The Five Year Forward View for Mental Health in England set out a number of priority actions for the NHS by 2020/21 which included:

7 day NHS – right care, right time, right quality and 24 hour access if facing a crisis.

Integrated Mental and Physical Health approach – increased access to psychological therapies.

Promoting good Mental Health and preventing poor Mental Health.

Prevention at key moments in life.

Creating mentally healthy communities.

A greater emphasis on people's experience of Mental Health.

Local Mental Health prevention plans.

1.3.5. *A Fairer NHS Greater Glasgow & Clyde (2016-2020)*

Inequality, Mental Health and human rights are inextricably linked. The rates of mental ill health for groups with protected characteristics are higher when compared to the general population. Discrimination is a vector that increases the likelihood of Mental Health issues for these groups. The experience of stigma and prejudice directly affects people who experience Mental Health issues. Mental ill health is covered by the Equality Act under the protected characteristic of disability.

A Fairer NHS Greater Glasgow & Clyde (2016-2020)[27] sets out the ambitions and actions of the Health Board in relation to the Equality Act (2010) and applies to all NHS GG&C staff. This means that staff, as part of their day to day business, must show how they will:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between groups of people with different 'protected characteristics';
- Foster good relations between these different groups.

The Five Year Strategy for Adult Mental Health will ensure Mental Health Services are accessible and meet the needs of all patients in compliance with the Act. The Mental Health Equality Development Group will support specific actions where required.

[26] Public Bodies (Joint Working) (Scotland) 2014
[27] A Fairer NHS GG&C 2016-2020

An example of Mental Health Services meeting the needs of specific groups is work with the Deaf community. This highlighted the challenges of delivering 'talking therapy' services particularly for British Sign Language (BSL) users. Services have developed: provision of information in BSL including websites; production of a glossary of signs on Mental Health terms for Deaf people; engagement with Deaf people to capture their experience of our services; training on Mental Health for BSL interpreters; and exploration of the sensitivity of self-management and primary prevention to Deaf people.

As part of the development work for the 5 Year MH Strategy an Equalities Impact Assessment was undertaken. More specific Equality Impact Assessments will be completed on key aspects of the strategy prior to implementation.

1.3.6. Scottish Government's Mental Health Strategy 2017-2027

This strategy puts a renewed focus on the priorities of:

- Prevention and Early Intervention;
- Access to treatment and joined up accessible services;
- The physical wellbeing of people with Mental Health problems;
- Rights, information use and planning.

The strategy aspires to achieve parity between Mental Health and physical health, and highlights some particular challenges for services:

- Only 1 in 3 people who would benefit from treatment from a mental illness currently receive it, on current estimates
- People with life-long mental illness are likely to die 15-20 years prematurely because of physical ill-health
- People with a Mental Health problem are more likely than others to wait longer than 4 hours in an emergency department.

1.3.7. 'Healthy Minds' 2017 Report by NHSGGC's Director of Public Health [28]

The report provides an overview of public Mental Health within NHS GG&C and describes opportunities for future development. Key messages include:

- Promoting Mental Health is very cost-effective and can provide long term savings in public services, including in Acute care.
- Mental health is strongly linked to the social determinants of health, including poverty, unemployment, inequality and discrimination. Tackling Mental Health issues is therefore an important part of our strategy to address health inequalities, and *vice versa*.
- The determinants of Mental Health and public Mental Health promotion require sustained multi-agency responses.

[28] Health Minds 2017 Report

- There is growing evidence on how to improve public Mental Health. NHS GG&C has an impressive history of innovation and implementation of evidence based interventions, but consistency, targeting and access could be improved.
- We require greater integration of physical and Mental Health care as evidenced so starkly in the high morbidity and mortality of people with mental illness.

The Director of Public Health's report also references an elected member-led Health and Inequality Commission for Glasgow City recently undertaken, the findings and recommendations from which will be of relevance to other HSCPs. A key recommendation from the Commission's report includes the need to increase support for community organisations in response to Mental Wellbeing – for example by tackling isolation and loneliness and building social connection.

1.4. Whole-system integration and dependencies

Mental Health Services benefit from a single system approach within Greater Glasgow and Clyde. This approach has supported service planning, management and governance across HSCPs and wider partners. To effect the changes proposed in this strategy it will require the continuation of a robust and coordinated management approach. It is proposed that such co-ordination would continue to be led by Glasgow City HSCP's Chief Officer, but very much require a collegiate approach across HSCPs and NHS GG&C. This will include co-ordinating the implementation of the 5 year strategy with the objectives of the 'Moving Forward Together' programme led by NHS GG&C[29].

Examples of Mental Health Services dependence on effective whole-system working are set out below:

- 3 of the 6 HSCPs provide inpatient beds, 2 of which provide Intensive Psychiatric Care beds on behalf of the system.
- Specialist services such as Esteem, Perinatal Mental Health and the Adult Eating Disorder Service are hosted by Glasgow City HSCP, but provided Board-wide.
- Consultant Psychiatrist on-call cover for Adult Mental Health, Learning Disability, Alcohol & Drug services and 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.
- The interaction of the various system components (including PCMHTs, OOH cover, CMHTs, inpatient beds, specialist services) are inter connected complex and reflects decades of planned change and development.

[29] Moving Forward Together

- In care groups with small critical mass of staff (e.g. clinical psychology in LD and in Alcohol and Drugs) system wide approach provides cover when required during vacancies, maternity leave etc.

Effective whole system working will also take into account the interdependencies of strategic planning activities for other care groups and services. This will be particularly relevant for other strategies that may involve changes in bed numbers, such as for Older People's Mental Health services which, when combined with proposed changes to Adult Mental Health bed numbers, may impact on the range of services provided from some hospital sites.

It is important to recognise that the vast majority of Mental Health problems are addressed within Primary Care – most commonly by GPs. Our Mental Health strategy recognises the scale and challenge of the Primary Care Improvement Plan that is currently under development. Mental Health Services will require to dovetail with that work.

Like the rest of the population, people with a mental illness will also go to their GP first with any health problem (and often with other problems too). We therefore recognise that close collaboration with colleagues in Primary Care will be critical in ensuring that people have their needs met by the right service – which may include diverting people to wider community resources. The significantly higher prevalence of chronic physical conditions (heart disease, diabetes) and their effects on mortality in people with Mental Health problems means that this is an area of priority for both primary care and Mental Health Services.

There are three sections within this strategy that specifically consider Primary Care issues – one on 'Primary Care Mental Health Teams' and one more generally on 'Primary Care'. A third section considers the specific challenges of physical health. These aim to highlight targeted developments and do not aim to cover the full range of activities undertaken within Primary Care.

Primary care services, including GPs and other community based resources have a significant role in all elements of mental health care considered within this strategy. We believe it important to acknowledge this at the outset of the strategy.

1.5. Financial Context

The Scottish Government is committed to improving Mental Health, and as part of its 2018/19 budget has identified investment in Mental Health Services and has provided a commitment to ensure expenditure grows in this area during 2018/19.

Such investment would effectively insulate Mental Health (Adults, Children and Older People) from most of the current and projected significant financial challenges facing other Health and Social Care Services and other public services. While only confirmed for 2018-19 at this stage the advised intention is that this special status will be maintained for a future years. Though directed for NHS spend it is expected also to be applied to Social Care.

In addition the Scottish Government has pledged further additional funding for Mental Health in 2018-19 with the expectation of further allocations in later years.

While this is a relatively privileged position there are still financial issues to be faced by the strategy

- The balance of resource within Mental Health Services is not presently optimally deployed.
- Transitional monies to enable change require to be sourced.

- Some savings (in the region of 1% per annum based on 2018-19) will still be necessary to enable budgets to keep pace with inflationary pressures whilst keeping Mental Health in balance.

Implementation of the strategy entails significant shifts in resources between services and represents major transformative change; the effect of the Scottish Government budget statement means that most of what is released will be available for reinvestment. 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.

1.6. Principles and Key Areas of Work

1. **Integration and collaboration**
   A whole-system collegiate approach to Mental Health across HSCPs/ NHS GG&C 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 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 you 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.

Following on from the CSR principles and drivers for change set out in Appendix A, the following principles underpin the strategy:

1.7. Service and Resource Changes

The table below summarises the proposed shift in service provision and resources within this strategy:

Saving		**Reduce inpatient beds through 'invest to save' programmes, productivity gains and alternative models of Health and Social Care.**
Productivity		**Productivity improvements in community and specialist services, maximizing their effectiveness and sustainability.**
Investment		**Focussed investment in service improvements, including Recovery, Bipolar Hub, Borderline Personality Disorder and Unscheduled Care.**
Investment		**Focussed investment in Mental Health improvement and primary and secondary prevention, including ACE reduction and mitigation in childhood.**

Figure 5 Shift in service provision and resources

To meet those objectives, the 5 year strategy has concentrated on the following strands of work:

1) Medium- to long-term planning for the **prevention** of Mental Health problems, including well-being-orientated care and working with children's services to promote strong relational

development in childhood, protecting children from harm and enabling children to have the best start in life.

2) **Recovery-oriented care** supporting people with the tools to manage their own health promoting recovery in inpatient provision and a range of community-based services, including HSCP and third sector provision.

3) **Productivity** initiatives **in community services** to enhance capacity while maintaining quality of care, along with **'invest to save'** initiatives.

4) **Unscheduled care**, including Crisis Responses, Home Treatment, and Acute Mental Health Inpatient Care.

5) **Shifting the Balance of Care** –

   (a) **Short Stay Mental Health beds:** the need to estimate the number and type of hospital beds that the system needs to provide in order to deliver effective care.

   (b) **Rehabilitation and Long Stay Beds:** moving away from hospital wards to community alternatives for people requiring longer term, 24/7 care, with residual mental health rehabilitation hospital beds working to a consistent, recovery-focussed model.

While these work strands focus on particular elements of the care pathway, they naturally overlap and interconnect with each other as part of the overall system of care for Adult Mental Health services.

1.8. Implementation

Mental Health Services could be considered to be a "complex adaptive system" in which each service element is dependent on many others to function properly. Changes in one part of the system may have consequences elsewhere, and those inter-dependencies need to be identified and managed carefully. Accordingly, implementation of the 5 year strategy is likely to be a very dynamic process where planning assumptions will be tested and learned from at each key phase of the implementation programme. This will require a degree of flexibility in the implementation programme to respond and adapt to the prevailing situation.

Once approved, the 5 Year Strategy will be accompanied by an Implementation Plan, setting out more detailed actions, including the proposed location of Mental Health hospital beds, the phasing of the change programme, workforce planning implications and the development of a framework for managing risk to provide robust service user and service indicators to inform of how the system of care is responding to the stepped changes in provision. At this stage, the consensus of professional opinion from those involved in developing the 5 year strategy is that the scale and timing of the proposed changes to inpatient care, in the context of the financial challenge, 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.

Equality impact assessment (EqIAs) will also be undertaken as specific implementation proposals develop to inform the overall the implementation plan.

The following sections in this document summarise the key work strands that will be crucial to delivering the aspirations of the 5 year strategy.

2. Prevention, Early Intervention & Health Improvement

Most mental illness begins before adulthood: research suggests that half of Adult Mental Health problems have begun by the age of 15, and three-quarters by the age of 18. About 10% of children and young people experience Mental Health problems, and once acquired they tend to persist.[30] About half of young people aged 12 to 25 with a Mental Health issue were not receiving Mental Health Services, even for young people with severe problems. Young people with Mental Health issues were eight times more likely to have contact with Criminal Justice services than young people without such issues.

Mental illness in children, young people and adults is strongly correlated with exposure to childhood adversity and trauma of various kinds. Adverse Childhood Experiences (ACEs) are an established indicator of exposure to such trauma.

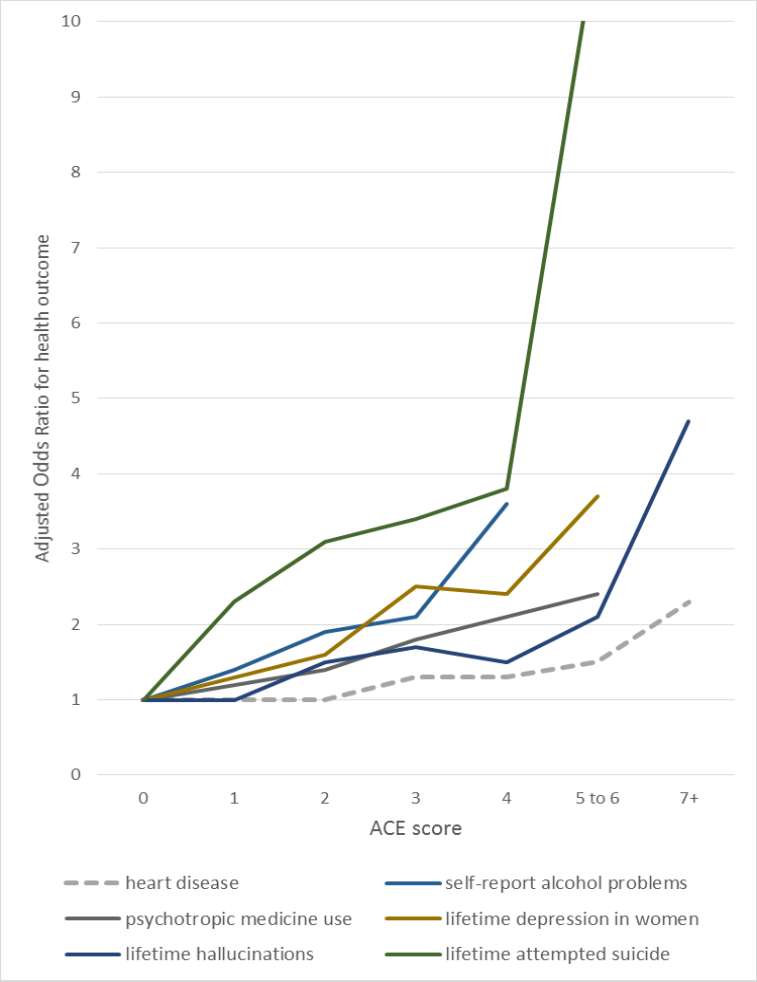


Figure 6: risk of adult mental illness by ACE score

ACEs range from verbal, mental and physical abuse, to being exposed to alcoholism, drug use and domestic violence at home. ACEs are especially strongly linked to Mental Health and Addiction

[30] Annual Report of the Chief Medical Officer for England 2013, p102

problems. Figure 6: risk of adult mental illness by ACE score shows that the risk of experiencing alcohol problems, depression, hallucinations and suicide is highly correlated and proportional to the number of ACEs that had occurred up to the age of 18 years. Physical and Sexual Health is also correlated with ACEs exposure, though to a lesser extent. The strength of the correlation between mental illness, substance misuse and Sexual Health is shown in Figure 7.[31]

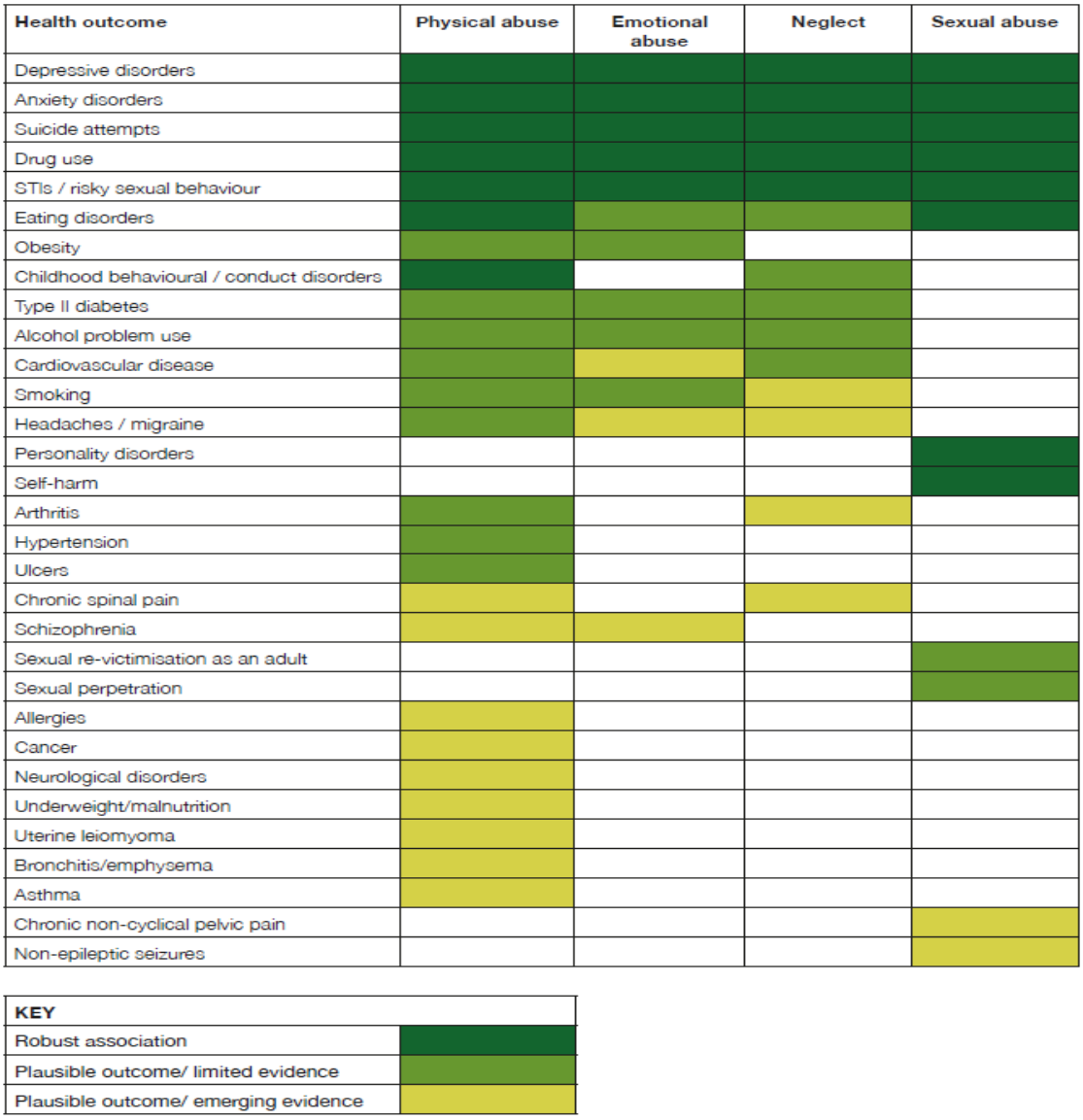


Figure 7: evidence for the association between ACEs and a range of health problems.

[31] The impact of adverse experiences in the home on the health of children and young people. UCL Institute of Health Equity, 2015.

Research by Public Health Wales demonstrates the extent to which ACEs reduction would be associated with improvement in a range of adverse outcomes (Figure 8).

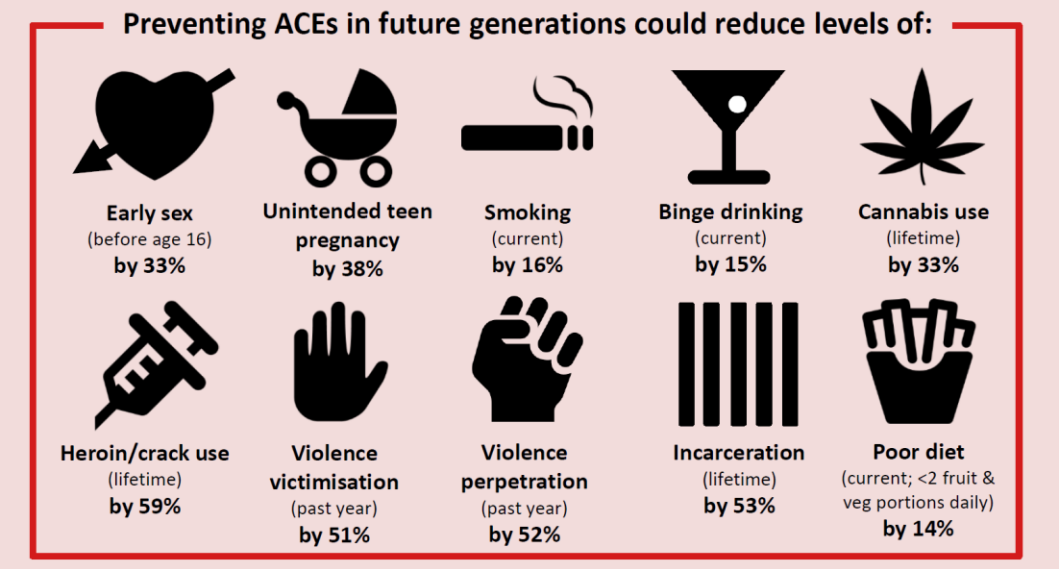


Figure 8: improvement in Health and Social outcomes if ACEs were prevented

Fortunately, there is strong evidence to support interventions to prevent illness and promote good Mental Health. Such interventions are typically low-cost and self-financing, even though returns on investment tend to take several years to accumulate. The impacts affect not only NHS expenditure, but influence spending by a range of public and private sector bodies.

Some of that health economics evidence is summarised in Figure 9, based on research by the Personal Social Services Research Unit at the London School of Economics.[32] The authors modelled the "return on investment" per £1 expenditure on fifteen interventions (not all shown in this chart).

Some interventions were not cost-effective (early intervention for depression in diabetes, befriending for Older Adults and Health Visitor interventions for postnatal depression). Some interventions had a net cost for the NHS, but made significant savings elsewhere (debt advice services, school-based anti-bullying initiatives and suicide prevention training for GPs). The remaining interventions showed a positive return on investment for the NHS as well as other agencies. Reducing suicide with protective barriers on bridges, screening for alcohol misuse and intervening early for psychosis were all strongly cost-effective. By far the biggest gains arose from preventing conduct disorder in children, offering a return on investment of £84 for every £1 spent.

[32] Mental Health Promotion and Prevention: The Economic Case. PSSU, LSE & Department of Health, 2011.

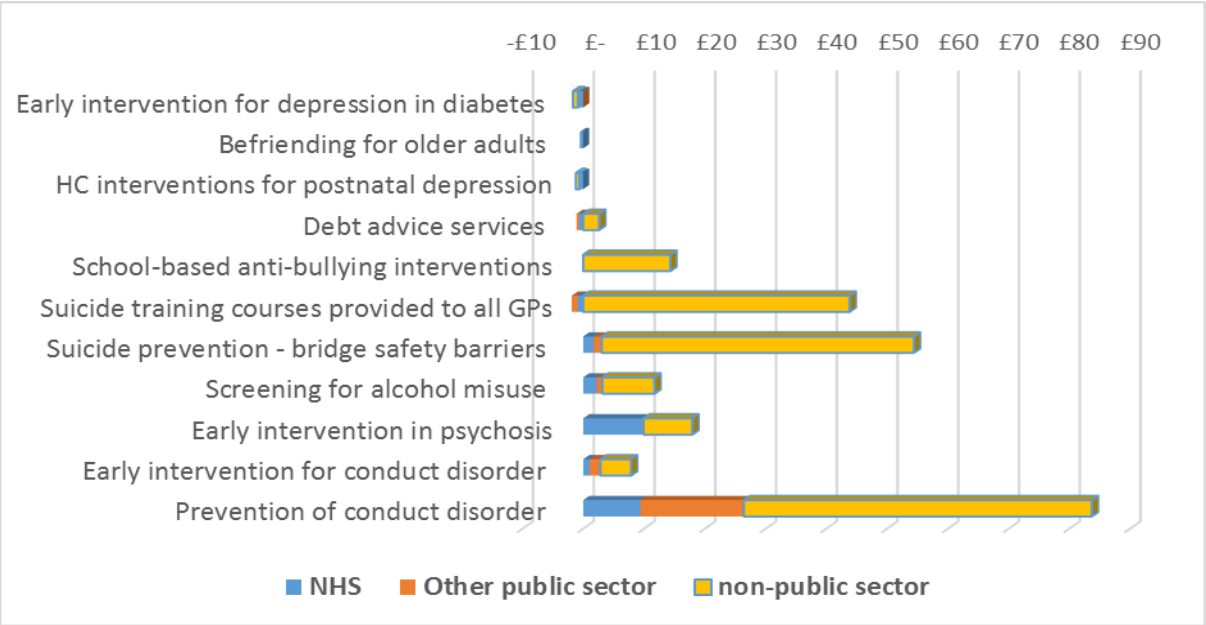


Figure 9: return on investment of £1 for a range of interventions

2.1. Current situation in Partnerships across NHS GG&C

A review of evidence has been undertaken by NHS GG&C staff in relation to Mental Health improvement for children, young people and adults. This has led to the two intervention frameworks shown in Figure 10: intervention frameworks in GG&C for children, young people and adults.

There are a wide range of developments across the two intervention frameworks however these have been opportunistic and consequently partial, with some partnerships and services more progressive and with further reach than others. A broad reflection on progress has been undertaken as part of the biannual Director of Public Health (DPH) report.[33] This highlights the significant areas for progress over the next five years which are listed below.

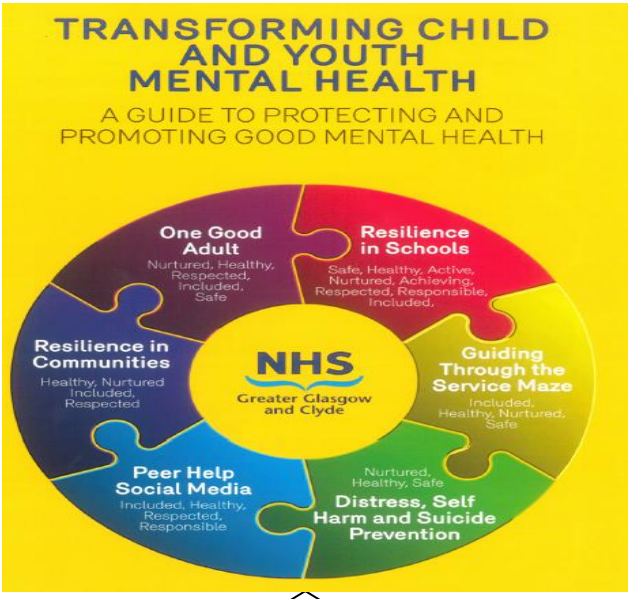
Primary Prevention aims to prevent a condition before it occurs. This is done by preventing exposures to hazards that cause the condition, altering unhealthy or unsafe behaviours that can lead to the condition, and increasing resistance to the condition should exposure occur. For example, there is a 20% to 33% lower risk of developing depression for adults participating in daily physical activity, and the reduced risks of developing dementia are estimated to be 20% to 50% for moderate physical exercise.[34]

However it should be noted that while this section of the strategy focuses on Primary Prevention and Education, Prevention is undertaken at various stages of a care pathway. Secondary Prevention intervenes for people at increased risk of a condition. Tertiary Prevention aims to minimise the impact of a condition once it has occurred.

This is done by detecting and treating the condition as soon as possible to halt or slow its progress, encouraging personal strategies to prevent re-injury or recurrence, and implementing programmes to return people to their original health and function to prevent long-term problems.

[33] Healthy Minds: Report on the health of the population of NHS Greater Glasgow and Clyde. Director of Public Health, November 2017

[34] Exercise: the miracle cure. Academy of Medical Royal Colleges, 2016.



Respond Better to Distress	❖ Improve responses to people in distress, both from services and wider community, including action to prevent suicide and better support for people who self harm
Promote Wellbeing for People with Long Term Conditions	❖ Promote holistic health for people with long term conditions – "healthy body, healthy mind", promote recovery approaches and social inclusion
Promote Wellbeing and Resilience with People & Communities	❖ Develop social connection, tackle isolation, build resilience, strengthen use of community assets - including social prescribing, strengthen self care and peer support
Promote Wellbeing and Resilience thru Work	❖ Promote mental health, wellbeing and resilience at work; address employability issues, including those affected by mental ill health
Promote Positive Attitudes, Challenge Stigma and Discrimination	❖ Promote positive attitudes to mental health and to people with mental illness, raise awareness of mental health issues, reduce stigma and discrimination and promote inclusion, including better access to mainstream services
Tackle Underlying Determinants and Promote Equity	❖ Address underlying determinants of good mental health, including financial inclusion, nurturing early years, healthy environments, active citizenship and participation, and ensure focus on promoting wellbeing of diverse communities

Promoting Mental Health in Adulthood

Figure 10: intervention frameworks in GG&C for children, young people and adults

2.2. Recommendations

The importance of the Early Years has been widely recognised in Scotland and is already reflected in many areas of work, including The Early Years Framework (2008), The Child Poverty Strategy for Scotland (2011), Children and Young People (Scotland) Act (2014), NHS Scotland Local Delivery Plan, the Health and Homelessness Standards, GIRFEC, the Early Years Collaborative, the Family Nurse Partnership and other initiatives. Building on a review of the impact of ACEs in Scotland and associated recommendations,[35] the Scottish Government included "tackling adverse childhood experiences" in its 2017 Programme for Government.[36]

This strategy recognises the importance of that on-going work, and the following programmes should continue:

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 (inc. 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.

Other initiatives will require joint working with other aspects of this strategy, including:

9. Access to 'distress' services delivered as part of the Unscheduled Care Review (see later chapter in this Strategy).
10. "Chronic" distress responses in collaboration with Primary Care for adults, relating to the Link worker role out and utilising social prescribing and allied methods.

[35] 'Polishing the Diamonds' Addressing Adverse Childhood Experiences in Scotland. Scottish Public Health Network, 2016.

[36] A Nation With Ambition: The Government's Programme for Scotland 2017-18. Scottish Government, 2017.

Finally, there is a need for development of new work streams, with the following priorities:

11. 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.
12. A new collaboration with Education and Social Care services to conduct and behavioural problems in primary-school age children.
13. 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.

3. Physical Health

3.1. Context

The Scottish Government's Mental Health Strategy 2017-27 confirms that people with Mental Health problems are more likely to die 15 to 20 years earlier than their peers in the general population from common physical health problems such as diabetes, heart disease and stroke. Addressing this and its causes is multi-factorial and will lead to longer and better quality lives for those living with mental illness

The National Mental Health Strategy has stated the priority of parity of physical health care with Mental Health Care – the idea that emotional and mental healthcare should be seen as deserving of equal status with physical healthcare.

As the Mental Health Foundation have stated:

A 'parity approach' enables NHS and local authority Health and Social Care services to provide a holistic, 'whole-person' response to each individual in need of care and support, with their physical and Mental Health needs treated equally. The relationship between physical and Mental Health is such that poor Mental Health is linked with a higher risk of physical health problems, and poor physical health is linked with poor Mental Health.[37] *:*

The push for parity of esteem comes from the recognition that people with long-term Mental Health problems experience a major inequality in terms of life expectancy, and have often failed to receive a truly joined up approach to care. But the need to remove silos and promote holistic service responses is a key part of the way ahead. As the 2016 Kings Fund report "Bringing Together Physical and Mental Health" demonstrated, the cost to the NHS from not creating integration between physical and mental health is staggering. They highlighted a range of recommendations that could drive real improvements in the health prospects for people with mental health problems and other long term conditions. The sub-title of this report: "A New Frontier for Integrated Care" also resonates with the advent of Health and Social Care Partnerships and further opportunities to create fully integrated approaches to health and social care.[38]

The March 2016 Mental Health & Learning Disability Inpatient Bed Census reported that 53% of all inpatients in Mental Health Services in Scotland had at least one physical health co-morbidity. In NHS GG&C, 31% of inpatients have two or more physical health problems.

3.2. Risk Factors

Multi-morbidity is common and patients can develop heart disease, diabetes and cancer at a younger age than the general population. In general patients with a mental illness are more likely to live in socially deprived areas, eat a less nutritionally rich diet, and lead a more sedentary lifestyle and to have difficulties with tobacco, alcohol and drug dependence. These issues are compounded by the side-effects of some medications, particularly obesity and diabetes.

[37] Mental Health Foundation. Parity of Esteem. [Last accessed 05.07.17]
[38] The King's Fund. Bringing together physical and mental health: a new frontier for integrated care. (2016) [Last accessed 05.07.17]

Non-modifiable risk factors include ethnicity and family history of physical health problems such as heart disease and diabetes. Of particular note in this regard is the substantially increased risk of diabetes in individuals of South Asian background.

Women with a serious mental illness (SMI) are more likely to have pregnancies that are unplanned or unwanted, and pregnancy outcomes may be less favourable for mother and infant. They are less likely to be offered appropriate contraceptive and pregnancy planning advice.

People with SMI experience a range of health inequalities, including poor access to physical health screening, fewer preventative interventions and lower engagement with specialist medical care.

3.3. Progress towards Parity

In keeping with the 'Rights for Life' agenda, people with mental health problems should have "the right to the highest attainable standard of physical and Mental Health, (including) timely access to a range of quality care and treatment, without discrimination."[39]

Within Greater Glasgow and Clyde there has, for some time, been a policy-led improvement approach to physical healthcare for people with Mental Health problems. In simple terms, this policy aims to support best practice in securing better health outcomes for our patients and enabling them to live longer and healthier lives.

The Physical Health Care Policy within Greater Glasgow and Clyde is intended to assist mental health care practitioners to assess physical health care needs of patients in our care, particularly those illnesses most likely to affect their general wellbeing and quality of life. The policy has been informed by feedback from patient focus groups and patient representatives.

As briefly referenced in the section on Primary Care, we have used innovation resources available for Mental Health and Primary Care to fund a nurse to implement the policy and train staff in Mental Health settings to identify and take action in relation to physical health problems.

Critical to on-going management of long term conditions such as diabetes is good information sharing between clinicians in both Primary and Mental Health Care Services. For several years we have been developing and refining a database to enable this (known as PsyCIS) which uses 'safe haven' techniques to share information between GP practices and Mental Health Services.

[39] Rights for Life [Last accessed 05.07.17]

3.4. 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 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

4. Recovery-Oriented and Trauma-Aware Services

"Recovery" in a Mental Health context means "being able to live a good life, as defined by the person, with or without symptoms."[40] Recovery takes a holistic view of mental illness that focuses on the person, not just their symptoms. Is a journey rather than a destination, and is profoundly influenced by people's expectations and attitudes. Recovery requires well-organised systems of support from family, friends and professionals.[41]

Recovery is not an intervention delivered by professionals, but instead the process or journey undertaken by people with Mental Health problems to live meaningful and satisfying lives. While service users "do Recovery", practitioners have an important role to facilitate that process.[42] Research has shown that the following are important factors on the road to recovery:[43]

- Good relationships, financial security, satisfying work and the right living environment.
- Personal growth, developing one's own cultural or spiritual perspectives, and developing resilience to possible adversity or stress in the future.
- Users feeling believed in, listened to and understood; getting explanations for problems or experiences, and having the opportunity to temporarily resign responsibility during periods of crisis.

While Mental Health Services have sought to recognise the importance of these factors as part of a "biopsychosocial" model of care, these are essentially *non-clinical* approaches, or at least do not require to be delivered within a clinical model of care. The same Recovery principles are important when delivering trauma-sensitive and "ACE-aware" services.

A recovery-based approach has the potential to improve quality of care, reduce admissions to hospital, shorten lengths of stay and improve quality of life. While service users will always have access to the clinical and therapeutic services they need, realising Recovery objectives will require services to embrace a new way of thinking about illness, and innovative ways of working. Those changes include, for example:[44]

- A change in the role of Mental Health professionals and professional expertise, moving from being 'on top' to being 'on tap': not defining problems and prescribing treatments, but rather making their expertise and understandings available to those who may find them useful.
- A recognition of the equal importance of both 'professional expertise' and 'lived experience' and a breaking down of the barriers that divide 'them' from 'us'. This must be reflected in a different kind of workforce (one that includes peer workers), and different working practices founded on co-production and shared decision making at all levels.

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[40] Definition used by the Scottish Recovery Network
[41] Mental Health Foundation: Recovery
[42] Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists..South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust (2010)
[43] Mental Health Foundation: Recovery
[44] Recovery Colleges. Centre for Mental Health, 2012.

- A different relationship between services and the communities that they serve. Enabling both individuals and communities to recognise their own resources and resourcefulness and recreating communities that can accommodate human distress.

Integrated services in HSCPs working with the Third Sector offers a promising context in which to bring about these service and cultural changes.

4.1. Models of recovery-oriented care

Mental Health systems across the UK have adopted a range of recovery-oriented service models, often working in partnership with Third Sector colleagues.

There are many examples of initiatives across HSCPs to develop and promote recovery –orientated care. These include the development of recovery communities and hubs in some services, employability initiatives and some early discussions around the development of 'recovery colleges' and 'peer support' (see below)

4.1.1. Recovery colleges

Recovery Colleges implement a profound shift from a clinical or therapeutic approach to an educational one. Although developing rapidly in England, Recovery Colleges are still in their infancy in Scotland. Figure 11 summarises cultural changes this shift in model encapsulates. [45]

A therapeutic approach	An educational approach
Focuses on problems, deficits and dysfunctions.	Helps people recognise and make use of their talents and resources.
Strays beyond formal therapy sessions and becomes the over-arching paradigm.	Assists people in exploring their possibilities and developing their skills.
Transforms all activities into therapies –work therapy, gardening therapy etc.	Supports people to achieve their goals and ambitions.
Problems are defined, and the type of therapy is chosen, by the professional 'expert'.	Staff become coaches who help people find their own solutions.
Maintains the power imbalances and reinforces the belief that all expertise lies with the professionals.	Students choose their own courses, work out ways of making sense of (and finding meaning in) what has happened and become experts in managing their own lives.

Figure 11: a therapeutic approach versus an educational approach

Recovery Colleges may have a particular role to play in facilitating a return to meaningful activity and paid employment. As part of the wider recovery agenda, not everyone with lived experience would

[45] Recovery Colleges. Centre for Mental Health, 2012.

be ready or able to undertake paid employment, but may want to be involved in meaningful activity, with an aspiration to get back into employment in the future.[46] A Recovery College could provide training and Peer Support Workers could support volunteers to become involved in setting up and being part of recovery focused events within their own communities.

4.1.2. Peer support

The Scottish Recovery Network's (SRN) definition of peer support is "a relationship of mutual support where people with similar life experiences offer each other support, especially as they move through difficult or challenging experiences". Peer Support is typically emotional and instrumental support which is mutually offered or provided by persons having a Mental Health condition to others sharing a similar mental health condition to bring about a desired social or personal change.[47]

The introduction of people with lived experience of Mental Health problems into the Mental Health workforce is considered to be "probably the single most important factor contributing to change towards more recovery oriented services".[48]

The Scottish Recovery Network has been promoting the development of peer support roles for almost 10 years. The Scottish Government Mental Health Strategy 2017-2027 promotes peer support as having "added value in Mental Health Treatment Services".[49] Evidence suggests that where people have the tools to manage their own health, and are supported to do so, such as through social prescribing – then their wellbeing may be improved. Peer support workers themselves report a positive impact on feelings of identity and self-worth, whether paid or volunteers.

The Implementing Recovery through Organisational Change (ImROC) Programme recommends the use of peer workers to drive the development of recovery focused organisational change. This would put the voice of those with lived experience at the centre of Mental Health Services.

Moving to a more recovery oriented service would be a significant culture and practice shift for many of our staff. Both the Networks would be able to deliver Recovery Training and Awareness sessions for our workforce, alongside the benefits of having people with lived experience in our services sitting alongside our clinicians and staff to help shift thinking. Similarly some awareness sessions for patients and carers and the general public would be required in relation to expectations of our services. The presence of peer support workers in Mental Health Teams can help to reduce stigma, and minimise a 'them and us' attitude.

[46] The route to employment: the role of mental health recovery colleges. Taggart & Kempton, CentreForum 2015.
[47] Peer Support Roles, SRN, Christie, p.5
[48] Peer Support Workers Theory & Practice, Centre for Mental Health, Repper, 2013
[49] Scot. Gov. Mental Health Strategy 2017-2027

4.2. Evidence

The Centre for Mental Health looked at six studies on the use of Peer Support Workers within Mental Health Services.[50] They measured number of bed days saved per peer support worker employed, expressed as the value of bed days saved divided by the costs (including on-costs and overheads) of employing the peer support worker. Peer Support Workers were assumed to fall into Band 3 of the NHS Pay Scale.

Six studies that were examined showed the benefit: cost ratio ranged from -1.30:1 (where there were no bed day savings relating to employment of a peer support worker, in fact bed days increased, to 8.54:1 ratio. On average using these six studies £4.76 is saved in bed days to every £1 spent on Peer Support. This is a significant saving without taking into account the other evidence that people with lived experience can provide a positive impact on outcomes for people with Mental Health issues.

Study	time period	cost per peer support worker (1)	value of bed-days saved per peer support worker (2)	Benefit: cost ratio =(1)/(2)
			(3)	(4
Chinman	6 months	£16,742.50	£142,989	8.54:1
Klein	6 months	£16,742.50	£41,679	2.49:1
Lawn	12 months	£33,485.00	£239,910	7.16:1
Rivera	12 months	£33,485.00	-£43,560	-1.30:1
Salzer	12 months	£33,485.00	£23,826	0.71:1
Sledge	9 months	£25,113.75	£130,018	5.18:1

Figure 12 Study of cost: benefit

Studies of a number of peer support services in England show evidence of reduced hospital admissions and re-admission rates, as well as shorter stays. Those discharged from hospital with some peer support also may make a more successful transition from hospital to home or the community. While offering preliminary support for the proposition that adding peer support workers to existing mental health teams may result in cost savings as well as a range of other health and social benefits, most studies have taken place in the USA and Australia. Peer support models have not undergone an economic evaluation in a Scottish context.

[50] Peer Support in Mental Health Care: is it good value for money? Trachtenberg et al, Centre for Mental Health, 2013

4.3. Proposal

It is proposed that a pilot of Peer Support should be developed and implemented over 1 to 2 years. The detail of the proposal will be developed as part of the implementation plan but at this stage it is considered that the pilot should ensure sufficient capacity to be able to make a difference; to be tested in a range of different settings, and to consider appropriate management arrangements. The cost of this proposed pilot will be refined as part of the development of an implementation plan.

There should be a review of the range of Mental Health Support Services that have been commissioned over the years separately by Health and Social Care which have elements of recovery and peer support. There is significant separate spend in relation to these services.

Recommendations : It is proposed that we should work in collaboration with people with lived experience, local Mental Health and SRN with 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.

5. Community & Specialist Mental Health Teams

5.1. Productivity and Quality Improvement

The Scottish Government Quality Strategy[51] outlines the ambitions for person centred, safe, effective and efficient service provision. The Scottish Government Mental Health Strategy for Scotland 2017-2027 sets out the requirements to improve prevention, early intervention, physical wellbeing, access to treatment and joined up accessible services. The new strategy aims to deliver on a human rights-based approach, so that people in the most marginalised of situations are prioritised in achieving health.

A range of quality improvement approaches based on IHI methodology, the Choice and Partnership Approach (CAPA) and the QuEST Efficient and Effective Community Services Tool Kit have been implemented in Scotland, and are applicable to Mental Health. Those approaches include:

5.1.1. Improved Productivity

- Delivering evidence-based care, especially in relation to the work of Pathways groups in NHS GG&C to describe best practice in Psychosis, Trauma, Bipolar Disorder and Borderline Personality Disorder.
- Matching demand, capacity and activity across the system.
- Eliminating waste and duplication, including unnecessary triage, gatekeeping, assessments, signposting and multiple teams working with the same patient.
- Providing "all the care you need, but no more" in a matched/stepped care model that uses patient outcome data to plan and guide care.
- Stopping interventions when they have not been shown to be effective.
- Making effective use of eHealth and telehealth resources, particularly to share information about conditions, manage communication at transitions, improve risk management, capture clinical outcomes, plan anticipatory care, seek advice about care without referral and access computerised forms of treatment where appropriate. System data should be used to inform service development.
- Investing system resources to encourage accurate user and carer expectations of services, the effective use of self-management, peer support and recovery approaches and resources.
- Recognising the importance of staff training, supervision and morale in providing effective care.

Further work will progress to identify and test the areas for change within CMHTs that will have the optimal impact on improving efficiency, effectiveness and releasing capacity to manage future demands.

[51] Scottish Government Quality Strategy

5.1.2. Recovery orientated 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 peers 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.
- 'Assisted 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.

5.1.3. Improving Access to Services

- Make the most of community-based resources to offer early support.
- Consider the 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" appointments to help 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.

5.1.4. Cultural Change

- 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.

5.2. Community Mental Health Teams

Adult Community Mental Health Teams (CMHTs) are part of a range of other NHS, Social Work and other community services that help people, or help someone who cares for someone else, when they have an issue with their Mental Health. CMHTs work with those suffering from complex conditions including: Psychosis, Depression, Anxiety, PTSD, Personality difficulties and Eating Disorders among others.

There are 16 Adult Community Mental Health Teams within the Greater Glasgow and Clyde area. Teams cover different parts of NHS GG&C and serve different size populations.

The table below highlights annual activity information across all 16 CMHTs:

Adult Community Mental Health Teams *(exc. Lanarkshire & A&B NHS Highl'd areas)*	Adult Community Mental Health Team Active Referrals	Adult Community Mental Health Team Episodes of Care	Number of contacts with Adult Community Mental Health Team (includes repeat contacts for the same individual)
16	19,500	29,000	219,000

Figure 13 CMHT Activity

Community Mental Health Teams (CMHTs) need to operate effectively and efficiently to meet population needs and to release capacity to manage the additional demand that will follow the planned reduction to inpatient beds. Financial and clinical pressures mean that current functioning needs to be re-assessed. Experience in other care groups and geographical areas suggest that productivity in community services could be improved without compromising quality of care.

We will therefore aim to increase efficiency and reduce variance where appropriate in order to improve the overall quality of care. We want to ensure that we have a system that fits an efficient, effective model that works for Community Mental Health Teams within NHS GG&C and learn from where effective and efficient practice and processes already exist.

5.3. Primary Care Mental Health Teams

Primary Care Mental Health Teams have their origins in Primary Care and were developed with the twofold intent of being able to offer General Practices more options for the high volume of patients who 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 the 'Mental Health System' for common psychological problems.

These services are not about minor or 'mild to moderate' illness - they are designed to provide 'high volume, low intensity' responses to common Mental Health problems, including depression, anxiety and less 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.

PCMHTs are effective in treating large numbers of people. We have implemented an outcome measure (CORE-Net) for all of the teams to allow continuous outcome monitoring for all patients. This system also facilitates clinical management, caseload management and clinician supervision.

Data from this evidences that around 60% of patients display both clinical and reliable change following treatment.

The PCMH teams have successfully implemented self-referral – which enables easy access and reduces the need for patient to first see their GP. Easy access and brief treatment means that the teams contribute significantly to the access standard for psychological therapies as a part of the Local delivery Plan.

Developments around 'low-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 by directing people to services more suited to their needs. Development in this area will be closely related to the work described elsewhere in the strategy in respect of primary care, models of recovery, community support and commissioning and prevention and early intervention.

Following the national recommendation from the Scottish Government's Reshaping Care and Mental Health Division in 2011[52], we continue to be committed to the rollout of the use of CORE Clinical Outcomes for Routine Evaluation (CORE) across mental health services. All Primary Care Mental Health Teams now use CORENet and work is beginning on the rollout across Community Mental Health and other teams.

[52] SG Reshaping Care & MH Division in 2011

5.4. Specialist Community Teams

In addition to CMHTs, which are in place within each HSCP in Greater Glasgow and Clyde, 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:

5.4.1. Esteem

Services were developed to provide Early Intervention (EI) for psychosis from the mid-1990s, when it was recognised that young people experiencing psychosis for the first time typically do not engage well with services, yet early professional help can minimise symptoms, functional impairment, family distress, substance misuse and risk of suicide.

Esteem is a multi-disciplinary team providing home-based care for first episode psychosis and has been a successful Early Intervention service in Greater Glasgow and Clyde over the last 14 years. It provides accessible treatment for psychosis, good clinical outcomes and high quality research. As with other EI services, its core aims are to improve outcomes, reduce relapse, foster optimism, support families and offer a range of therapeutic and care interventions (psychological, pharmacological and vocational).

It offers a Board-wide service without fixed age limits, but typically supporting people aged 16 to 35 years. Like other teams in GG&C, Esteem has a role in reducing demand on inpatient care, and supporting sustainable caseloads for CMHTs. A service review is underway at the time of writing (Jan 2018), and this review will focus on:

1. **Eligibility Criteria** for the service- to reduce clinician based variation and target the resource at the greatest need.
2. **Extended contact.** At present, contact with Esteem is capped at two years, with patients returning to "generic" CMHT thereafter. It is likely that some patients would benefit from specialist input for up to three years, reducing the risk of relapse and hospital admission. Providing resource to Esteem to provide that care might be cost-effective for the system as a whole.
3. **Alternatives to inpatient** admission and consistency in criteria for admission and discharge to hospital will be agreed. The possibility of one specialist admission site for GG&C will be considered.
4. **Employability** is a recognised issue for many people with psychosis, and the personal and economic return on investment to support a return to education or employment is well-established. A range of options for enhancing this in Esteem will be considered.
5. A revised **service development** plan is likely to incorporate a range of developments such as enhancing the use of technology, developing peer support roles and increasing access to psychological therapies in the form of groups.

5.4.2. Adult Eating Disorder Services (AEDS)

Eating disorders (ED) are serious psychological disorders, with the highest mortality rate of all psychiatric disorders. Specialist care is required due to the complex combination of both psychiatric and physical health problems; multidisciplinary working is essential. 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. The development of the team allowed GG&C to safely manage ED patients whilst making substantial savings from historical use of the private sector.

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 this and improve this further, consideration will be given to measures that could reduce admissions to Adult Mental Health short stay beds. This will involve consideration of the potential benefits of a proposal for the development of an eight place hospital based day unit which could minimise the use of general psychiatric beds. Other measures may include a clinic for patients with an ED illness of a severe and enduring nature so that these can remain out with the CMHT. These will be considered further as part of the development of an implementation plan.

5.4.3. 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.

Examples of complex traumatic events which may lead to CPTSD include childhood sexual abuse, physical abuse and neglect, recruitment into armed conflict as a child, being a victim of domestic abuse, trafficking, experiencing torture and exposure to genocide campaigns or other forms of organised violence.

Glasgow Psychological Trauma Service also delivers some National and Regional services across Scotland including our 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.

5.4.4. Borderline Personality Disorder Network

People with a Primary or Secondary diagnosis of Borderline Personality Disorder (BPD) occupied an average of 8,900 bed days in NHS GG&C Adult Acute admission wards each year over the past three years. This translates to an average occupancy of at least 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.

There is a rapidly expanding evidence base for a range of treatment options that have been shown to be effective in the treatment of BPD. However provision of formal programmes of care is not systematically available in NHS GG&C.

It is proposed that the implementation plan considers introducing a matched care approach to the provision of care and treatment for BPD within secondary care services with a view to providing individuals with evidence based treatment options based on their level of clinical need and suitability. It would allow improved access to evidence based therapies by offering the most effective interventions for a focused period of time, and delivering these interventions in an efficient way.

Care pathways have been developed that can deliver a baseline of coordinated clinical care management across a service network based in CMHTs and complemented by specialist delivery of "STEPPS" and "MBTi" group-based information and support, with Metallization Based Therapy (MBT) and Dialectic Behaviour Therapy (DBT) available for those who would benefit. Investment in such programmed care could allow for an intake of 160 new patients each year, with treatment lasting up to 18 months. A programme of staff training and supervision will support the sustained delivery of the programme.

A proposal has been developed for consideration to establish such specialist services. Based on published evidence, it is anticipated that the service would allow a reduction of between 12 to 18 Adult Acute admission beds across NHS GG&C compared to current usage.

In addition, there are also likely to be secondary savings associated with reduced attendance at A&Es, reduction in need for crisis services and reduced contact within mainstream Mental Health services, especially CMHTs. These secondary savings, while less tangible, are probably more important in terms of allowing for greater capacity within existing services especially in a time of increased demand and reduced resources. This release of increased capacity within CMHTs and crisis services is likely to be crucial in allowing community services to support proposed wider bed reductions. This proposal will be considered further as part of the development of an implementation plan.

5.5. 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).

   Extend a network of programmed care and treatment for people with Borderline Personality Disorder Board-wide (This proposal will be considered as part of the financial framework for the implementation plan)

5.6. Primary Care

The new GP contract signals significant changes for Primary Care and it will be important that the Mental Health Strategy develops in tandem with this. This section makes brief reference to developments between Mental Health and Primary Care Services.

There is a long established working group (the Primary Care and Mental Health Interface group – PCMHIG) in the Greater Glasgow & Clyde area that specifically works on issues that arise between primary care and mental health. This group has representation from GPs and the LMC, Public Health, wider Primary Care Services and Mental Health. It is co-chaired by Clinical Director from both Primary Care and Mental Health.

This group has a sub-group that oversees the implementation and on-going development of the physical health care strategy, but the group also looks at GP contract issues, access to Mental Health Services (including for addictions, dementia and other areas), prescribing issues and general joint working (including problem resolution and policy development).

It is proposed to maintain this group as an effective forum to tackle on-going joint working requirements – particularly as the Primary Care Improvement Plan and the GP Contract develops and is implemented.

There are funds available nationally to enable on-going developments and work has begun in several areas utilising this: developing PsyCIS, implementing physical health care policies and training Primary Care staff on brief psychological interventions they can use in daily practice. These are areas that we would intend to build on in future.

Of course, the Primary Care environment extends to whole communities and the first port of call when experiencing mental health problems for people living in these communities is often their GP. This continues to place considerable demands on an already busy general practice and sometimes may not be the best place to meet the person's needs. This may also be true of Mental Health services – from the point of view of the patient; what Mental Health services offer may sometimes not meet their needs.

In a similar way, there are a range of services that support communities – examples would be stress centres and healthy living centres. There are existing national resources – e.g. Breathing Space, Samaritans – and developing methods – e.g. eCBT – that may offer additional and /or more efficient ways of meeting these wider population needs.

In this sense, the work we need to do in primary care is closely related to models of recovery and peer support and commissioned social care services that are discussed elsewhere in this strategy.

However, when considering the whole system of Mental Health delivery, there may be opportunities to think of doing things in a different way.

Recent developments in primary care offer new possibilities which could support the strategy's aims:

(a) As part of national policy, Link Workers are being introduced to support GPs to signpost to community services and supports and to case manage some individual patients. Link Workers are generic 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.

(b) The Primary Care Mental Health Fund has been used to test new approaches across the primary care and Mental Health Interface.

(c) The proposed GP contract aims to reduce GP workload and enable GPs to spend more time with complex patients by recruiting additional staff as part of an extended Primary Care team for the practice led by the GP possibly including mental health workers. These proposals will require to be addressed by each HSCP within their primary care implementation plan.

(d) Recent proposed changes to the content of the Mental Health summary on the clinical portal potentially offers GPs better access to information to inform patient care and options for onward referral.

Recommendations

1. To monitor, evaluate and share learning from the PCMH 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.

5.7. Commissioned Social Care Services

Social Work Services have played a vital role in supporting previous hospital reprovision programmes through the commissioning of community based services which support people to live as independently as possible in the community. People are supported in a range of service models either at home or in other homely settings such as supported accommodation. The integration of Health and Social Care provides the organisational framework to provide Health and Social Care services in an even more integrated way for the benefit of service users.

Over recent years social work services across HSCPs have experienced challenges in matching rising demand within a challenging financial environment. These issues are requiring HSCPs to re-examine existing models of care to ensure services are delivered in the most effective and efficient way and that are targeted at those with the greatest need.

Successful support services enable people to access the right level of support, in the right place at the right time. Support services need to be able to respond flexibly as people's needs change and support people to move from crisis into recovery. There is a fundamental shift in the balance of care proposed within the 5 year strategy: from hospital to community services. Achieving this will require HSCPs to both extend and maximise capacity within its community based services.

Consideration will be need to be given to whether some people currently being cared for in community settings are at the appropriate care setting for their needs and whether some people can be supported in a less intensive way. This will include consideration of whether different models of care, potentially at an intermediate level to further support patient discharge, are required.

However, overall as Adult Mental Health Inpatient beds reduce, the system needs to ensure an appropriate level of reinvestment into community care services.

5.7.1. Profile of Commissioned Social Care Services

Social care support is currently provided in a range of ways in accordance with national standards and guidance, including the promotion of self-directed support where appropriate. Some examples of this are set out below:

1. **Access to 3rd sector commissioned services**
   Section 5.8 provides further details of the non-statutory Community Services commissioned by HSCPs. These services can be open to people without need for Social Work assessment.

2. **Individual care packages**
   This support is available for people who are eligible for a Social Work budget and require support at home or to access community resources.

3. **Mental Health Supported Accommodation/Mental Health Care Homes**
   Historically intended to offer time-limited support to people as part of their recovery, the flow of people moving on from this kind of accommodation is slower than the demand for new places. Accommodation needs to have a "recovery" focus, rather than becoming a form of long-term care in the community.

4. **Nursing Homes/Specialist Residential Homes**
   A small proportion of people need mid- to longer-term support in specialist residential or nursing homes. However, it is recognised that there are currently gaps in the availability and quality of provision of to support the discharge of some people currently within NHS hospital care as part of this 5 year strategy. Commissioning solutions may therefore have to be developed to address these service gaps.

5.7.2. Summary of Main Challenges

The main challenges for social care commissioned services in the context of the 5 year strategy are as follows.

- Maximising the capacity of services by ensuring they are recovery focussed and promote move on to less resource intensive models of support.

- Services need to become more episodic despite the fact they may be supporting people with higher levels of illness and risk.
- Recruitment and retention of staff across care sector.
- Rising costs of Social Care due to living wage and sleepover costs increases.
- Limited availability of Mental Health nursing care places that can support people with challenging behaviours, particularly physical aggression.
- Gap in community service provision for people with complex/challenging behaviours.

5.7.3. Recommendations

In addition to addressing the issues outlined above, it is considered that the following measures will be necessary to help to successfully deliver on the aspirations of the 5 Year strategy. Consideration of these issues will progress as part of the development of a robust implementation plan:

Recommendations:

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.

5.8. Community Services: Non-statutory Services

Providers of non-statutory Health and Social Care services include both non-for-profit' organisations (known as the 'third or independent sector') as well as 'for-profit' organisations and businesses (known as the 'private sector'). These services provide an extensive range of services that support people to live as independently as possible in the community. Where possible, these services can prevent someone's condition or illness from escalating to the point where statutory Health or Social Care services are required, or alternatively enable someone to be discharged from statutory Health and Social Care services. The 3rd and private sectors are therefore a critical part of the overall care pathway for individuals.

There are many examples across HSCPs of existing, strong partnership arrangements with non-statutory services that have developed innovative service solutions that support recovery. This will need to be developed further as part of the desire to see a greater emphasis on recovery oriented care.

In order to make the necessary shifts in the balance of care away from hospital beds outlined in the 5 year strategy, there is a need to consider what the impact is likely to be at the various tiers of care that support inpatient care. As specialist Community Mental Health Teams (CMHTs) review their caseloads to adapt to functioning in a care system with less Inpatient Beds, providers of non-statutory community services will require to adapt to meet the new demand. HSCPs recognise that, in some cases this may require additional investment, whether to better support current services or to look to develop new service approaches. However, given the current strain on public sector finances, collectively we will also need to ensure that current resources are used and targeted as effectively as possible.

Below is a summary of some of the key issues arising from engagement with non-statutory services that will need to be jointly considered in taking forward the implementation phase of the 5 year strategy:

1. Further embedding recovery orientated 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.
- 'Assisted 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.

2. Improving Access to Services

- Make the most of community-based resources to offer early support.
- Consider the 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" appointments to help 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.

3. Cultural Change

- 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.

Recommendations

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.

6. Unscheduled Care

Unscheduled care is a major driver 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. Since Unscheduled Care services influence rates of admission to and discharge from hospital, they are closely linked to service costs. Unscheduled care services also carry most of the risk associated with Mental Health care.

The Mental Health Unscheduled Care Review (UCR) aims to define the future strategic direction of unscheduled Mental Health care services for NHS GG&C. The main purpose of the review is to define the future strategic direction of services with a focus on the following services:-

- All Mental Health Crisis/IHTT Services within NHS GG&C.
- NHS GG&C Out of Hours (OOH) CPN Service.
- NHS GG&C Mental Health Liaison Services (Adult, OPMH, Addiction).
- NHS GG&C Duty Doctor out of hours cover arrangements.
- NHS GG&C Mental Health Court Services.

Unscheduled Care resources are summarised in Figure 14 Unscheduled Care Resources, GG&C Wide

Current Unscheduled Care provision in GG&C	
Assessment and admission	Available at Gartnavel, Stobhill, Parkhead, Leverndale, Dykebar and Inverclyde Royal Hospitals, 24/7
Medical cover	Resident junior doctors at GRH, Stobhill, Leverndale, Dykebar, IRH Peripatetic Higher Specialist Trainees one North and one South of the Clyde for Adult, OPMH, LD and addictions services. One Consultant Psychiatrist covering Adult, OPMH,LD and addictions services North and one South of the Clyde. One Consultant Psychiatrist Board-wide for Forensic and one for CAMHS.
Liaison	A single liaison team covering all Glasgow Acute sites (QUEH, GRI, GGH, Stobhill) during working hours; associated teams serve RAH and IRH. Adolescent Self-Harm Team CAT OPMH Court Liaison
Crisis	In Glasgow, service provides home treatment and crisis resolution, and acts as an access point for known patients (at weekends, for Glasgow, West Dun and East Ren patients). Access via CMHT's where emergency assessment is done.

IHTT Inverclyde Community Response Service	West Dun has its own crisis team servicing a similar function. Assessment and home treatment where appropriate of all emergency presentations in Renfrewshire Provides a similar model to Glasgow, but is attached to CMHT ,and provides a liaison role to Emergency Department
OOH	Provides OOH assessment and treatment for all Emergency Departments board wide, telephone and face to face assessment to all self-referrals, referrals from primary care and NHS 24. Can provide home visits if requested

Figure 14 Unscheduled Care Resources, GG&C Wide

6.1. Analysis

Unscheduled care services can be considered in four components, set out in Figure 15 Components of the unscheduled care systemOnce aggregated over time and place, "unscheduled" care usually reflects predictable demand, and a key goal for the Strategy is to match demand to a prompt and effective response. Service provision is inconsistent across the Board area. While recognising that some flexibility is required to meet local needs, there is nonetheless scope for a more standardised approach to maximise efficiency and effectiveness.

It is important to note the increasing demand in particular for psychiatric liaison services into acute hospitals (for example, at the QEUH, there has been a 22% increase in ward referrals with no corresponding resource increase). In terms of resource allocation, GGC Liaison services are currently at the lower end of staffing benchmarks in comparison to other areas within the UK and further investment is considered necessary to meet current and future demand.

Sector	Service (adult, addictions and OPMH)
1. Community	Crisis, OOH and Home Treatment teams
2. Emergency Department (ED) and Acute hospitals	Liaison in hours Duty Doctor and Crisis/OOH team out of hours
3. Mental Health Inpatient	Ward staff and duty doctors OOH
4. Court system	Court liaison (working hours only)

Figure 15 Components of the unscheduled care system

The pressures on each part of the system are different:

6.1.1. Community

a. There are four service models in operation (Crisis, OOH, IHTT and Community Response) in different areas and at different times across the Board.

b. There are gaps in service, particularly in Emergency Department (ED) cover from 5-8pm weekdays.

c. Home treatment is not available Board-wide, although studies show it is well-liked by patients and can replace inpatient care.

d. Interfaces between teams are not always clear to referrers and not always managed well, for example the transfer of calls from Crisis to OOH teams. Similarly, the role of Crisis teams in supporting CMHTs and follow-up after hospital discharge is not always clear.

e. Health and Social Work services are not always well integrated, especially in relation to preventing admission or facilitating discharge from hospital.

f. Out of Hours CPN services experience a high volume of calls from NHS 24 and Primary Care which do not require specialist Mental Health assessment.

g. 'Digify' Mental Health interventions and supports. A programme of digital innovation is required to bring tele-health care adequately into Mental Health services and meet a new generation of digital treatment and condition management options which efficiently utilise professional capacity for improved outcomes.

6.1.2. ED and Acute

h. There is a perception in ED that access to OOH Mental Health assessment is difficult to arrange and slow to respond.

i. There is a lack of alternative pathways for care other than to Mental Health services for people in distress.

j. There is no Liaison Service provided to Emergency Departments across Glasgow City on weekdays from 5pm till 8pm and at weekends and public holidays between 9am and 5pm. This service gap is covered by the duty doctor in Glasgow, the IHTT in Renfrewshire and the Community Response Service in Inverclyde.

k. There are differing service models for access and provision to Emergency Departments across the Board area, with variation in response times and response pathway for Emergency departments and associated departments such as AMU, IMU & MAU.

l. No handover between OOH CPN service and Liaison can lead to delays in access to Mental Health assessment.

m. Sustainability of recruitment and retention of staff and consistency of access to Emergency Departments and Acute Medical wards remains challenging.

6.1.3. Mental Health inpatient

n. Bed modelling data shows that inpatient occupancy rates are too high, and so the system requires "internal" boarding which can challenge the delivery of quality care.

o. Although nominally "short stay", about 1/3 of Acute Mental Health wards are occupied by people deemed clinically fit for discharge, but whose stays have been prolonged beyond three months by delays associated with non-clinical factors including housing and support needs.

p. It can be hard to find an "Acute" bed, even though the risks presented by patients in the community may be higher than those receiving inpatient care.

q. Although the system provides different levels of care intensity (e.g. in descending order from IPCU to open wards to home treatment to CMHT treatment), transitions between these levels of care are not formalised, and each interface can be difficult to negotiate.

r. There are currently six acute OOH Mental Health admission sites across NHS GG&C, each with resident junior medical cover 24/7 provided from four rotas. Some rotas are only just compliant with contracted hours, and so need locum cover for any absences.

s. Sustaining a compliant rota in Inverclyde requires allocating more junior doctors to that service than daytime service or training would normally need.

6.1.4. Court system

The Court Liaison service largely operates independently of the other system elements. Following phase 1 of the Unscheduled Care Review, it was agreed that the service would extend its days of operation from three to five days per week. This change has met the immediate needs of the system and no further intervention is proposed as part of this strategy.

6.2. Unscheduled Care Summary

It is proposed that mental health unscheduled care provision will be standardised across the GG&C area, as set out in the diagram Figure 16: unscheduled care summary

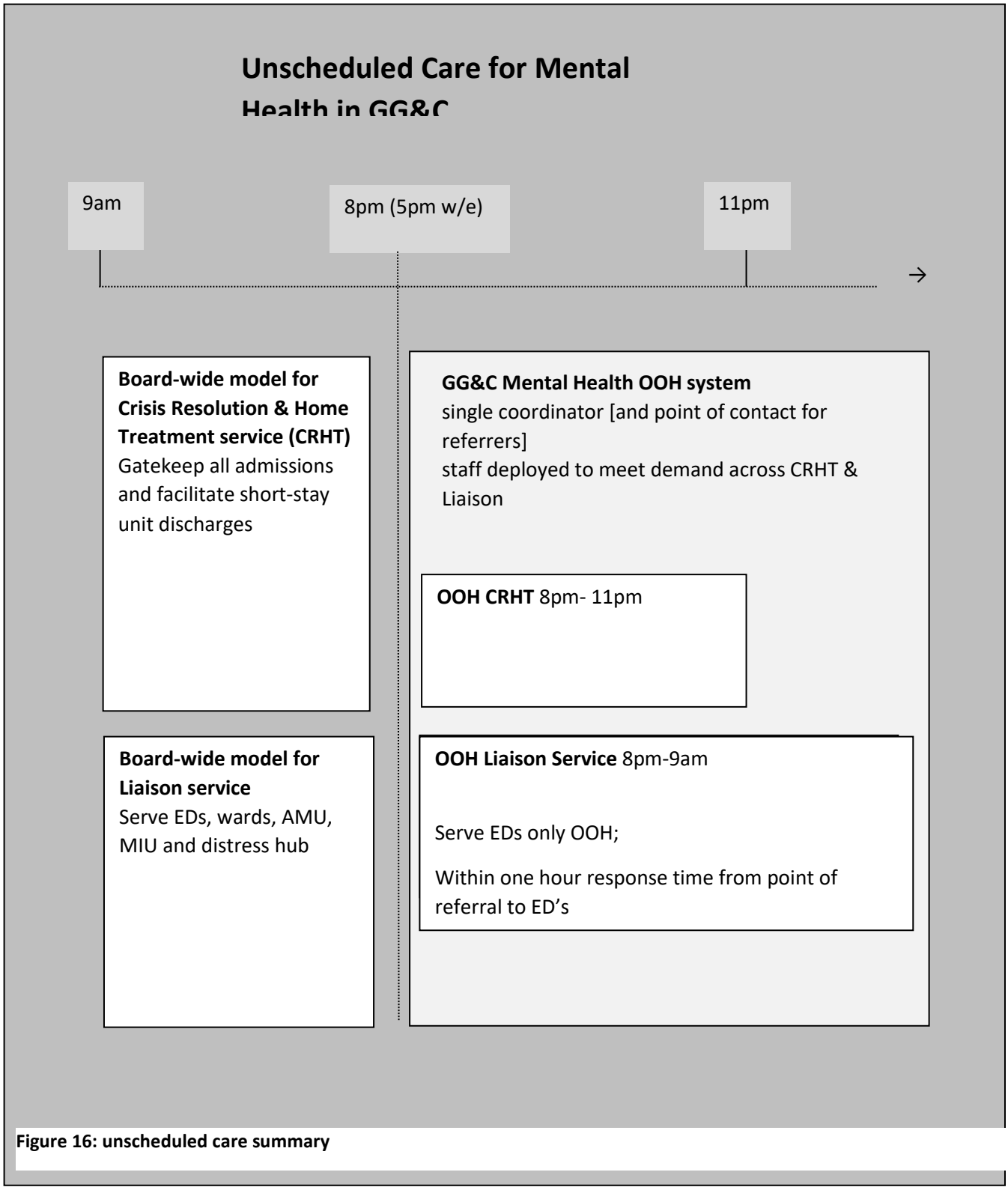

Figure 16: unscheduled care summary

6.3. Recommendations

Community response

1. Integrate crisis, home treatment and OOH models so that they are provided consistently across the Board area as a comprehensive Crisis Resolution and Home Treatment (CRHT) service, available for community care 8am to 11pm, 7 days a week. The CRHT teams and liaison service will each have locality sub teams to maintain local communication, engagement and reflect local structures. Each team will have a multidisciplinary staffing profile and skill mix, which will allow OOH staff to be deployed across Liaison or CRHT responses as required.
2. CRHT service model includes the following:
    a. Home Treatment capacity Board-wide gatekeeping access to all acute Mental Health beds. Capacity to visit up to three times daily until 11pm, 7 days per week. All clients referred to GG&C services will be given access to a home assessment by the team where indicated
    b. Provide a single phone number for all unscheduled care arising OOH. An experienced clinician could offer guidance to referrers, directing calls to local CRHTs (or CMHTs and other daytime services) as needed.
    c. CRHT gate keeps all admissions and facilitate all discharges, where clinically appropriate, from Acute Units. This could be achieved either by close liaison between CRHTs and short-stay wards, or by the CRHT managing the entire care journey from admission to discharge and back to routine care.
    d. Discharge from hospital is facilitated by home treatment by the CRHT where clinically indicated.
3. Community services interface with new "distress" pathways as described in (10) below.

Emergency Department (ED) and Acute

4. There is a single Liaison service Board-wide, providing cover to EDs 24/7.
5. 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
6. 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 CRHT
7. Implement a face to face response time of <1h for referrals from ED, including some prompt productivity changes to support this new target.
8. Secure recurring investment for liaison services transformational posts received and to enhance and develop CRHT 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)

9. Pathways from primary care, police, NHS 24 and self-referral will be clarified.
10. 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
11. 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.)

7. Shifting the Balance of Care

Part A

7.1. Short Stay Mental Health Beds

Adult Acute Inpatient services are a critical component within the wider system of Mental Health provision and it is important to define the nature, purpose and value of inpatient care within this wider system.

The Commission on Acute Adult Psychiatric Care[53], set up by the Royal College of Psychiatrists, developed a working definition of the purpose of Inpatient care as being to provide treatment when a person's 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. Admissions should be purposeful, integrated with other services, as open and transparent as possible and as local and as short as possible.

In keeping with the underlying principle of viewing admission to hospital as a key step in the therapeutic pathway towards recovery, it is essential that there is a clear awareness and understanding of functions and limitations of acute adult inpatient care. Integration with other services, especially crisis, CMHTs and Social care, is crucial in ensuring transition across the therapeutic pathway. Equally important is that the skills and competencies of multi-disciplinary teams within acute adult inpatient services adequately reflect the needs of patients flowing through the system.

This section describes current bed state and provides estimates of the potential for future bed reductions, with associated risks.

Two methods have been used to model future bed provision: an external benchmarking against UK national bed numbers, and an internal benchmarking against bed provision in different NHS GG&C areas.

[53] Commission on Acute Adult Psychiatric Care

7.2. Overview

There are 286 short-stay adult beds in NHS GG&C, distributed across six sites and 14 wards, as set out in Figure 17: distribution of short-stay Mental Health beds across GG&C

Site	Adult short-stay wards	Beds	IPCU
Gartnavel Royal	3	60	12
Leverndale	3	72	12
Inverclyde	1	20	8
Dykebar	2[a]	37	None
Stobhill & Parkhead	5	97[b]	12
Total	14	286	44

Figure 17: distribution of short-stay Mental Health beds across GG&C

[a] one ward currently on Leverndale site

[b] includes 4 AEDS beds

7.3. Internal benchmarking: Short-Stay beds

The optimum performing hospital site within NHS GG&C has been used to support the bed modelling principle. For the purpose of this report it is called 'Site A'.

Site A currently uses the fewest bed days per head of population, both before and after adjustment for deprivation. If all hospital sites functioned as Site A does, there would be 39 fewer beds required across the system. If bed occupancy (currently 104%) were to be reduced to a more sustainable 95%, that would reduce the potential for bed savings to 20 fewer beds.

There are reasons to believe that this internal benchmarking is viable, since "balancing measures" of wider system impact of low bed numbers show:

- Site A has a below average rate of internal boarding and has one of the lowest rates of external boarding.
- Site A is near to the average for both rehabilitation beds (4.3 compared to Board average of 4.8, range 2.7- 7.1) and Hospital-Based Complex Care (HSBCC) beds (17.9 compared to Board average of 16.7, range 9.6-21.7) per 100,000 weighted population.
- Readmission rates <28 days and <133 days per 100 discharges at Site A are also close to the Board average.

- Site A has the second highest number of complaints per 100,000 unweighted population (16.4 compared to a Board average of 10.), and is slightly higher than average for complaints upheld per 100,000 unweighted population (5.7 compared to 4.6 for the Board as a whole).
- Site A has the second lowest deprivation suicide rate in the Board, and a level of Category 4/5 incidents that is below average.

Site A has low levels of beds occupied for more than 3 months.

Bed modelling suggests there is scope to further reduce beds required with additional interventions, as set out in Figure 18: "layering" of interventions to reduce short-stay bed requirements, set against Site A baseline

Intervention	Bed reductions per item	Total bed reductions
1. All short-stay units to function as Site A, but with no greater than 95% occupancy	-20	20
2. As 1, but with a 15% reduction in stays more than 3 months (Total of 116 beds attributable to >3months LOS per year. 15% reduction of this figure)	-17	37
3. As 2, but with an additional 50% reduction in beds occupied by people with BPD (24 beds attributable to this group, 50% reduction in this)	-12	49
4. As 3, but with a 10% reduction in short term (LOS < 14 days) admissions through Board-wide implementation of home treatment (around 1990 admission per year for LOS< 14 days, 38 beds attributable to this group. Directly admitted to hospital ie not internal transfers or court/prison referrals)	-4	53

Figure 18: "layering" of interventions to reduce short-stay bed requirements, set against Site A baseline

There is additional activity associated with patients from South Lanarkshire currently admitted to ward 4b in Leverndale hospital which equates to an average of around 9 beds. Transfer of this activity with associated resources, would support the wider programme of bed reductions.

NB There is the potential of an overlap in the bed savings between 4 & 5 as about 15% of the admissions <14 days are attributable to patients with BPD.

The performance of Site A occurs in parallel with an emphasis on proof of concept quality improvement initiatives including the Scottish Patient Safety Programme (SPSP) and the RCPsych Accreditation for working age Inpatient Mental Health Services.

7.4. External benchmarking: cross-check

It is not possible to make direct comparisons between local and UK benchmarking data, because deprivation weightings are applied in different ways. However external benchmarking data allows NHS GG&C provision to be assessed against deprivation-weighted services across the rest of the UK.

NHS GG&C has 19.9 beds per 100,000 populations when weighted for deprivation using UK benchmarking norms.

Applying the same proportion of bed reductions set out above would mean that using UK benchmarking norms

- Acute beds would be 15.5/100,000, and below the lower UK quartile (which is 16.8)
- It is not possible to do the same calculation for Rehab & IPCU beds, since these are not disaggregated in the national benchmarking dataset.

An average UK Benchmarking NHS Mental Health provider Bed profile has been produced, which shows that NHS GG&C has a higher % number of Hospital Based Complex Clinical Care beds counted across care groups.

The UK Benchmarking recognises that the Independent Sector is largely excluded from the comparisons, where this could be a factor. Although this complicates the profile, consideration will be given to a comparative NHS GG&C wide profile once the range of parallel strategies for Adult Mental Health, Older Adult Mental Health and Forensic Mental Health are progressed.

7.5. Key Challenges

1. The primary risk is of gaps in access to Adult Acute inpatient care within NHS GG&C due to inadequate beds to match clinical demand. This has potential direct consequences for patient, staff and organisational safety as well as organisational reputation. There are associated financial risks due to an increase in out of area placements due to gaps in capacity. This risk is particularly Acute due to the predominantly unplanned and at times statutory nature of acute adult admissions. An additional unintended consequence might be an increase in detentions as a means of access to an admission bed.
2. Potential delays and barriers to the 'flow' of patients along the acute pathway leading to delays in discharge even when the individual is clinically well enough to leave hospital. Delays in discharge, which occur for a variety of reasons, have a significant impact both for the individual concerned and for the wider organisation. Major pressure on Social Care services and budgets for commissioned services are likely to have a direct impact on access and availability of social care and commissioned resources that are crucial to facilitating discharge for individuals with complex needs.
3. Adult Acute beds becoming the default or 'fall back' option for other care groups as a result of gaps or pressures within inpatient provision within those areas. Such a position leads to significant challenges, not least due to lack of integration with other services and a gap in skills and competencies of staff in meeting the individuals needs thereby potentially leading to delays in flow and/or gaps in quality of care provided.

4. A potential consequence of reduced acute admissions beds could be an increase in the acuity and complexity of patients who are admitted to hospital and of those being treated in community settings. This has wide ranging implications for staff and patient safety, staff morale and sickness rates as well as on recruitment. An unintended consequence might be an increase in enhanced observations, use of locums and bank staff to manage the increased acuity that is likely to have a financial impact.

The above issues will be reflected in the development of the risk management framework referred to in section 10 of this strategy document.

7.6. Recommendations

1. Based on the modelling described above, over the period of the 5-year Strategy, short-stay beds could be reduced by up to 53 beds, assuming there is sufficient 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 is not anticipated the potential risks of reducing the number of IPCU beds could currently be mitigated to a level that would result in a ward closure.
2. In order to support the above bed reductions, while managing existing and future demand for inpatient care, the recommendation would be for the development and adoption of an Adult Acute care pathway across all adult acute inpatient sites, which would allow for clarity about the role and purpose of an adult 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 adult acute inpatient sites. This would in conjunction with greater operational consistency in implementation of care pathways and standards 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 adult 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 Adult 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.

Part B

7.7. Mental Health Rehabilitation and Hospital Based Complex Care (HBCC) Beds

The Scottish Government's national guidance for Hospital Based Complex Care (2015)[54] 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". Presently, many people can spend several years and more in a long term / HBCC bed within Adult Mental Health services, often in a typical ward environment with limited access to a single room.

There is wide variation in how rehabilitation beds are used across the system, with some wards caring for a mix of people requiring more intensive rehabilitation alongside people with longer term needs. There is also a need for a more integrated approach to rehabilitation across the Health and Social Care pathway.

7.7.1. Background

Rehabilitation can be used as a generic term for therapeutic work conducted by a range of services; this paper outlines the role of specialist stand-alone rehabilitation services who meet the needs of specific sub-groups of service users.

People using rehabilitation services:

• 80% have a diagnosis of a psychotic illness (schizophrenia or schizoaffective disorder), and many will have been repeatedly admitted to hospital prior to referral to rehabilitation services.

• Many experience severe 'negative' symptoms that impair their motivation, organisational skills and ability to manage everyday activities (self-care, shopping, budgeting, cooking etc.) and place them at risk of serious self-neglect.

• Most have symptoms that have not responded to first-line medications and require treatment with complex medication regimes.

• Around 20% have co-morbidities such as other mental disorders, physical health problems and substance misuse problems that complicate their recovery further.

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

7.7.2. Analysis

There is currently wide variation across rehabilitation inpatient wards, often caring for people with significantly different needs within the same ward. Delivering time-limited rehabilitation for a proportion of patients within the same ward as providing 'loosely' defined rehabilitation/continuing care (for severe challenging behaviour and long-term complex care)can diminish quality of care and outcomes for all service users.

[54] SG National Guidance for HBCC (2015)

Access to rehabilitation services for suitable acute mental health inpatients varies across services (e.g. bed availability in some areas, waiting lists in others). Time to complete assessment of suitability and engagement for rehabilitation varies across services (e.g. 6 – 12 weeks), with the service user typically occupying an acute inpatient bed at that time. Rehabilitation efficiency and effectiveness impacts on acute inpatient services (e.g. inflating length of stay when rehabilitation is unavailable); a redesigned rehabilitation service could contribute to improved flow in acute inpatient services.

There is variable follow-up post-discharge by specialist rehabilitation services, undermining the person's ability to maintain gains made in rehabilitation upon discharge, and potentially increasing demand on acute wards for readmission. The care governance of post-rehabilitation accommodation options impacts on suitable post-rehabilitation options.

Rehabilitation service users have variable access to supported accommodation (or equivalent) provision within the GG&C area, which can impact on effective discharge planning. Many rehabilitation services have functioned with an ambiguous expected length of admission; this can lead to continuation of treatment in hospital after recovery has reached a plateau. This can have the consequences of limiting access to rehabilitation beds, increased waiting times for rehabilitation (while in an acute inpatient bed), and service-users with an identified rehabilitation need being discharged from acute wards (possibly increasing the prospect of readmission).

Royal College of Psychiatrists guidance[55] has been taken into account when modelling potential bed numbers and configurations for rehabilitation inpatient services. For the categories of inpatient rehabilitation care referred to in the preceding paragraphs, the guidance translates to the following estimated total inpatient requirement to serve the adult population of GG&C area:

- Intensive Rehabilitation Beds: 3 units totally approximately 45 beds
- High Dependency Beds: 1-2 units totalling approximately 21 beds
- Hospital Based Complex Care beds (formally 'long stay'): 1-2 units totalling approximately 21 beds

The above is based on an optimum unit bed size of 15 beds, giving a total bed complement of 87 beds.

Presently NHS GG&C formally categories rehabilitation beds as either 'Rehab' beds or 'Long Stay' beds. However, the latter category is known to care for a mixture of high dependency rehab patients and long stay patients, sometimes within the same ward. Taking that into account, current rehabilitation bed usage across NHS GG&C is broadly as follows:

- Intensive Rehabilitation Beds : 4 wards totalling 39 beds
- High Dependency Beds : 51 beds
- HBCC beds : 46 beds
  Total bed compliment = 136 beds

Therefore moving to the benchmark for rehabilitation inpatient services could equate to a reduction in the order of 50 beds (or 2 -4 wards depending on variations in ward sizes). For the purposes of comparison, this modelling still includes a complement of hospital beds for long stay / HBCC patients. However, in line with the principles set out in the 2015 Hospital Based Complex Care Guidance, it is recommended that non-hospital, community based alternatives be developed to

[55] Rehab Services Guidance Royal College of Psychiatry Guidance

replace the residual number of long stay / HBCC bed capacity (i.e., for those patients with predicted lengths of stay in excess of 5 years who are effectively 'living' in a hospital ward environment.) The total number of beds to be provided in a community setting for such patients is estimated to be approximately 21 beds.

For clarity, these beds have **not** been included in the total number of beds proposed for closure and instead, it is viewed as a transfer of beds from a hospital to a community setting. The development of an implementation plan will consider whether these beds should remain NHS beds or whether they should be commissioned in a different way. Once these beds have all transferred to a community setting, the remaining Mental Health rehabilitation hospital bed compliment would be in the order of 66 beds, with the 2 types of hospital based rehabilitation ('intensive' and 'high dependency') provided in separate ward environments..

When considering resource release from potential bed closures, it is important to acknowledge that funding will be required to be reinvested in community services.

It will be for the implementation plan to recommend how funding released from bed reductions should be reinvested. This will be informed by the issues raised in section 5.7 of this strategy. It is also anticipated that funding will require to be reinvested in nurse staffing for residual hospital rehabilitation wards to meet the necessary skill-mix standards and also to further promote the recovery ethos that will be necessary to maintain patient throughput.

7.8. Recommendations

The recommendations for shifting the balance of care and improving the quality of care for people requiring rehabilitation and longer term care are set out below:

Recommendations

1. The recommendation is for 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.

2. 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.

3. It is recommended that inpatient rehabilitation services are designated as either "**Intensive**" or "**High Dependency**" **Rehabilitation & Recovery Services.** Intensive wards would have an expected patient length of stay of around 6-18 months to promote patient throughput, with high dependency wards having a length of stay of up to 3 years.

4. 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.

5. 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.

8. Service User & Carer Engagement

8.1. Service User Engagement

Involving service users and their representatives in service planning is a core component of the development of the 5 Year Strategy. There is a well-established Patient Focus Public Involvement (PFPI) Group (a sub group of the Mental Health Quality and Care Governance Group) across Greater Glasgow and Clyde. This has acted as a reference group to support engagement around the 5 Year Strategy. Service user involvement has also been provided through the Mental Health Network.

More generally, throughout the GG&C area each HSCP has in place 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 closely monitored to ensure they meet the requirements of the agreed specification of service provision.

In their contact with Mental Health Services, service users should expect:

• To define recovery goals together with the service

• Services support progress towards recovery /living well with their condition

People with Mental Health problems should be able to say that they have a positive experience of their contact with services and say:

• I get the treatment and support I need when I need it

• Accessing services is straightforward

• I was diagnosed early

• I and those around me and looking after me feel well supported

• I am actively involved in decisions about my care

• I am treated with dignity and respect

• My care plan focuses on my recovery as I have defined it

• I have meaningful occupational interests and social involvement

Service user involvement will remain a core component of the Implementation Plan to be developed to take forward the recommendations within the 5 Year Strategy.

8.2. Carers

Supporting carers is a key priority at a local and national level and this is reflected in current health and social care policy and legislated through the Carer (Scotland) Act 2016. The key policy drivers (around enabling care and treatment at home, shifting the balance of care from hospital to the community, supporting recovery in mental ill health, preventing admission and re-admission to hospital and facilitating speedier discharge from hospital), will require the support of carers and this needs to be underpinned with an ethos of carers as 'partners in care'.

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. The 6 standards within the triangle of care are:

1) Carers and the essential role they play are identified at first contact or as soon as possible
2) Staff are "carer aware" and trained in carer engagement strategies
3) Policy and protocols re: confidentiality and sharing information are in place
4) Defined post(s) responsible for carers are in place
5) A carer introduction to the service and staff is available
6) A range of carer support services is available

HSCPs are working on an on-going basis to support the delivery and achievement of these aims.

The Carer (Scotland) Act will be implemented on 1st April 2018 and there will be a duty on HSCPs to identify and support adult carers via an adult support plan and young carers via a young carer statement. The underpinning principles are that adult carers are supported as key partners and that the focus for young carers should be, where possible to alleviate the caring role through a family based approach.

Health and Social Care staff are well placed to identify both adult and young carers recognising that carers often start their caring role when someone is diagnosed with a mental illness and/or treated for a mental illness. As such, the carer's journey runs parallel to the service user / patient journey andneither should be looked at in isolation.

Whilst all caring situations are unique, engagement with mental health carers highlight that there is often much stigma attached which can be isolating for carers and their own health and well-being can be compromised.

8.3. 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 experience and mental health carers as well as 3rd sector groups.

8.4. Recommendations

1. Ensure staff are aware of their roles and responsibilities in respect of duties and powers of Carers Act for 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

9. Workforce

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 are set out below.

9.1. Nursing

Full implementation of the 5 year strategy anticipates a reduction in Adult 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, management are confident that a phased approach to the implementation of the strategy will see the successful redeployment ofall 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. This is 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.

9.2. Medical

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, activity which has been absorbed into the posts set out above.

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

Board-wide locum costs for medical staff across Mental Health, LD and Addictions services amounted to £2.1M 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% in the year to date (December '17). However if service gaps should appear, clinical safety and service viability usually means that locums must be used, even when costs are high.

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 overexisting job plans. Any requirement to move consultant posts across localities would require time and careful planning to avoid the risk of service gaps needing to be filled by non-NHS locums.

9.3. Psychology

Overall, in recent years, across GG&C, 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.

9.4. Occupational Therapy

There is not a standard workforce model in place within the organisation for Occupational Therapy. However a workforce plan has been developed across Partnerships for each care group and in addition, an occupational therapy data base is being tested across the mental health system to capture detailed and up to date analysis regarding workforce.

Occupational Therapy will have a role to play in the work streams of the 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 the occupational therapist in order that adjustment of resource can be made based on need.

The majority of the Occupational Therapy workforce is based within secondary care currently. However earlier intervention to Occupational Therapists and potentially a shift towards primary care would enable occupational therapists to facilitate supported self-management techniques and utilise their expertise in vocational rehabilitation at a much earlier stage. Employment and meaningful occupation/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, perhaps through making reasonable adjustments at an early stage and helping people to find appropriate work which in turn assists with recovery.

Recommendation

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

10. Finance

In order to develop a financial framework to support the Mental Health Strategy 2018-2023 collaboration will be required from the six HSCPs within the boundary of NHS Greater Glasgow and Clyde. In addition consideration will need to be given to the financial arrangements which exist with neighbouring health boards as a consequence of the service level agreements which are in place. It will be important to be mindful of the whole system dependencies which are in operation and to robustly consider the financial implication of change on this basis.

An initial framework has been completed as a start point describing the current financial budget position and is illustrated at Figure 19

	Glasgow City	East Dunbartonshire	East Renfrewshire	Inverclyde	Renfrewshire	West Dunbartonshire	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Health Community Services	22,212		1,245		4,609	5,138	33,203
Health Inpatient Services	37,427				7,591	2,040	47,059
Health Specialist and Training Services	24,380						24,380
Council Purchased/Commissioned Services - Residential	5,450	476	255	1,395	2,605	765	10,946
Council Purchased/Commissioned Services - Non Residential	8,820	1,420	1,459	155		2,015	13,869
Council Community Services	5,110	493	554	2,277	1,633	1,112	11,179
Gross Expenditure	**103,399**	**2,389**	**3,513**	**3,827**	**16,438**	**11,070**	**140,636**
Health Community Services	- 157				- 161	- 1,257	- 1,575
Health Inpatient Services	- 4,934				- 3		- 4,937
Health Specialist and Training Services	- 9,213						- 9,213
Charges To Service Users		- 33					- 33
Charges to Health Boards		- 85					- 85
Council Purchased/Commissioned Services - Residential					- 2,251	- 49	- 2,300
Council Purchased/Commissioned Services - Non Residential						- 96	- 96
Council Community Services							-
Income	**- 14,304**	**- 118**	**-**	**-**	**- 2,415**	**- 1,402**	**- 18,239**
Net Expenditure	**89,095**	**2,271**	**3,513**	**3,827**	**14,023**	**9,668**	**122,397**

Figure 19 Indicative Health and Social Care Adult Mental Health Budget

10.1. Health Budgets

Figure 19 Indicative Health and Social Care Adult Mental Health Budget indicates a gross health budget of £105M comprising inpatient, community, training and specialist services. Training services include post graduate education for Doctors and Psychologists and are substantially funded by NHS Education Services (NES). The budgets devolved to the HSCPs from the Health Board are largely clinical and include the staffing resource required to deliver the current service, clinical supplies including pharmacy associated with the service and, to a lesser degree, funding to directly purchase beds and services from third party providers. The expenditure budgets do not include accommodation costs which are managed on a whole system basis by the Facilities Directorate of NHS GG & C.

Income is around £18M. Approximately £8M relates to NES income for training, in excess of £6.5M relates to income received from other health boards for both community and inpatient services and the small balance relates to miscellaneous income, for example secondments to Scottish Government, arrangements with wider local authority partners.

Whilst the majority of the income budgets relating to income from other boards are devolved to HSCPs some work is on-going to ensure alignment is accurate and complete.

It should also be noted that the charging basis for bed activity is broadly in line with the annual published health costs commonly referred to as blue book costs. A total cost is calculated inclusive of all direct costs and allocated overheads. Any retraction of services which may result in loss of income has potential to disproportionately impact HSCP budgets which are not representative of the full cost of providing the service but rather the clinical element only.

The Health Boards which contribute income in greatest measure are Lanarkshire Health Board largely in respect of patients residing in the Cambuslang and Rutherglen localities and Highland Health Board (via Argyll and Bute HSCP) largely in respect of Helensburgh and Cowal and Bute patients.

10.2. Social Care Budgets

Combined social care budgets across GGC amount to £36M split between direct services in the form of social work teams and more significantly services commissioned from third sector organisations such as self-directed support options 1-4, supported living, residential care, carer support, recovery, advocacy and employability.

10.3. Future Financial Context and Prospects

The Scottish Government has provided a clear commitment to Mental Health in its budget for2018-19 committing to making available an extra £17M nationally to support expansion of specific services and in addition requires Health Boards and Integration Authorities to ensure that "this is in addition to a real terms increase in existing 2017-18 spending levels".

The additional £17M is to

- Support improvements in childhood by transforming CAMHS (£5M nationally and around £1.25M for GGC)
- Increase the mental health workforce in key areas like A&E, prison health care and primary care (£12M nationally and around £3M for GGC)
- Be followed by further instalments to support implementation of the national mental health strategy.

Together these monies offer the opportunity and the potential flexibility to advance significant areas of the GGC strategy consistent with national aims.

While currently only proposed for 2018-19 the Scottish Government intends to continue to prioritise mental health in future years. However notwithstanding this intent initial plans for 2018-19 suggest the need for some savings of the order to enable budgets to keep pace with inflationary pressures whilst keeping mental health budgets in balance. Although this is a one year budget offer, this strategy assumes that this commitment will continue in future years and savings requirements will be consistent with those experienced in 2018/19.

The principal disinvestment will be confined to the contraction of inpatient services as set out in Section 6 with a no change position forecast for community mental health teams and specialist services (but with a presumption of improved productivity and performance as indicated in Section

4). The main areas requiring reinvestment include recovery, unscheduled care and social care move on support.

10.4. 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 will see the withdrawal of the final 2 AMH acute wards from Parkhead Hospital to be reprovided on the Stobhill site, and 2 wards of Older People Mental Health complex care beds from the Birdston Complex Care facility to reprovision on the Stobhill & Gartnavel inpatient sites.

- Phase 3 – The consolidation of Alcohol and Drugs Addiction inpatient services in a new build ward 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 will be developed through HSCP and NHSGGC capital planning processes. Implementation timescales will depend on the availability of capital funding.

10.5. Transitional Funding

The change programme required to engineer and deliver a significant shift in the balance of care will 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. For the strategy to progress across GGC will depend on accessing transitional funding within the overall funds available coupled with the ability to use funds flexibly in support of strategy aims.

10.6. Future Financial Framework

This will be developed in early in the course of 2018 based on a more detailed examination of cost savings and priorities for new investment together with a proposed allocation formula possibly along the lines of that agreed by the HSCPs previously for hospital based complex care.

It is assumed that a single system financial framework is based on the following:

(a) The commitment measures for 2018-19 in relation to mental health is able to be maintained for the lifetime of the plan
(b) Some annual savings in the region of 1% will continue to be required
(c) The level of transitional monies required should be estimated and sourced
(d) Future investments in mental health should largely be self-financing
(e) Allocations of new monies should be utilised flexibly in support of the strategy

Further work to develop the Financial Framework to support the strategy will aim to:

- Develop a single system financial framework and model of allocation.
- Agree resource shift and scale.
- Determine disinvestment and reinvestment required taking cognisance of impact on other boards.
- Complete detailed work to describe and cost end point bed numbers / staff profiles / commissioned services / other.
- Plan and cost year by year phasing to include estimated impact of reducing income.
- Determine attribution of disinvestment / reinvestment across the 6 HSCPs.

Recommendation

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

11. Managing Risk

This section seeks to anticipate risks associated with the proposed service changes and to identify a suite of measures that could be used to recognise and mitigate potential risks associated with service redesign.

Mental Health services manage significant population and individual risk. Destabilisation through service change and especially staff turnover is recognised to have potentially adverse effects on safety.[56]

11.1. Risk Management Framework

Alongside the development of an Implementation Plan for the strategy, there will development of a framework for managing risk. 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. At this stage, the consensus of professional opinion from those involved in developing the 5 year strategy is 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 in Figure 21, below.

Therefore, while thestrategy demonstrates that it will be possible to make 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.

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

Figure 20 estimated service risk at different levels of change

[56] Kapur et al, Lancet Psychiatry 2016: Mental health service changes, organisational factors, and patient suicide in England in 1997–2012: a before-and-after study

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 in Figure 22, 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
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

Figure 21risks and potential early warning signs

Recommendation
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.

12. Management and Governance

As described earlier, mental health services currently benefit from a single system approach within Greater Glasgow and Clyde. This approach has strengthened service planning, management and governance across HSCPs and wider partners. To effect the changes proposed in this strategy will require the continuation of a robust and coordinated management approach.

12.1. Governance Arrangements

In addition to is responsibility for managing adult mental health services provided within Glasgow, Glasgow City HSCP, through its Chief Officer, has a responsibility for co-ordinating the strategic planning of adult mental health services on behalf of other HSCPs within Greater Glasgow and Clyde. Glasgow City HSCP also hosts a number of GG&C wide professional leadership roles for adult mental health services, including for medical, nursing and psychology staff. These professional roles also have a strong connection with NHS GG&C Board responsibilities for governance and public health. It is anticipated these leadership arrangements will continue, although clearly a collegiate management responsibility is also necessary across HSCPs and NHS GG&C to ensure a successful implementation of the 5 year strategy's recommendations.

System-wide governance is co-ordinated by the 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. In addition, HSCP governance structures and arrangements are in place to oversee local operational matters.

The development of the 5 year strategy is overseen by a Programme Board with management representation for all HSCPs, along with membership from professional leadership roles. (Terms of Reference shown in Appendix B.)

12.2. Recommendations

1. NHS GG&C and HSCPs 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.

Appendix A

A Clinical Services Review: Core Principles and Drivers for Change
CSR Core Principles

- Best clinical outcomes are achieved for patients
- Services are safe and sustainable
- Services are person centred
- Services are effective
- Services are integrated between primary and secondary care & health and social care
- Services are efficient making best use of resources
- Services are affordable and provided within the funding available
- Services are accessible and provided as locally as possible
- Services are adaptable achieving change over time
- Services are provided at the right time, in the right setting, in a manner which promotes recovery & minimises the disabling impact of mental illness
- Services are provided on both a needs and age appropriate basis

CSR Drivers for Change

1. The health needs of our population are significant and changing;
2. We need to do more to support people to manage their own health and prevent crisis;
3. Our services are not always organised in the best way for patients; we need to ensure it is as easy to access support to maintain people at home, when clinically appropriate, as it is to make a single phone call to send them to hospital;
4. We need to do more to make sure that care is always provided in the most appropriate setting;
5. There is growing pressure on primary care and community services;
6. We need to provide the highest quality specialist care;
7. Increasing specialisation needs to be balanced with the need for coordinated care which take an overview of the patient;
8. Healthcare is changing and we need to keep pace with best practice and standards;
9. We need to support our workforce to meet future changes.

Appendix B

Programme Board Term of Reference

Programme Board Objectives

To develop a commissioning strategy/capacity plan (and resultant financial plan) for adults and older peoples mental health set within the context of National and Local vision for Mental Health services. The programme of work will also seek to identify consequential impacts on community services as a result of bed modelling

Context

HSCPs recognise significant financial challenges this year and projected for future years. There remains a desire to protect front line services (CMental HealthTs etc) and shift the balance of care. Services have a history of whole system planning and in-patient/estate rationalisation with appropriate alternative community development.

Outputs

- The development of a GG&C mental health commissioning strategy.
- Core element will be a bed model for the HB area including numbers, mix and locations.
- Identification of the community social care and health infrastructure required to support smaller in-patient cohort.
- A financial framework that delivers significant savings to HSCP medium term financial plans and identifies the impact of the proposals
- The development of an HSCP Mental Health performance/accountability framework

The outputs will be informed by the following:

- National Mental Health Strategy
- GG&C 5 year vision for Mental Health services
- National and local in-patient benchmarking analysis
- Application of Hospital Based Complex Clinical Care Guidance (including learning from application to frail elderly services)

In the interests of efficiency and expediency, it was agreed that the role and function of the Programme Board should be incorporated in to the existing system-wide mental health planning group.

Appendix C

Location of Adult Mental Health Beds in Greater Glasgow & Clyde