**WHAT PEOPLE TELL US?**

**Feedback / key messages from people who use Mental Health Psychiatric Services and people who care for them**

Mental Health Psychiatric and wider mental health related services across the six Health and Care Social Partnerships across NHS Greater Glasgow & Clyde are further developing our approach to engaging openly and effectively with people who need to access care. This includes redesigning services and changing how staff and services work with people who access care.

We have previously asked people who access services, carers and family members about what matters to them the most when they need to use the services we provide. We intend to build on previous and informal work already undertaken and now want to:

* Sense check what people have previously told us and identify anything new or changed.
* Better understand what matters to people with protected characteristics.
* Seek to engage with more people to help us with the next phase of engagement.

What people who use services have told us so far

In summary, people who use mental health services told us what matters is that staff and services:

• Take time with them and listen to them

• Take care of people, look after them and make sure they get the right treatment when they need it

• Explain all they need to know and involve them in decision making

• Are knowledgeable, safe and can be trusted

• Show they care, are compassionate and show empathy

• Are friendly, kind, competent and staff are professional

• Communicate with the people who matter to them regarding their progress and condition

• Provide good continuity of care and well-managed frequent service delivery in relation to their needs, at the right time and at the right intensity

• Offer assertive community treatment and respond more adequately to people’s diverse social, psychological and biological needs as opposed to being hospitalized.

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| **People who use Mental Health Psychiatric and wider mental health services and people who care for them more particularly identified:** |
| * Involving service users and their carers in all aspects of their care. Roll out of Triangle of Care training / awareness. Communication needs to improve between services and service users * Increase collection of patient experiences of mental health services, e.g. outcome measures, expanding the use of patient satisfaction questionnaires, recording of verbal feedback and actively involve service user/carer population in service review/redesign including to define models of community services which they would find supportive. * Resources are required to support GP’s to manage people presenting with mental health issues. Create written referral pathways for all mental health services and communicate these to GP’s and other referrers. Further development of non-statutory services, to provide non-psychiatric mental health support locally for people experiencing poor mental health, third sector services to offer different support to care by statutory services. * Further work required at local level to establish what’s available within the community and how to access. Update HSCP and NHSGGC websites to provide current non-psychiatric and psychiatric mental health service information and contact details. * Extending hours of business for statutory and third sector services to include evenings and weekends. Establish a response to supporting service users/carers in distress. Increase the availability of mental health professionals within emergency departments or looking at an alternative environment to support people in distress, i.e. a distress / mental health hub and Third sector commissioned services should have self-referral route. * More mental health awareness training within local communities. Further education, training and promotion of self-management at local community level. Further training and promotion of advance statements. * Increase mental health services, statutory and third sector peer support workers with lived experience. * Improve communications between statutory services, particularly when service users have co morbidity. Review path through statutory services to ensure a smooth service user pathway e.g. CAMHS-Adult or Adult-Older Adult. Need to improve how services communicate and work with each other to ensure that care is provided without any delay for the individual. * Reduce waiting times for psychiatric statutory services. |

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| **People who use Mental Health Psychiatric and wider mental health services and people who care for them also highlighted related issues:** |
| * Impact of changes to the benefits system, the depletion of sheltered housing and other determinants of mental health are not being addressed. * Apprehension that health problems are not being picked up early enough. Concerns about how to address the barriers to accessing care such as childcare issues, mobility, gender, race, poverty and stigma. People also concerned about rates of people taking their own life after a period of decline. * Not enough being done to convince communities that support comes from a variety of sources, across a wealth of resources in our communities and in the lives of individuals. Statutory services are still perceived as being the main point of contact when needs arise. * A need for “safe places” for people to go to. Many people think of statutory services as the first port of call for any needs that they may have. * Pressure on services from the GP to the community mental health services through to inpatients services, perceived to be at breaking point. * Anxiety about how to get back into a service quickly if needed. A perceived fall in the amount of available mental health support in the community. “What will happen if services are closed and the lack of the visibility of services if bed numbers reduce?” * A concern that people are not being listened to by clinicians or involved enough or in other options as the clinician focusses on the clinical treatment. Not enough time is given by the clinician to people. * People who use the services need to be more involved in the development of the services that they need, as well as developing new approaches there is a need to build on and improve existing services |

Implementation: **Early** range of improvements to services

The following have been developed and put in place to deliver what people who access care have told us:

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| * Online / digital delivery - appointments via Attend Anywhere, Psychological Therapies Groups Service, reducing unnecessary travel for participants. * A pilot one-stop hub for people with Bipolar disorder (piloted and discontinued following evaluation) * Patient Initiated Follow Up (PIFU) for patients requiring lower intensity support or moving towards discharge, with freedom to contact community team and reducing unnecessary appointments. * Standardised assessment tools to reduce duplication for patients and staff, and the time taken to complete assessments. * A Borderline Personality Disorder (BPD) pathway offering at least one therapy (in the community instead of hospital) across the health board area. * Responses to the impact of Covid – additional capacity in Eating Disorder services and mental health screening for people hospitalised by Covid (ending Mar 2024) * Mental Health Assessment Units for people with mental health problems who do not require physical / medical treatment avoiding the need to attend emergency departments. * Acute Hospital Liaison Service to provide support to people with mental health issues in acute hospitals where physical healthcare needs are being addressed. * Introduced Psychological interventions into Care Homes. * Increased Mental Health Officer capacity. * Increased mental health support in Police Custody services and introduced Psychological Interventions in Prisons. * Increased support for Young Onset Dementia. * Different local developments within HSCPs, including Physical Healthcare nurse to support physical wellbeing of people with a severe mental illness (West Dunbartonshire) and Wellbeing nurses in Primary Care (Renfrewshire, West Dunbartonshire) * Mental wellbeing training for non-mental health community staff across multiple agencies (NHS, HSCPs, Local Authorities, Third Sector). * Collaborating with the Third Sector to support distribution of the Communities Health and Wellbeing Fund, for grass root activities that address social isolation, loneliness, and Covid impacted mental health inequalities. * Expansion of computerised Cognitive Behavioural Therapy (cCBT) which can be accessed at people’s own pace and without needing to attend appointments. * MyApp: The ‘My Mental Health’ app which provides a collection of self-help resources. * Distress Response Services providing non-clinical responses to distress. * Trials embedding Recovery Peer Support Workers in community teams to help people leaving hospital, reduce readmission and length of hospital stay (paused pending review as evidence from the project is limited because workers were unable to go into hospitals during Covid). * Local HSCP peer support developments include ‘The CIRCLE Recovery Hub’ (Renfrewshire) – a community recovery hub for mental health and addictions and trial of a Recovery College – empowering individuals as students, not patients, while supporting recovery through learning instead of treatment. (East Renfrewshire) * Community Links Workers embedded in GP practices (aligned with primary care strategy) to support and signpost people to non-clinical support and wellbeing resources. * Adopted the Triangle of Care model of improving communication and agreeing care and support with people who access services and their carers (to be implemented into practice) * Mental Health Network membership, to provide a service user voice to, the Mental Health Strategy programme board and key sub groups. |

Implementation: **Ongoing** range of improvements to services

In addition to the service changes and the completed tests of implementing strategy changes outlined above, the following strategy improvements have started implementation or testing:

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| * Trials embedding pharmacists in a range of Community teams (test of change to March 2025) to improve the quality of prescribing, improve patient outcomes and release medical capacity. (Adult Community Mental Health, Child and Adolescent Mental Health, Forensic Mental Health, Older Adult Mental Health) * Informing and agreeing with people the levels of scheduled service contact frequency. This is to reduce variance for those people who need more structured care and attention for their mental health, the right care, at the right time and in the right place and better organising scheduled use of our workforce and resources. * Using additional funding to improve waiting times (and deliver the national standard 90% of people starting a psychological therapy treatment within 18 weeks of referral, with an additional local target to reduce longest waits for Psychological Therapy treatments). * Working to improve the physical health of mental health patients, partly through introduction of an electronic tool to support more structured physical healthcare monitoring. * Working with the Mental Health Network on maintaining and expanding:   + Inpatient Patient Conversations   + Feedback postcards in waiting areas and feedback sessions with community mental health teams   + Borderline Personality Disorder Dialogues group where service users have contributed to the content and design of guidance and training materials   + Redesign groups, including: Design in the Dale (Leverndale), Mental Health Policy Training Implementation Group, Advance Statement Work, Carer’s Pathway, Physical Health Care Reimplementation Group, Psychological Therapies Steering Group, and the Perinatal Mental Health Network |

Implementation: **Future** improvements to services proposals

Future improvements to services include the following:

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| **NEXT:**   * Community Rehabilitation Service, supporting mental health rehabilitation in a more appropriate and homely setting, away from hospital, and earlier hospital discharge as a result. * Expand Care Home Liaison to provide more urgent and routine specialist mental health support to care homes to reduce inappropriate 999 calls, hospital admissions, and lengths of stay. * Expansion of the BPD pathway, delivering more in the community to further reduce hospital admissions and stays for people with this condition.   **THEN:**   * Initially for Adults, develop a Community Mental Health Acute Care Service (CMHACS) to provide more intensive support in the home setting to avoid hospital admission or to support earlier discharge and reduce length of stay, then expanding this for older people. * Build on Post (Dementia) Diagnostic Support, expanding service provision and introducing Dementia Care Practitioners to support patients at a more advanced stage of dementia.   **AFTER THAT:**   * Seek to agree new ideas for Mental Health and Wellbeing in Primary Care (as pilot proposals to improve services were no longer able to be funded from original central funding). * Consider different ways to reintroduce and expand peer support. * Develop implementation proposals for further services and support in the community |

**Summary**

Mental Health services intend to continue to improve the way psychiatric and wider mental health services are delivered in future, responding to what people have told us.

We aim to:

* continue improving the partnerships between people who use these services, their families, carers and staff/services delivering agreed treatment, care and support
* deliver the amount of treatment needed at the right time, at the appropriate level of intensity of treatment, reducing unwarranted variation and connecting people to support