

ADULT MENTAL HEALTH PLANNING FRAMEWORK – 2013/16

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BACKGROUND

New Planning Framework Period 2013 -16

- This Framework seeks to set out the policy, priorities and outcomes for NHS GG&C adult mental health services delivered primarily through Mental Health Services and CH(C)P's for the 3 year period 2013-2016.
- Improving the quality of life of people with mental health problems, prevention of illness and promotion of mental well being, are influenced by both access to mainstream health and local authority services and supports, and by the wider actions of a range of partners in relation to community resilience, employment, reducing the prevalence of suicide and self harm, tackling inequalities, financial & social inclusion & broader community planning.
- This Planning Framework has built on a range of previous work and in effect has distilled and summarised the significance of this work in terms of:
 - National and local policy and priorities
 - Outputs /Outcomes to be delivered
 - The contribution of the above outcomes to the GG&C NHS Corporate Themes
- The NHS GG&C Corporate Plan for 2013-16 sets out 5 strategic priorities along with the outcomes that require to be delivered for those 5 priorities. The corporate priorities are::
 - Early intervention and prevention of ill health
 - Shifting the balance of care
 - Reshaping care for older people
 - Improving quality and effectiveness
 - Tackling inequalities
- The Corporate Plan also calls for existing Planning & Policy Frameworks to be reframed to reflect the direction set out in the Plan, by setting intermediate outcomes linked to measurable indicators, in order to deliver against the strategic priorities.
- In a change from previous years, it is recognised that as the essential drivers of the 6 Policy Frameworks have been incorporated into the Corporate Plan, it would be sensible to integrate the key policy drivers within each of the Planning Frameworks, rather than having detailed separate documents

CHP Integration Timetable and Progressive Development of Joint Commissioning Strategy.

- In preparing the Planning Framework for Adult Mental Health, account has been taken of the intention of the Scottish Government to create integrated Health and Social Care Partnerships, which will be accountable for an agreed set of outcomes. It is anticipated that joint commissioning strategies will be progressively strengthened and developed from 2013 onwards.

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NATIONAL CONTEXT & TARGETS

- Faster Access to Psychological Therapies – deliver faster access to MH services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014. (NHS GG&C Target to be agreed during 2012-13).
- Delayed discharges – no people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015 (NHS GG&C Target = 0 by April 2013)
- Suicide - reduce suicides rate between 2002 and 2013 by 20%.
Note that a refreshed national suicide prevention programme will be launched in early 2013

NHS GG&C PLANNING CONTEXT 2013 – 2016 INCLUDING LAST THREE YEARS STOCKTAKE

Stocktake

- Balance of care shifts/ reduced levels of inpatient activity have occurred but are now plateauing out.
- Clyde Strategy implementation completed except Inverclyde long stay
- Crisis services redesign implemented
- PCMH specification and redesign being implemented 2012/13
- Development of national and regional forensic secure services implemented
- Development of local eating disorder services implemented
- Model staffing and skill mix for inpatient services agreed and progressively being implemented

Context

- Continued public sector financial constraint seeing Board savings level of between 1-3%
- SG MH Strategy published August 2012 and further process of stock take of current position, must do's and should do's is currently work in progress. "Must do's" are reflected in National targets above. Range of wider themes for adult mental health reflected in the National Strategy include:

Mental Health of those with Physical Illness

- GPs and other partners to increase the number of people with long term conditions and a co-morbidity of depression or anxiety receiving appropriate care and treatment for their mental illness
- Development of social prescribing and self help

First Episode Psychosis

- Early intervention services to respond to first episode psychosis

Mental Health and Alcohol

- Alcohol Brief Interventions (ABI's) are a HEAT Standard 2012/13 in primary care, A&E and antenatal. Develop delivery of ABIs to respond to depression (and other common mental health problems) with a particular focus on primary care.
- more effectively link the work on alcohol and depression and other common mental health problems to improve identification and treatment, with a particular focus on primary care

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- Support to family and carers
 - Extension of use of peer support
 - Developing the outcomes approach to include, personal, social and clinical outcomes
 - Improved recording of ethnic monitoring
- Clinical Service Review process and summary of emerging case for change will provide the framework for further service redesign beyond extant plans
 - Broadly stable population but significant risks of increased demands for service supports in context of consequences of recession, austerity policies and erosion of benefits safety net. Whilst such pressures are likely to be experienced by all services the major impact is likely to require:
 - Ensuring assessment and care planning consider employability, and money issues and facilitate access to appropriate supports
 - Increased early intervention and support through primary care mental health supports

At this stage we are initiating work to explore the links between a wider “civic response” to the impact of the austerity measures and the specific implications for mental health supports. Additionally we have not “bottomed out” the balance between productivity gains and increased demand. During the period of the planning framework we will undertake work with a range of partners to develop a clearer framework of response in relation to both the connections between mental health services and wider supports, and additionally any potential implications for additional investment in this area which may be required.

- Requirement to ensure consistent needs based, rather than age based, access to services to comply with Equalities Act implementation from October 2012.

Local priorities

- Deliver national targets for access to psychological therapies, delayed discharges and suicide reduction
- Develop case for change and service redesign proposals through clinical services review process
- Consolidate inpatient services for Parkhead and Stobhill on the Stobhill site
- Transfer inpatient services from SGH to Leverndale to support the wider acute developments of the SGH site
- Maximise variability of service responses related to individual needs, whilst reducing the level of variability associated with local variation unrelated to individual needs
- Improve the management of people with multiple co morbidities so that service users experience a coherent response to their multiple needs
- Improve support to carers
- Improve our understanding of the health gap and specific consequences for mental health services
- Explore the scope for improved productivity and levels of patient facing time through specific work to understand the range of activity in community teams which can deflect from patient contact and reduce productivity
- Seek to mitigate the impact of the recession and benefits safety net erosion on peoples mental health, through:

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- ensuring increased activity in promotion, prevention and early intervention supports in extended primary care supports
 - Ensuring assessment and care management processes take account of support requirements relating to money, employability and appropriate engagement and support to carers
- In line with Commitment 15 of the new Scottish Mental Health Strategy, develop a range of social prescribing and related initiatives that strengthen access to wider community-based supports for mental health and resilience
- Address longstanding inequities of access to specialist service supports in the GG&C area
- Ensure appropriate levels of support to carers whose own mental health may be made more vulnerable through their caring responsibilities
- Further develop the culture of using the range of information sources and lean methodologies to inform local practice beyond the current more variable “islands of excellence”

RESPONDING TO THE CORPORATE PLAN THE FIVE PRIORTIES

1. EARLY INTERVENTION AND PREVENTION OF ILL HEALTH

Overall Position & Issues

Range of self care, self management supports and early intervention supports in place through primary care, stress centres, early intervention in psychosis

A number of key reports and policy documents have highlighted the importance of developing a strategic approach to improving population mental health. "Keeping Health in Mind", the Director of Public Health's biannual report for Greater Glasgow and Clyde, published December 2011 sets out range of prevention approaches, closely connecting with the previously published national policy, "Towards a Mentally Flourishing Scotland and our locally developed framework, "No Health Without Mental Health". The material in the planning framework below sets out a range of the priority actions required to drive improvements in population health, and to mitigate the predicted psycho-social impacts of the continuing economic recession.

MH in Focus identifies high levels of local health needs and in particular:

Current barriers to access for age appropriate responses for access to psychological therapies/crisis supports require early resolution to comply with Age Discrimination Act Implementation Oct 2013

The physical health of people with MH problems is worse than that of the general population, and this is an area of priority for service users. We have developed a Physical Health Care Policy to address this and this confers significant benefits in directing clinicians to identify physical illnesses early and address treatment. This approach will be supported by ongoing liaison with GPs and Primary Care through our Interface working group which focuses on areas of common interest with General Medical Services and MH services – for example in the early detection and treatment of depression and good practice in prescribing. Close collaboration is also focused on MH input to initiatives such as Keep Well through this liaison group.

RESPONDING TO THE CORPORATE PLAN THE FIVE PRIORTIES

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OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
<ul style="list-style-type: none"> • Outcome to be delivered in next three years • Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved 	<ul style="list-style-type: none"> • Brief description of change or development required to deliver this outcome to provide direction to local development plans 	<ul style="list-style-type: none"> • These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development
Increase the detection of mental health problems at an early stage	<ul style="list-style-type: none"> • Roll out access to first onset psychosis service GG&C wide 	<ul style="list-style-type: none"> • Increased geographic catchment for accessing ESTEEM support • Increased caseload and completed episodes for early intervention support from ESTEEM
Maintain and improve access to physical health checks	The Physical Health Care Policy (PHCP) has been completed and approved. A range of pilot sites have been identified and operation guidance produced to support this. The pilot will report in Autumn 2012 and it is anticipated full implementation and identification of measures will follow.	The PHCP details a range of health measures that are specific to conditions on a patient by patient basis. Ultimately the outcome measure will be reduced levels of morbidity and mortality in the adult MH population. Intermediate measures to be identified through the pilot work and then specified
Ensure delivery of HEAT target for waiting times for access to psychological therapies for all age groups (HEAT Target - Deliver faster access to MH)	<ul style="list-style-type: none"> • Ensure equal access to psychological therapies regardless of age 	<ul style="list-style-type: none"> • Compliance with HEAT target waiting times for access – 18 weeks RTT from December 2014. • Target trajectory - <ul style="list-style-type: none"> ○ 10% of patients having waited > 18 weeks RTT from March 2013 ○ 4% of patients having waited > 18 weeks RTT from March 2014

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services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014.)		<ul style="list-style-type: none"> • Proportionate access to psychological therapies by SIMD
Refine care pathways to ensure access to early intervention services at the appropriate stage	<ul style="list-style-type: none"> • Ensure redesigned primary care teams are operating consistent with service specification and delivering access targets 	<ul style="list-style-type: none"> • Increased numbers accessing primary care psychological therapies
HEAT Target – Suicide prevention training : reduce levels of suicide	Continuing to maintain HEAT standard for ensuring at least 50% of front line staff are trained in suicide prevention skills	Percentage of front line staff trained in suicide prevention skills, maintained above 50%, backed by enabling policies, protocols and practice guidance for staff
Suicide Prevention and Self Harm: positively impacting on trends in rates of suicide and self harm	<p>Responding to the emerging recommendations of the GGC Suicide Prevention Planning Group (SPPG) for service improvement and multi-agency working</p> <p>Continued support for the multi-</p>	Establishment of suicide prevention programmes leading to positive impact on predicted trends in suicide and serious self harm, with a particular emphasis on high risk, multiply disadvantaged groups

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	<p>agency Choose Life programmes in each area, in developing comprehensive suicide prevention programmes and specific connections to action on equalities, financial inclusion and employability agendas</p> <p>Ensuring all planning entities (CH(C)Ps / Sectors) working toward responsive services in development of GGC-wide systems and protocols incorporating best evidence in suicide prevention and self harm</p>	

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<p>Improvements in key measures of population mental health and key determinants</p>	<p>Comprehensive Mental Health Improvement Action Plans in place and implemented in each Sector/CH(C)P, ensuring resourced, robust and strengthened partnership approaches with Local Authority / CPP areas. To include development of social prescribing approaches and community assets approaches to support above, drawing on “No Health Without Mental Health” framework</p> <p>Each MH improvement action plan should explicitly address key inequalities dimensions and prioritise higher need sections of the population</p>	<p>Improvements in key mental health indicators for whole population and for higher risk sections of the population, along with improvements in key contributory factors for poor mental health, such as excessive alcohol consumption.</p> <p>"Local mental health improvement action plans should be populated with measures to be selected from the National Adult Mental Health Indicators material developed by NHS Health Scotland - each indicator will have its own frequency of reporting, e.g. annually for suicide rates http://www.healthscotland.com/uploads/documents/6011-mhi_brief_2702_22008.pdf</p> <p>"Connecting with this national indicators package is the detailed report available from Glasgow Centre for Population Health, 'Mental Health in Focus' http://www.gcph.co.uk/publications/284_mental_health_in_focus which provides additional guidance as to indicators suitable for use at Board-wide and/or more local levels, along with relevant baseline data for multiple indicators.</p> <p>"Additionally the nationally published Mental Health Improvement</p>

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		<p>Outcomes Framework for Scotland provides detailed guidance on the planning and selection of short-, medium- and long-term outcome indicators for the major domains of mental health improvement work</p> <p>http://www.healthscotland.com/understanding/evaluation/planning/mental-health.aspx</p>

Finance & Workforce Issues

- Access to psychology time required for OPMH either through increase in dedicated psychology in OPMH or through access to AMH psychology time
- Enabling the development of the staffing capacity to roll out ESTEEM GG&C wide.

Overall position & issues

Achieved substantial balance of care shifts through development of community and crisis services GG&C wide with 34% reduction in inpatient activity since 2003 without prejudice to the quality measures of readmissions and boarding out

Inpatient activity now plateau'd out

Modestly reducing population probably more than offset by increases in risks associated with recession/loss of range of benefits safety nets

Benchmarking internal and external suggests some modest further scope for shifting balance of care in next 3 years but pace of change to be reviewed in context of service pressures

Constraints on feasibility and phasing of achieving balance of care shifts are in part dependant on access to capital which has to date proved problematic

Carers (and in this context MH Carers) suffer from stigma and discrimination, often through lack of awareness.

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<p>Fewer people cared for in settings which are inappropriate for their needs;</p>	<ul style="list-style-type: none"> • Median lengths of stay discharges are based on "right length of stay" 	<ul style="list-style-type: none"> • Delayed discharge targets achieved. (No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting , once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015) • Reduce the range of variability in the range of average and median lengths of stay between areas
<p>Perverse incentives to contain workloads between community, crisis and inpatient services are worked through so team</p>	<p>Undertake work on productivity of community teams to understand current activity and propose service and activity targets</p>	<p>To be determined based on outcome of work</p>

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<p>caseloads and activity are consistent with the most appropriate setting and interventions to meet service user needs rather than the “inverse care law”</p>		
<p>More carers are supported to continue in their caring role. (Resilience)</p>	<p>Caring Together: The Carers Strategy For Scotland 2010-2015 sets out the action that is being taken with partners to provide better support to family members and carers to enable them to offer care & support without themselves coming to harm. This includes:</p> <ul style="list-style-type: none"> • Services are able to identify carers including young carers • Provide information and advice to carers to support their role • Ensure carer representation in local health partnerships and mental health system wide PFPI systems • Ensure staff are aware of the importance of involving and learning from carers expertise and experience of services • Development of carer/mental health carer training and development packages via GG&C anti stigma partnership • Utilisation of Carers Information Strategy funding to assist delivery of identified needs 	<ul style="list-style-type: none"> • Families/ carers are routinely involved in learning from Significant Incidents • Carers including young carers are identified through single shared assessments in community and inpatient settings • DH triangle of care assessment tool used within all acute inpatient areas • Carer feedback is used for service improvement • Develop training packages for NHS GG&C, 6 x GGC Local Authorities and support materials for newly identified MH carers

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Minimising and mitigating the impact of capacity reductions in community services on the capacity to sustainably shift the balance of care	<ul style="list-style-type: none"> • Modest further reductions of capacity of acute inpatient beds 	<ul style="list-style-type: none"> • Stable or reducing levels of inpatient activity (admissions/ OBD's/Boarding/Readmissions)

Finance and workforce

The financial outcomes we need to achieve in the next three years are a shift in spending from hospital services. However at a time of financial constraint it seems unlikely that savings can be reinvested in community services.

3. RESHAPING CARE FOR OLDER PEOPLE

- Not applicable to Adult MH but see references to access to age appropriate services elsewhere in this Plan.

4. IMPROVING QUALITY AND EFFECTIVENESS

Overall position & issues

- Range of environmental improvements to inpatient wards previously implemented but continue to have ward environments which are of lower quality with reliance on shared ward spaces which raise both quality issues for individual patients, can exacerbate patient safety challenges, and can constrain the flexibility of wards to meet needs due to limited single sex/single room accommodation
- HAI/patient feedback has raised issues as follows:

HAI

The standards for healthcare acquired infection continue to be implemented across all mental health in-patient areas. A point prevalence study was conducted in early 2012 which show that NHS Greater Glasgow & Clyde mental health areas remain below the national rate for HAI in these settings. Seasonal monitoring of norovirus outbreaks demonstrate relatively low activity (adult & older peoples MH wards) in comparison to RAD and other acute areas. The Healthcare environment inspectorate visits will extend to mental health in-patient areas this year and a significant area of work has been undertaken to prepare for this, there remains however significant issues in relation to the standard of some of the estate.

Patient Feedback

- A variety of mechanisms are in place for gathering patient experience within mental health services. This includes questionnaires, focus groups, PFPI structures and 'you said, we did' models within in-patient areas. Service user organisations are integral to these approaches and are directly involved in eliciting feedback from patients and carers.

Service users have told us through a range of national and local work what they want from services. This includes:

- Involvement in decisions and respect for preferences
- Emotional support, empathy and respect
- Clear information and support for self care
- Fast access to reliable health advice
- Effective treatment delivered by trusted professionals
- Attention to physical, and environmental needs
- Involvement of and support for family and carers
- Continuity of care and smooth transitions

4. IMPROVING QUALITY AND EFFECTIVENESS

The majority of people are happy with their care and rate their relationship with health care staff as very good. Other themes include the importance of ensuring smooth transition between services, improved discharge planning and co-ordination of care where multiple services are involved.

- Out Of Hours redesign
- Service specification and productivity KPI's development
- Outcome framework development

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Improving environment of inpatient wards	An agreed and costed plan to ensure that all in-patient environments are of a consistent and measurable standard.	<ul style="list-style-type: none"> • No of wards with improved environments
Deliver inpatient reconfigurations as per previous commitments to deliver both balance of care shifts and efficiency savings <ul style="list-style-type: none"> - Parkhead/Stobhill /Ruchill - SGH to Leverndale - As per Case for Change re inpatient services 	<ul style="list-style-type: none"> • Develop and produce a coherent and co-ordinated inpatient configuration plan that reflects effective engagement and views of users, carers, staff, which is clinically and financially effective. • This may require concentration on less sites but more quality. • Energy cost implications of service redesign to be included within the plan. 	<ul style="list-style-type: none"> • Agreed MH plan as a result of Case for Change outcome that sets the direction for future inpatient services

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<p>Making further reductions in avoidable harm and in hospital acquired infection</p>	<ul style="list-style-type: none"> • Implement proposals of National MH Scottish Patient Safety Programme as a member of implementation group • Implement standard operating procedures for control of infection within hospitals. • Implement recommendations from HIS report on learning from significant clinical incidents 	<ul style="list-style-type: none"> • Evidenced based/National approach to MH SPSP approaches • Point prevalence study on rates of infection within mental health hospital settings • Seasonal monitoring of Norovirus outbreaks • System wide learning from SCIs
<p>Delivering care which is demonstrably person centred, effective and efficient</p>	<ul style="list-style-type: none"> • Ensure effective engagement throughout the Case for Change process • More effective ongoing engagement with MH leadership • Service User / carer participation in service reviews, scrutiny and assurance functions 	<ul style="list-style-type: none"> • Readmissions and boarding : stable or reducing • Patient feedback measures inform service delivery / clinical practice • SCI's are completed within the appropriate timescale • Waiting Times targets achieved • Quality Improvement Productivity Measures (LEAN, DCAQ) implemented across community mental health teams.

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<p>Patient engagement across the quality, effectiveness and efficiency programmes</p>	<ul style="list-style-type: none"> • Model for OOH redesign is developed and implemented 	<ul style="list-style-type: none"> • Outcome of engagement process influences Case for Change • Routine series of focus meetings built in to MH leadership meetings • Patient participation in SPSP programme • Scottish Recovery Indicator (SRI 2) implemented across adult mental health teams
<p>Improve appropriate access on a range of measures including waiting times, access to specialist care; physical access and needs responsive access</p>		<ul style="list-style-type: none"> • Access to Psychological Therapies Target compliance (18 weeks referral to treatment from December 2014) • No deterioration in MH waits for A&E admissions • No increase in levels of people admitted outwith daytime services

Finance and workforce

Develop improved understanding of productivity and effectiveness of community services and develop and implement service and productivity KPI's.

Release fixed cost and unit cost savings to mitigate impacts of delivering savings plan targets.

4. IMPROVING QUALITY AND EFFECTIVENESS

Overall position & issues

- unequal geographic access to specialist service
- access to some services (e.g. psychological therapies) for needs which are not age specific is currently differentiated on the basis of age rather than need

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<p>We plan and deliver health services in a way which understands and responds better to individuals' wider social circumstances; and we contribute to achieving higher levels of public awareness of mental health issues, combined with lower levels of stigma and discrimination</p>	<p>Services planned and delivered in a way which ensures a greater understanding of individual's wider circumstances, and which contributes to reduced levels of stigma and discrimination in the population, in line with resources of Anti Stigma Partnership and its thematic groups – e.g. LGBT communities, perinatal MH, Mental Health Carers, Employment</p> <p>Consider outputs from Gender Based Violence routine enquiry pilot, to determine the implications and feasibility of a roll-out across MH services GG&C wide.</p>	<ul style="list-style-type: none"> • MH Improvement and Inequalities training opportunities – increased uptake across CH(C)Ps / Sectors and within Partner agencies (Measures such as # staff trained; # agencies accessing training, etc) • Public attitudes surveys examining trends in mental health awareness, stigmatising attitudes (e.g. via See Me campaign commissioned research)
<p>Information on how different groups access and benefit from our services is more routinely available and informs service planning</p>	<p>Clarify baseline recording levels and explore feasibility of improving recording levels</p> <p>Undertake specific piece of work to clarify implications of knowledge base re differential prevalence, utilisation, factors in experience of protected groups and their significance for the functionality and characteristics of service models as an input to the CSR process</p>	<p>Degree of baseline recording of protected characteristics in service utilisation activity information.</p>
<p>Physical health needs of mental health patients are addressed equitably as</p>	<p>Physical health care of patients is a significant element of this and we are addressing this through the</p>	<p>See Section 1 above</p>

4. IMPROVING QUALITY AND EFFECTIVENESS

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compared with the general population.	Physical Health Care Policy – see Section 1 above Further work is undertaken to identify the health gap and actions to mitigate this drawing on work on the Health needs assessment/Clinical Services Review.	Health gap is identified Range of actions are identified based on outcome of work
Reduce inequalities gap - Financial Inclusion / Anti Poverty measures	Seen as key drivers in increasing the inequalities gap – CH(C)Ps / Sectors MH Improvement Action Plans to ensure adequate service provision targeted at high risk groups, and to incorporate financial inclusion support, employability services and other anti-poverty measures as integral elements.	<ul style="list-style-type: none"> • Uptake of financial inclusion services across CH(C)Ps / Sectors • Availability and access of FI services to at risk groups, including clients of MH services
Geographic access issues resolved		<ul style="list-style-type: none"> • Specialist services activity for areas previously without access to such services
Age discriminatory access to Psychological Therapies /liaison/crisis supports is resolved		<ul style="list-style-type: none"> • Increased access to psych therapies • Overall increase and compliance with HEAT target • Proportionate access by SIMD • Proportionate access by age

Finance and workforce

The financial challenge we need to meet in the next three years is to demonstrate that we have shifted our use of resources to deliver on these inequalities outcomes and have considered the inequality impact in all of our financial decisions.