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RCGP Scotland consultation response
Adult secondary mental health services- quality standards
17 March 2023

RCGP Scotland are grateful for the opportunity to respond to this consultation and support the development of quality standards for Scottish adult mental health secondary care services: we like the use of PANEL principles in doing so. We were pleased to have been invited to the workshop and that an RCGP Scotland representative, Dr Munro Stewart, is a member of the Mental Health Quality and Safety Board.

We thought that the proposed standards are refreshingly concise and simple, which will help with their understanding and implementation. We need to see timescales for that implementation and suggest that we are starting from a very significant capacity shortfall: the standards will help the service define what is needed and support a necessary increase in workforce and resource. They will also help patients and their families understand much better what secondary care mental health services will offer them. We did think that the language was pitched above the literacy levels of some patients and suggest a patient-friendly version. We also thought that there were some significant omissions and are aware that introducing standards without the workforce to meet them can add stress to already-overstretched staff.

We also recognise the workforce and services challenges in specialist care where there is a shortage of psychiatrists, psychiatric nurses and other clinicians. However, that applies to general practice too: GPs and their teams undertake more mental health consultations than any other profession. 90% of people with mental health problems are cared for entirely within primary care, which includes people with serious and enduring mental illness (SMI), and prior to the pandemic, around 30% of people who see their GP had a mental health component to their illness.[1] We note the rise in mental health workload, being felt throughout the system, including in primary care. We would see a consultation on quality standards as an opportunity for a wider national conversation about what can be expected of mental health services, including those delivered by GP practices, but also a very welcome opportunity to help provide the best mental health care that we can, at a time of great need. There is a shortage of inpatient beds, too, adding stress to those who work in mental health, and being hospitalised far from home is associated with poorer outcomes and can add to distress if family or friends cannot readily visit.

We would like to extend the definition of secondary care outlined in the first sentence: “Secondary mental health care services are there to meet the needs of individuals who have longer term or complex psychological or mental health conditions (e.g. Complex trauma, or severe depression) that cannot be met by their GP or other primary care services”. There is also a role for secondary care in managing those who require acute admission for reasons of safety

relating to mental health and not all those will have complex or longer-term conditions. We feel that is especially important to highlight when there are anticipated changes relating to the Mental Health Law Review. In addition, these are areas of acute difficulty and stress both for patients and clinicians, with impacts felt in primary care too. This additional focus is also needed as we have an established shortage of Mental Health Officers (53 FTE shortfall in 2020).)[2]

We very much welcome the emphasis on equality and note especially that those living in poverty are at high risk of poor mental health. The recent report of the Health Foundation outlines the extent of poor mental health as a contributor to Scotland's worrying and large excess in premature mortality. We are a European outlier for health inequalities, with Scotland having "the lowest life expectancy in Western Europe. [3] The report goes on to say that there are "especially high inequalities for causes of death that are avoidable (i.e. are treatable through healthcare or preventable through healthcare and policy action), particularly the so-called deaths of despair". Those deaths of despair are due to alcohol, drugs and 'probable suicide'. In combination, they make up two thirds of absolute inequalities in total mortality in young (15- to 44-year-old) men in Scotland. [4]

Currently we would suggest that there is little systems account taken of that, both in terms of initial access but also what happens if patients miss appointments, and their ongoing care. A Scottish study of over 800,000 patient records has shown a strong association between missed appointments in general practice and higher physical and mental health morbidity and mortality: "Patients with long-term mental health conditions who missed more than two appointments per year had a greater than 8-fold increase in risk of all-cause mortality compared with those who missed no appointments. These patients died prematurely, commonly from non-natural external factors such as suicide".[5] It is difficult to think that wouldn't be paralleled in secondary care too.

We would like to see discussion round continuity of care, too. In a primary care setting, continuity brings "better clinical outcomes for an array of conditions; reduced mortality; better uptake of preventative services; better adherence to medication; reduced avoidable hospital admissions; and better overall experience of care among patients who prefer continuity and are able to obtain it."[6] We know that some of the improved outcomes are mental health ones and again, it is likely that similar factors operate in a secondary care setting. What we hear from our patients, particularly those with severe and enduring mental illness, is that they see a succession of doctors and nurses, who don't know them or their situations. The more patients see a particular doctor, the more that trust is built [7] and this has been shown to increase a sense of security and reduce anxiety.[8] Continuity improves dementia outcomes too. [9] The RCGP website has more on this topic.[10]

We feel that relational care is key in mental health settings, and GPs report of patients who, despite being severely ill, will resist or refuse referral because they anticipate seeing a clinician they don't know. And how much easier (and quicker!) for the clinician, as well as the patient, to

re-engage at a time when needs and vulnerability are likely to be high. Long term continuity reduces costs and improves outcomes in general practice, and we would suggest this is likely to hold for mental health services too, where relational care is key. We would like to see continuity as an outcome measure, as from the GP perspective, we believe we see its lack negatively affecting access and engagement. The lack of continuity will likely be accounted for by staff shortages, as well as organisational approaches, yet another reason to prioritise workforce planning.

Finally, we hear from GPs that some have very low referral rates to specialist mental health services. This is because: they know that their patients will not be seen for such a long time that referral has little current relevance; or they have no sector psychiatrist; or patients are resistant to being referred as services can seem distant and threatening, and that referrals - even ones which seem very justified - may be rejected and that then often adds to the patient's feelings of being unworthy or not worth helping, however unintended. This is unmet need which is invisible to secondary care mental health services, but very evident in primary care.

Part 1: Questions On All Of The Standards

1. How far do you agree that the standards will improve the experiences of people using secondary mental health services?

Strongly agree

2. How far do you agree that the standards will improve the outcomes of people using secondary mental health services?

Neither Agree nor disagree

3. How far do you agree that the standards clearly set out to individuals, their families and carers what they can expect from a secondary mental health service?

Agree

4. We know that currently not everyone has the same experiences or outcomes when they engage with mental health services. We want these standards to help make sure that services meet everyone’s needs whoever you are and whatever your background. How far do you agree that the standards will help do this?

Agree

5. Do you have any suggestions for how the standards could go further to help ensure that services meet everyone's needs regardless of who they are or their background?
The overwhelming need is for more capacity - especially of workforce - and this is not acknowledged sufficiently in the document. Having the standards will help highlight the shortage too, but they will have limited impact without additional trained staff to deliver them. The cost of living crisis will have an adverse effect on people's mental health, and GPs, who undertake the vast majority of mental health work in the community have falling numbers.

Many of the standards are excellent. However we believe that there are some omissions - and it is those in part, and the lack of capacity - will likely mean that the very good standards descriptors won't be fully matched in terms of outcomes. We have reflected that in our comments on outcomes. The language of the standards is fairly transactional, which is probably necessary, but we would like to see an emphasis throughout on compassionate care and perhaps that reflected more in the commentary.

Finally, the current shortfall means that frontline staff are under pressure to provide and fill the gaps when they simply do not have capacity. The current gap between demand or expectation and what is available should be described and accounted for by government, rather than falling to frontline staff. It is difficult for staff to always maintain trust and respect if the workforce is under severe pressure or undervalued, or having to deny people services they want, yet both are key to maintaining a positive psychological environment for patients facing mental ill health or distress.

We hear reports of some members of the team feeling unsupported both in primary and secondary care where detention is required, anxious about unnecessarily infringing someone's rights but sometimes being reluctant to take the safe route of detention because of that, with adverse outcomes. The Mental Health Law Review implies that some are over-detained and this needs to be considered too in terms of further pressure on scarce staff. Some GPs are profoundly under-supported in the community when having to detain someone, in a way that should be seen as unacceptable.

6. Are there any other areas of mental health services in which you think these standards could apply outside of adult secondary services? If so, which services?
Some of these - especially round workforce would usefully apply to general practice, although general practice no longer has the capacity to ensure an adequate - and adequately supported - workforce for the work presenting to it. We are aware that if the National Care Service proposals go ahead then some of this landscape may change substantially.

7. Please share with us any of your thinking on your answers above and give us your views on the standards overall.
Please see our response to Q5

Part 2: Access Questions

8. How far do you agree that the standards within this theme will improve the experiences of people using secondary mental health services?

Strongly Agree

9. How far do you agree that the standards within this theme will improve the outcomes of people using secondary mental health services?

Neither Agree nor disagree

10.How far do you agree that the standards within this theme clearly set out to individuals, their families and carers what they can expect from a secondary mental health service?

Agree

11.Do you think there is anything missing from the Access standards?
We support these principles – and would like to see more emphasis on digital exclusion and literacy, as that is sometimes not accounted for – especially in letters to patients. We welcome that communication will be in a "clear and accessible format" but suggest that should also account for Scottish literacy norms, too. Whilst that is implied, it needs to be made clearer. As there are often long waits for appointments reminder letters – and especially texts – should be seen as normal practice.

Those who fail to attend a face-to-face appointment we feel should have that immediately converted to a telephone consultation as the mental health practitioner will still have allotted time for that. This itself would reduce inequalities. There needs to be a standard around DNAs and actions taken. If a GP refers someone, who is for instance displaying psychotic symptoms and has suspicious ideation, that patient should not be discharged following a DNA but rather the onus be on secondary care services to follow them up. Non-attendance should be seen as an intrinsic part of access and be measured and managed. Non-attendance rates should be considered in terms of an indicator: good appointment systems, communication and prompting should minimise those, and throughout, compassion and understanding for care needs is crucial.

Access to inpatient beds has not been addressed. There needs to be adequate numbers as the outcomes are poorer for those unable to be hospitalised locally, and it adds to the distress of inpatients if it is difficult for them to see family or friends.

We would want GPs to be informed of patients' waiting times and what is being offered to them in the interim. With long waits, it is the GP who continues to maintain care and support for patients until their specialist appointment. The standards will need defined indicators to be meaningful and we would suggest: emergency wait times of less than 4 hours, urgent care appointments within 72 hours and routine care within 6 weeks. [11] This reflects that GPs refer a

tiny minority of patients they see with mental health problems and only do so for those with moderate to severe illness, or where multiple first line interventions have not worked, and most have high levels of need. (Although there will be somewhere a diagnosis can only be secured by a specialist team (E.g. ADHD or autism in line with national guidelines) and who may or may not have such urgent needs).

These standards give a clear and helpful framework for individuals and their support networks, but what is possible now will fall short of the expectations of many due to capacity and training issues. The standards themselves are excellent but outcomes are also governed by other factors. We need much more on engagement as well as initial access.

12.We know that currently not everyone has the same experiences or outcomes when they engage with mental health services. We want these standards to help make sure that services meet everyone's needs whoever you are and whatever your background. How far do you agree that the Access standards will help do this?

Agree

13.Do you have any suggestions for how the Access standards could go further to help ensure that services meet everyone's needs?
The standards are very good - but omit the important interface with general practice and detail round that. It is now estimated that half of clinical errors occur at the interface and the omission of general practice in consideration of the standards means that there are hazardous gaps.

Further detail will be needed for some standards - and some of that might be usefully incorporated now to help both expectation and planning: please see the accompanying explanation.

14.Please share with us any of your thinking on your answers above and your views on Access standards overall.
There is a lack of detail round some of the access outcomes. For instance, we strongly welcome the emphasis on inequality and that that should be a determining factor in prioritising care. But how will that be done, and are the public aware of the consequences? It may mean that someone from a socioeconomically deprived background (for instance) should rightly be seen by specialist services sooner than someone with the same condition in another living setting, as their prognosis is worse. Some people who feel they should be seen may not be appointed specialist help at all, because of our shortfall in service capacity, and we need detail on how that will be communicated to patients, and that not all fall to the GP or mental health services. Where there is a mismatch between demand and need, there should be clinical definition of that, and then Scottish Government public messaging to explain and support.

PLEASE ALSO SEE Q43 BELOW.

Part 3: Assessment, Care Planning, Treatment and Support Questions

15.How far do you agree that the standards within this theme will improve the experiences of people using secondary mental health services?

Agree

16.How far do you agree that the standards within this theme will improve the outcomes of people using secondary mental health services?

Agree

17.How far do you agree that the standards within this theme clearly set out to individuals, their families and carers what they can expect from a secondary mental health service?

Agree

18.Do you think there is anything missing from Assessment, Care Planning, Treatment and Support standards?
We particularly welcome the care plan approach, and echoing our comments elsewhere, that will need more capacity to implement. We like the emphasis on transparency, the patient being informed of what care they can expect and how it will be delivered. Recognising the need for family involvement is important and good to see that acknowledged.

We suggest that there be a standard, within each section, relating to the interface with general practice. As specialist services become increasingly pushed due to rising demand and workforce shortages, patients turn to their GPs. Sharing care plans would be very useful as that would help GPs signpost and support within the context they offered. Those need to include detail round what happens with acute deterioration, and when someone still under specialist care becomes severely ill and requires detention. In that situation it should be expected that a patient under ongoing specialist care be detained by them and not the GP, bringing the added benefits of a short term (rather than emergency) detention order. Without care plans, patients in need turn to their GPs, where we also have a large and growing mismatch between demand and capacity, further compromised by the recent proposed cuts in primary care mental health and wellbeing spending.

We would like to see a standard round prescribing. How that is monitored is another interface issue where assumptions can be made and patients fall between services, with the risk of potential (and sometimes serious) harm. We would like to see a standard of a Shared Care Agreement (SCA) for any prescribing requiring one, with clear information about who will monitor, and how that will be resourced. We also need to see national agreements, reflected in local drug formularies, for all drugs that should either be initiated by a specialist, or prescribed in secondary care on an ongoing basis. For those with severe enduring mental illness (and especially those on anti-psychotic drugs) there needs to be agreement about who will monitor

and address cardiometabolic risks when there is added hazard from medications, essential for primary and secondary prevention. Such patients are not only at high risk from their mental health condition but from physical illness, too, and may not always be able to access help for that through the standard routes.

The role of a care co-ordinator is good to maintain support and structure between the different multidisciplinary roles in the care team.

We note standard 2.9: "Services will ensure that teams have an adequate staffing skill mix to provide a wide range of assessments and therapeutic interventions based on needs in their community". This is a good standard to have, though how "adequate" is defined will also need to be specified. However, this staffing mix does not exist currently, and whilst we need to work towards this, it may raise expectations of delivery of care which simply cannot be met just now. It would be useful to see that acknowledged here. We also need to see a clear path to escalation where staff feel standards aren't being met, and one that they feel comfortable using.

After 2.12 we suggest the inclusion of sustainable care when planning, using triple bottom line principles, so that care doesn't limit its future provision through unsustainable practice, nor does it have adverse environmental, or social impacts. There are mental health benefits brought by climate change initiatives, including better local access to services, improved public transport and leisure opportunities, and access to physical activity, safe active travel and green spaces. Whilst these do not apply specifically to secondary care, the importance of these approaches is paramount, and we suggest over-arching.

2.14 "Services will use demographic data, engagement intelligence, national prevalence rates and data on wider determinants of health to identify groups with poorer mental health and direct resources accordingly." Will that include data from GP systems too? – which contain the most complete record across the lifetime of the prevalence of conditions and prescribing. That would be welcomed but would need the current work round data sharing processes to be accelerated.

19.We know that currently not everyone has the same experiences or outcomes when they engage with mental health services. We want these standards to help make sure that services meet everyone's needs whoever you are and whatever your background. How far do you agree that the Assessment, Care Planning, Treatment and Support standards will help do this?

Agree

20.Do you have any suggestions for how the Assessment, Care Planning, Treatment and Support standards could go further to help ensure that services meet everyone's needs

See Q18.

21.Please share with us any of your thinking on your answers above and your views on Assessment, Care Planning, Treatment and Support standards overall.

See Q18.

Part 4: Moving between and out of services Questions

22.How far do you agree that the standards within this theme will improve the experiences of people using secondary mental health services?

Agree

23.How far do you agree that the standards within this theme will improve the outcomes of people using secondary mental health services?

Disagree

24.How far do you agree that the standards within this theme clearly set out to individuals, their families and carers what they can expect from a secondary mental health service?

Agree

25.Do you think there is anything missing from the Moving between and Out of Services standards?
We maintain that there had been insufficient thought or emphasis given to the interface with primary care. The move 'out of services' is in fact a move into general practice ones. Once again, we need a standard round the interface. We hear from some GP colleagues of patients with severe illness being discharged to GP care, when there may not be the capacity to take on intensive input for someone unwell. Some specialist services see Practice Mental Health Nurses (who virtually always have a specialist psychiatric nurse background) as fulfilling a CPN role, whereas they are there to relieve GP pressures as part of the Scottish GP contract. We need a standard relating to discharge planning and letters, and ensuring the GP is aware when a patient has been discharged.

RCGP Scotland has long called for an interface group in every health board, and close interface working especially needed in the mental health arena, where transitions and boundaries are often hazardous in terms of patient care. We would like to see that set as a quality standard.

We are also aware that especially those who have been an inpatient for a while, can be traumatised or even institutionalised by the experience, and understandably so. Often there is a

very sharp and rapid ‘step down’ into the community with little support at a time when it is much needed, some then experiencing further deterioration in mental health. Again, that would be usefully incorporated into a standard round discharge planning.

26.We know that currently not everyone has the same experiences or outcomes when they engage with mental health services. We want these standards to help make sure that services meet everyone’s needs whoever you are and whatever your background. How far do you agree that the Moving between and out of services standards will help do this?

Neither Agree nor Disagree

27.Do you have any suggestions for how the Moving between and out of services standards could go further to help ensure that services meet everyone’s needs?

28. We know that substance use and mental health difficulties can be co-occurring. We want to ensure that people with both a mental wellbeing concern and substance use receive access to treatment that is tailored to their needs. How far do you agree that we should include a specific standard on support for those with substance use issues within these standards?

Strongly Agree

29.What should a standard around substance use contain?
Co-morbidity is the norm, especially for those with more serious mental illness, and the 'deaths of despair' (the triad relating to alcohol, drugs and apparent suicide) the leading absolute cause of premature death in men in Scotland. [12]

All too often, at odds with the evidence, mental illness is seen as an isolated entity, involving a single condition. Mental health staff need to not only be trauma-informed but be addiction-informed too, and that not be seen as a barrier to entering mainstream secondary care services. Overly-specialised, exclusive services can present barriers to referral and therefore access to care. We welcome the Scottish Government’s rhetoric on reducing siloed care (especially for those living with addiction) but that is often not reflected in service delivery.

30. Please share with us any of your thinking on your answers above and your views on the Moving between and Out of Services standards overall.

Explained in Q25.

Part 5: Workforce Questions

31.How far do you agree that the standards within this theme will improve the experiences of people using secondary mental health services?

Agree

32.How far do you agree that the standards within this theme will improve the outcomes of people using secondary mental health services?

Disagree

33.How far do you agree that the standards within this theme clearly set out to individuals, their families and carers what they can expect from a secondary mental health service?

Agree

34.Do you think there is anything missing from the Workforce standards?
The processes here will help understanding and expectations. But the outcomes depend on sufficient workforce and there is a current major shortfall. So, it is difficult to answer all these questions with that paradox. Reporting on workforce will help in longer term planning but the shortfall is so significant, that it will be a considerable time till actual outcomes improve, and staff trying to fill gaps may become ever-more pushed and stressed.

35.We know that currently not everyone has the same experiences or outcomes when they engage with mental health services. We want these standards to help make sure that services meet everyone's needs whoever you are and whatever your background. How far do you agree that the Workforce standards will help do this?

Agree

36.Do you have any suggestions for how the Workforce standards could go further to help ensure that services meet everyone's needs?
These are excellent recommendations for standards, and many of us would like to see those applying to primary care too. But we know that because of shortfalls in both workforce, and long-term workforce planning, we are quite a way from achieving these. With regards to safe staffing levels, this needs to be agreed with professional organisations such as the Royal College of Nursing and the BMA, and it be clearly delineated where the responsibility for adequate staffing levels lies. The co-ordinator would help with the escalation routes, sharing data over safety, protecting whistle-blowers and ensuring an external route for staff to raise concerns.

Objectives need to be 'SMART' and some of these are very open to interpretation. Some will be perceived and interpreted differently by patients and those who deliver care.

As the funding for mental health services is a governmental responsibility, we suggest it be apportioned on the basis of what good, acceptable care looks like, and these standards will support that modelling. Instead, and all too often, we see an inadequate floor to funding and attempts then made to accommodate care within those limits.

The service provided needs to be psychologically safe to provide excellent care to patients, as outlined earlier; with sufficient resource for those working in this environment to feel supported within their team. We recommend that the introduction to this section includes detail on the estimated shortfall of the various clinicians in terms of their numbers. Of note is that the 2022 National Workforce Strategy for Health and Social Care in Scotland refers to mental health extensively, and especially primary care initiatives (which have largely failed to happen and have now had their funding cut). However it includes almost no detail about secondary care mental health clinician shortfalls which are also significant. This is a worrying omission and alongside this paper we urgently need one on workforce if standards are going to be met.

37. Please share with us any of your thinking on your answers above and your views on Workforce standards overall.

Explained in Q36

Part 6: Governance and Accountability Questions

38.How far do you agree that the standards within this theme will improve the experiences of people using secondary mental health services?

Agree

39.How far do you agree that the standards within this theme will improve the outcomes of people using secondary mental health services?

Agree

40.How far do you agree that the standards within this theme clearly set out to individuals, their families and carers what they can expect from a secondary mental health service?

Agree

41.Do you think there is anything missing from the Governance and Accountability standards? Again, there is no mention of the GP, who often has now to help support those waiting for a specialist service or step in when it is not there. As a minimum, we would want a standard requirement for data round DNAs, referrals returned to the GP, and short-term detentions undertaken by the GP. All detentions undertaken in general practice should be subject either to a Significant Event Analysis or a Datix process and seen as an adverse outcome.

42.We know that currently not everyone has the same experiences or outcomes when they engage with mental health services. We want these standards to help make sure that services meet everyone's needs whoever you are and whatever your background. How far do you agree that the Governance And Accountability standards will help do this?

Agree

43.Do you have any suggestions for how the Governance And Accountability standards could go further to help ensure that services meet everyone's needs?
The consultation (including in its introduction) does not consider acute psychiatric emergencies in the community which require specialist input. We have recommended that every emergency detention certificate (which are done by GPs) are considered a significant event. These are potentially dangerous situations and are hugely difficult for GPs, who are often unsupported as they try and assess and admit a patient. There will be situations where someone presents de novo severely ill and a danger to themselves or others, and emergency detention certificates are then almost inevitable. But often these patients are known to specialists and still under their ongoing care, or have waited too long for an appointment, or the GP has asked for help and not been able to get it. We would like the Mental Welfare Commission to be more involved in assessing this area of work and to look at the wider factors which make it difficult for staff.

The gold standard for this situation is a short-term detention certificate (which also gives the patient more rights) but that can only be done by an approved medical practitioner. This emergency work can engage a GP for hours, whilst they negotiate with ambulance and police services and the process often becomes unnecessarily public and degrading for the patient. This is a very important aspect of access not covered anywhere in this consultation. It is also one where it is crucial that - especially for patients living with severe long term mental illness and their families - there should also be user understanding of what might happen in these crisis situations.

44.Please share with us any of your thinking on your answers above and your views on Governance and Accountability standards overall

See Q43

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Part 7: Implementation and Measurement

45.Overall, what support do you think services will need to implement the standards?
1. A significantly expanded mental health workforce and an implementable workforce plan.
2. Reversal of the decision to reduce primary care mental health and wellbeing funding which will inevitably mean that primary care is less able to manage the mental health problems presenting to it.
3. An interface group in every health board to establish the boundaries and bridges between primary and secondary care and ensure safe joint working.
4. That all mental health staff have generic training not only in trauma, but also health inequalities, alcohol and drug use.
5. That there be specific and explicit pathways round acute psychiatric emergencies in the community setting, sharing of information with the GP, prescribing shared care agreements and discharge planning.
6. That there is a national conversation round public expectation and the limits of what can be delivered by acutely stressed secondary (and primary) care mental health services.

A key aim of the standards is that they are measurable. By measuring the standards, we will be able to celebrate and share good practice, identify any issues and drive improvement in services. We will work with services to ensure that measurement doesn't add unnecessary burden and findings are used in a supportive way. We are proposing that the standards are measured in two ways: Firstly, by services across the country filling out a self-assessment tool to collect information and data to find out how the standards are being implemented across their services. A self-assessment tool is a way for services to gather information to allow them to evaluate how well they are meeting the standards. The tool will allow services to 36 provide evidence to show that they are meeting the relevant standards, supporting them to recognise good practice and make necessary improvements to the services that they deliver. It is proposed that this self-assessment would be a continual way to drive improvement in services over time. The number and frequency of self-assessments is still to be decided. Secondly, we propose another way to measure performance, by collecting and publishing data on a number of indicators. An indicator is information collected across the country that provides a measure of how well services are meeting the standards. Service providers will be asked to submit data on these indicators, which will be analysed and published to allow the Scottish Government and the public to understand how services are performing against the relevant standards and how well they are delivering for the people who use them. It is proposed that this data on indicators would be collected, analysed and published on a regular basis. The frequency of collection is still to be decided.

46.How far do you agree that some of the standards should be measured using a validated self-assessment tool?

Agree.

But we need to be cognisant that some of our most vulnerable will have problems with literacy, with language, with bureaucracy.

We also need to find ways of capturing the experience of mental health clinicians too.

47.How far do you agree that some of the standards should be measured using a range of indicators?

Strongly Agree.

48.Please explain the thinking behind your choice.
Please refer to Q5. We recommend a slightly wider range of standards and indicators than outlined here. Mental health is complex, and a range of indicators will be needed to capture that. We also believe that there is a need for a small number of additional standards as outlined above.

However, we are also aware of the complexity of current governance with staff who already manage unnecessarily large bureaucratic burdens. So we also need to ensure simplicity.

49.Please give us your views on these possible questions to include in the self assessment. Please provide any further suggestions for self-assessment questions you may have

Many GPs do not have a sector psychiatrist and there needs to be a working interface between GPs and mental health services. There are currently high levels of unaddressed need which will not be captured with secondary care self-assessment and will only be addressed once GPs perceive that there is enough capacity in the system for their patients to be seen.

Mental Health Law Review- https://www.mentalhealthlawreview.scot/workstreams/scottish-mental-health-law-review-final-report/
Triple bottom line principles- https://networks.sustainablehealthcare.org.uk/networks/psych-susnet/article-applying-triple-bottom-line-services

[1] https://elearning.rcgp.org.uk/pluginfile.php/175878/mod_book/chapter/616/RCGP-PS-mental-health-nov-2017.pdf
[2] National Workforce Strategy for Health and Social Care in Scotland. Scottish Government. March 2022.
[3] Media_892338_smxx.pdf (gla.ac.uk)
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[10] Continuity of Care work at RCGP

[11] https://www.nhsinform.scot/waiting-times/about-waiting-times
[12] Allik M, Brown D, Dundas R, et al. Deaths of despair: cause-specific mortality and socioeconomic inequalities in cause-specific mortality among young men in Scotland. Int J Equity Health 2020;19(1):215. doi: 10.1186/s12939-020-01329-7 [published Online First: 2020/12/06.