NHS
Quality
Improvement
Scotland

# Improving the quality of mental health services in Scotland

## A strategic work programme 2005 – 2008

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## Foreword

Mental health services in Scotland are facing several challenges – a new Act, which will make new demands of services and their workforces; the establishment of Community Health Partnerships (CHPs); and the development of new ways of working with other agencies. These are all appearing at a time when demographic changes and new patterns of training mean that, more than ever before, the way the skills and commitment of people working in the services are deployed will be crucial to their success in meeting the needs of people with mental health problems.

The NHS Quality Improvement Scotland (NHS QIS) strategic work programme introduces an approach that will support services and those using them through this period of change. It starts from the commitment that has brought each person working in mental healthcare into the services. This has to do with bringing about wellbeing and freedom from distress for each person for whom the service exists. We wish to build on the way professions and agencies already co-operate informally in localities, and the joint work in planning and implementation which has been developing between agencies in the last few years. We will also build on the work that has already been carried out, including the extensive NHS QIS reviews of services against the *Clinical Standards for Schizophrenia.*

We believe that through the approaches outlined in this document, services can both meet peoples' care needs and take responsibility for the way resources are managed to allow that to happen. It is at that local level that the real decisions and styles of practice which influence the delivery of services are made; we wish to influence those processes for the better, while supporting people in their challenging but rewarding work.

Our experience suggests that the approach taken in this work programme has the potential to improve the quality of mental health services. Implementing the work programme effectively is the challenge that lies ahead and working together is the best – and only – way to achieve this. We are confident that we can improve the quality of mental health services in Scotland through working in partnership with all stakeholders.

**David R Steel**
**Chief Executive**

# 1 Introduction

Mental health has been one of the key clinical priorities for NHSScotland since 1995[1]. One in four people will experience some kind of mental health problem in the course of a year[2]. There is clear evidence of a continuing high prevalence of mental health problems in the Scottish population (as for the rest of Europe), and of the loss of quality of life for those affected. There is also extensive evidence demonstrating the effectiveness of a range of treatments and interventions: social; psychological; and pharmacological. These are provided by a combination of primary and secondary health services, as well as care from local authorities (housing and social care) and from voluntary organisations, increasingly in close association with service users and informal carers.

## Vision

Our vision of how services for all people with mental health problems and their informal carers should be structured comes from the essential features in *A Framework for Mental Health Services in Scotland (1997).* The key points are that:

- services are accessible and easy to use, clearly directing people to where help can be found
- provision is timely, suitable to an individual's present needs, and if required, there is contact available around the clock
- services are locally available in the first instance, enabling the majority of people to stay in their own communities, with appropriate assessment and management of risks
- work is in partnership with users, focused on meeting the full range of their needs
- regaining independence, quality of life and positive mental health are as important as the treatment of symptoms
- there is efficient and effective use of evidence-based approaches
- NHS services collaborate in partnership with other agencies, statutory and voluntary
- resources are managed to the best advantage of service users
- staff are supported through training, professional development and supervision.

1 Scottish Office Department of Health. 1995. *Priorities and Planning Guidance for the NHS in Scotland 1996 - 2007. NHS MEL(1995)51*. NHS MEL. Edinburgh: Scottish Office.

2 Singleton N, Bumpstead R, O'Brien. M, et al. 2001. *Psychiatric Morbidity Among Adults Living in Private Households: the Report of a Survey Carried out by [the] Social Survey Division of the Office for National Statistics on Behalf of the Department of Health, the Scottish Executive and the National Assembly for Wales.* London: The Stationery Office.

The strategic work programme outlined in this document aims to ensure services:

- are aware of the care needs of every person with a mental health problem (and the support required by their informal carers) that the service should be meeting
- put in place mechanisms to track how well needs are being met, and
- highlight any deficiencies which may have occurred so that they can be corrected.

**Working in Partnership**

A number of organisations, including the Mental Welfare Commission (MWC) and the Mental Health and Well Being Support Group (MHWBSG) have a role in the review of mental health services. There are other partners including the Care Commission, NHS Education for Scotland (NES) and the Social Work Inspection Agency (SWIA) and it is vital that the work we do complements what these organisations are doing and avoids over-burdening frontline staff.

The Scottish Executive is also committed to joint working and is taking forward the concept of joint inspection. We will actively participate as this develops.

We will continually look for opportunities to work with other organisations and we will concentrate on the areas where our approaches and the skills of our staff can add most value.

We are committed to involving local partner organisations in our work programme. Our agreed approach will link that work with other agencies to improve the capacity of the system to deliver high quality care.

In common with all other NHS Boards, we are committed to achieving and delivering an effective partnership with patients, carers and the public in all our work. Our *Patient Focus and Public Involvement Framework* was published in December 2003. We have recently appointed a patient public involvement officer to work specifically in the mental health field.

**Overarching principles**

Our strategic work programme is based on the following key principles:

- delivering services to meet the needs of users and their informal carers
- learning from past experience of implementing quality improvement initiatives
- developing a clear focus on the experiences of users and carers
- adopting a long term approach while focusing in the shorter term in supporting local mental health services to implement the *Mental Health (Care and Treatment) (Scotland) Act 2003*

- achieving consistency with the service elements template in the Scottish Executive Health Department's (SEHD) *A Framework for Mental Health Services in Scotland (1997)*
- applying, the recently published clinical governance principles developed by NHS QIS to mental health services
- dealing with the complex and difficult issues that have delayed implementation of change. This needs to be handled in a co-ordinated way with partner agencies to join up the work of all local service partners in support of quality improvement
- promoting responsibility among managers and the workforce to take charge of their own local processes of quality improvement
- creating a culture within services to ensure the collection, appropriate use and accurate communication of the right information to the right people at the right time.

These principles need to be shared by all the stakeholders involved in using and providing mental health services as they are integral to the improvement of all mental health services.

## 2 The NHS Quality Improvement Scotland approach

### Background

No single organisation can hope to provide all the services an individual with a mental health problem may require. Local services have to work in partnership, listening all the time to the continuing experience of service users, those who care for them and partner agencies. Despite the efforts of staff providing these services and some excellent innovations, there remains no shortage of reports into the problems of mental health service provision in Scotland. Many of these difficulties appear to lie within systems that are proving to be slow to change and adapt to meet the requirements placed upon them. One of the more recent reports is the *National Mental Health Services Assessment - Towards Implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 - Final Report*. It highlighted:

- the limited availability of emergency, crisis and specialist services, including psycho-social interventions
- the limited skill mix of treatment teams
- difficulty in shifting the balance of care from hospital services to community-based provision
- the frequent absence of adaptive and responsive management and leadership
- a greater emphasis on short term treatment rather than longer term recovery.

### Improving the situation

Mental health services are a key theme in the NHS QIS work programme, building on work developed by our predecessor organisations (see Appendix 4). Different approaches to quality improvement have been taken over the years and it became clear that work in this area was not yet linked together in a coherent plan. While we must learn from the experience of these different approaches, we recognise that if we are to assist in improving mental health services across Scotland, we must develop a cohesive and strategic work programme.

We intend to focus our activity on key areas where practice - or the lack of it - is known to have a detrimental effect on service quality. It will involve building on existing work we have done to roll out routine assessment of both the risks to and needs of users and informal carers across Scotland. The extent to which these identified needs have been met would then form the basis for a proxy routine measurement of outcome by implementing the following two key components:

- **Integrated Care Pathways** (ICPs) based on shared planning and meeting individuals' needs.
- To further develop and support the use of a range of tools to improve the **monitoring of outcomes** for individual users. These include audit processes and needs assessment tools, which incorporate the views of service users.

This approach depends on better information systems to standardise the delivery and recording of care processes which will help services measure how they are performing. We will work closely with the Information Services Division, the organisation with national responsibility for taking this forward within NHSScotland.

Experience shows that it remains very difficult to implement outcome measures in mental health in a way which is valid and acceptable. Currently there is very limited data collection in mental health. Although it is appreciated that the measurement of mental health problems is a complex matter, consensus on data collection is required for the service to move forward.

Some of this work, like the development of an information culture and ICPs, is already happening. We, however, require feedback from these developments to determine how we can use these to achieve the aim of improving the quality of mental health services.

## Integrated Care Pathways

The main focus of this new approach will be the establishment and quality assurance of locally agreed ICPs.

### What is an ICP?

An ICP is a specified outline of care, planned to help patients with a similar diagnosis or set of symptoms move progressively through their journey of care to achieve positive outcomes. The process of creating an ICP involves people from different professions working together to agree on what key elements of care should be provided at each stage of the patient's journey. The advice and experience of local service users and their informal carers is central to this process. An ICP will be based on evidence of effectiveness or, where that is not available, on what can be agreed to be good practice. How it is developed locally depends on the care partners agreeing how local services can meet individuals' requirements, using their expert knowledge of the resources available. The role, advice and experience of local service users, and their informal carers, is central to this work.

## Why an ICP?

The development of ICPs in mental health offers new opportunities for quality improvement which are under the control of local agencies. Their use as a tool is well developed in healthcare and they provide many benefits. An ICP can reduce duplication of work, improve communication, and clarify who does what, where and when. An ICP can also provide a valuable multidisciplinary record of care. One of the most valuable benefits of an ICP is that it can be used to record when important elements of care have been provided, and therefore highlight when some elements of care have been missed out. The reasons why some elements of care have been missed out can then be looked at, and actions taken when necessary. If such exceptions occur frequently, it suggests that changes in the way services are provided locally are required or that the ICP needs to be revised. The strength of this approach is twofold.

- Individual needs must be met by effective and consistent services. The process must also provide the evidence that local service providers require to adjust and improve services.
- Effective quality improvement demands that this is done on the basis of evidence of what is actually happening to the people being treated. It is important to start off building an ICP with a 'chunk' of the journey of care, to make the task achievable.

## National/Regional/Local

There can never be a national ICP as such, the contents and the responsibility for delivering them has to be a local matter. National organisations can help by collation of the evidence base, gathering of experience and the analysis of successful models.

In contrast to ICPs, Managed Care Networks (MCN) operate across different geographical boundaries and, therefore, usually at regional or national level. Managed Care Networks are slightly different from Managed Clinical Networks (which cover health only) as they work across health, social care and other agencies. In this document, MCN refers to Managed Care Networks.

The people responsible for a sequence of care pathways for the same problem in several localities could link together to form one MCN, perhaps involving a specialist centre for that condition. An MCN, unconstrained by these geographical boundaries can ensure equitable provision of high quality effective services, across the regions or nation.

## Co-ordinating the work on ICPs

Our role in NHS QIS will be in supporting people to develop their local ICPs, by providing information, developing any knowledge network that is

required, and working with (not taking the place of) existing national groups. We will develop a **quality assurance scheme** for local ICPs and will work with other partners to ensure implementation. Although ICPs have developed within health, they are about care. We would expect that it will become important to other agencies not only that a service has developed ICPs but also that it can demonstrate that quality assurance processes are in place and that these lead to improvements in services. In developing the quality assurance scheme we wish to closely involve organisations such as the Social Work Inspection Agency (SWIA) and the voluntary sector as partners. NHS QIS knows that, in mental health, crucial elements of care are provided by non-health organisations; our values make it explicit that care is about the whole person, and that person's recovery.

The appointment by NHS QIS of a National ICP Co-ordinator for Mental Health will allow us to co-ordinate the work of a national network to support and advise on the implementation of ICPs and develop a quality assurance programme throughout Scotland.

## Quality based 'outcomes'

Mental health outcomes do not fall into a traditional model of outcomes for other conditions. The perceived difficulties with measuring outcomes have meant that an important aspect of service provision – the extent to which service users have had their needs met – has not been taken into account systematically. Our approach is pragmatic; we do not believe that developments in this area can await a full evidence base. Therefore, NHS QIS will support the development of a range of approaches, including needs assessment tools, which can be used in a number of ways to support audit cycles.

During their first contact with mental health services all users (and, increasingly their informal carers) undergo some form of assessment of their needs in conjunction with the team. Identifying these needs is a key task, as it has implications for how much and what sort of resources the user is likely to require during his or her contact with the service. So far, this task has been dominated by a professional view on the user's situation, but this leaves many users with the feeling that issues have been missed or under-prioritised. For services to become more responsive this needs to change so that there is truly joint assessment of needs and a move towards outcomes based on the users view. Joint and multi-agency assessment of needs should be an integral component of locally agreed ICPs.

### Information

The success of an ICP is dependent on the availability of information systems which are easy to use and which allow the necessary information to be obtained as required. The Scottish Executive Health Department - Mental Health Division and the Improving Mental Health Information Programme

(iMHIP) are currently developing a Scottish Mental Health Information Strategy. We will continue to work with these organisations to promote and support the development of information systems, which will become essential for the establishment and quality assurance of locally agreed ICPs.

The Scottish Mental Health Information Strategy recognises that progress is required in three areas:

- Development of an **information culture** within care organisations that values teamwork, trusts data and respects colleagues' opinions, and appreciates the benefits of information gathering, use and sharing.
- Agreement on minimal **information sets** to be shared to support joined-up community care for individuals. There is work on standardisation of core information in encounter/intervention records, and information to support care transitions (referrals, discharges and transfers).
- Defining the core functions of electronic **information systems** to support delivery of mental healthcare. A high level functional specification has been developed and is being fed into local and national options appraisal, specification and procurement discussions.

We will continue to publish clinical indicators, and monitor the availability of robust data that will allow the development of indicators in mental health. We will also encourage other NHSScotland organisations to use such information appropriately and effectively – with the ultimate aim of improving the delivery and outcomes of patient care.

It is also proposed that we should seek to ensure that quality improvement processes are built in to the workings of mental health services within Community Health Partnerships (CHPs). This should focus on the key problem areas described in the *National Mental Health Services Assessment - Towards implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 - Final Report*.

**Our strategic work programme**

Our strategic work programme gives a context within which our activities can be developed with the aim of delivering better outcomes for those receiving mental health services. Although our remit extends only to the health service, we are fully aware of the important role played by other agencies in improving mental health services. We believe in the importance of involving all our partners in shaping future developments.

Our strategic work programme can be found in Appendix 2.

## 3 Measuring success

In order that our strategic work programme is successful, we will make use of our strong links with other organisations and groups. This will also require a clear commitment by NHS Boards, CHPs and partner agencies to the quality of mental health services. The development of an information culture, where up-to-date information is shared within agreed principles of confidentiality across service boundaries on the basis of a common data set is also necessary. Success will not just be an achievement for NHS QIS, but for everyone working in mental health in Scotland.

Key elements of success, as described in our strategic work programme will include:

- the establishment of locally agreed ICPs for each significant diagnostic group or stage in a treatment process to make each individual journey of care responsive to need
- supporting the development and implementation of a range of tools to support the monitoring and audit of outcomes for individual users of care
- evidence of good partnership working with other organisations.

We will specifically measure success using the indicators contained within the work programme (see Appendix 2). In addition, we will report regularly to services, our partner agencies and people in Scotland on our progress in delivering this work programme.

# 4 Appendices

## Appendix 1

## Background on NHS Quality Improvement Scotland

NHS Quality Improvement Scotland (NHS QIS) was established as a Special Health Board by the Scottish Parliament in 2003, in order to act as the lead organisation in improving the quality of healthcare delivered by NHSScotland. We do this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

Quality improvement means improving the services, care and the results of treatment provided to all people. To do this, we take account of the scientific evidence, the needs and preferences of service users, and the experience of health professionals.

All NHS organisations are accountable for continuously improving the quality of their service, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish. NHS QIS is committed to ensuring that systems for making sure that healthcare is safe and effective, care is patient-centred and that the public are involved are in place throughout the NHS. This is often referred to as clinical governance.

## Appendix 2

## NHS Quality Improvement Scotland Strategic Work Programme (Mental Health) 2005 – 2008

| Objective | Rationale | Indicators for Success | Timescale |
|---|---|---|---|
| **Strategic Work Programme** | | | |
| Implement NHS QIS Mental Health Strategic Work Programme. | Mental health services are a key theme in the NHS QIS work programme, building on work developed by its predecessor organisations. | • Appoint a Mental Health Clinical Advisor | Appoint by December 2005 |
| | | • Appoint a Patient Public Involvement Officer – Mental Health | Completed |
| | | • Establish internal NHS QIS Mental Health Team | Completed |
| **ICPs** | | | |
| Support the development of ICPs to improve the consistency of delivery and recording of care processes in mental health services. | There is a demonstrated need to improve the consistency of delivery and recording of care processes in mental health services. There is evidence that ICPs help address these issues. A quality assurance scheme would underpin this work. | • Appoint an ICP National Co-ordinator | Appoint by December 2005 |
| | | • Establish a national steering group to support and advise on the implementation of ICPs | Establish by March 2006 |
| | | • Work in partnership with the public and service to support the development of local ICP implementation plans | Commencing June 2006 |
| | | • Develop a quality assurance scheme for ICPs throughout Scotland | Develop and pilot in 2006/07<br>Implement in 2007/08 |

| Objective | Rationale | Indicators for Success | Timescale |
|---|---|---|---|
| **Outcomes** | | | |
| Develop and support the use of a range of outcome monitoring tools. | The use of tools to monitor outcomes provides information to improve the experience of individual service users. | • Publish Clinical Indicators on Mental Health | Scoping commenced in June 2005 |
| | | • Report the recommendations from the Scottish Schizophrenia Outcomes Study (SOSS) | Report by December 2005 |
| | | • Conduct seminar to inform NHS QIS' work in outcomes | Conduct by March 2006 |
| | | • Develop and support the use of :<br>- Needs assessment tools<br>- Outcome monitoring tools | Develop and pilot in 2006/07<br>Implement in 2007/08 |
| **National Audits and Reviews** | | | |
| Conduct relevant national audits and reviews. | National audits and reviews will inform the development of mental health services. | • Audit of services against the Scottish Intercollegiate Guidelines Network (SIGN) Guideline on Attention Deficit and Hyperkinetic Disorders | Report by September 2007 |
| | | • Audit of alcohol related presentations to Emergency Departments | Report by March 2008 |
| | | • Audit of Intensive Psychiatric Care Units | Commission in 2006/07<br>Report in 2007/08 |
| | | • Thematic review of services against *Clinical Standards for Schizophrenia* | Commence in 2007/08<br>Report in 2008/09 |

## Appendix 3

## Outcome of consultation

A draft strategic framework was consulted upon between April and June 2005. The framework together with a consultation response questionnaire was widely circulated by post, email and available on our website. During this consultation period, we also held a series of roadshows in Aberdeen, Dingwall, Edinburgh, Glasgow and Perth to provide a forum for interested parties to discuss the document with us.

Throughout the consultation period, comments were received from a wide range of individuals and organisations, including service users, carers, healthcare professionals, NHS Boards, voluntary organisations and professional bodies. All comments received were considered and we have made efforts to address these in this document. It is clear that there is a widespread ambition to improve the quality of mental health services, and many thoughtful points were made to us. NHS QIS can only achieve its aims by working with others in a system of quality improvement; we are very grateful to those who took the trouble to respond, and would wish to maintain a dialogue in the future as part of our work programme.

NHS QIS supports quality improvement in all mental health services – in the community, primary care, for the older person, for children and young people and for specialist services. Learning disability is the focus of a separate work programme. NHS QIS believes that the triple approach of care planning, outcome assessment and information mindedness is relevant to all these areas with appropriate modification to meet particular needs.

# Appendix 4

## Findings from previous NHS Quality Improvement Scotland work in Mental Health

### NHS QIS and mental health

Clearly, there are many challenges facing the service. Our role is to help identify the issues that require to be addressed and work with services to make improvements. Our work on mental health has so far included:

- the development of *Clinical Standards for Schizophrenia* in 2001
- two rounds of visits to review the performance by services against the *Clinical Standards for Schizophrenia*, leading to the publication of national reports in 2002 and 2004
- the assessment of tools for determining the needs of patients and outcome measurement (SSOS) between 2002–2005
- an audit of implementation, in 2003–2004, of the recent SIGN Guideline for *Postnatal Depression and Puerperal Psychosis* produced in June 2002
- the production of a Health Technology Assessment (HTA) on *Prevention of relapse in alcohol dependence* in December 2002
- the publication of a *Best Practice Statement for Admissions to Adult Mental Health In-Patient Services* in April 2004
- the production of a SIGN Guideline on *The management of harmful drinking and alcohol dependence in primary care* in September 2003, which was subsequently updated in December 2004
- the production of a SIGN Guideline on *Attention deficit and hyperkinetic disorders in children and young people* in June 2001, which was subsequently updated in August 2005
- support for the Scottish Electroconvulsive Therapy (ECT) Audit Network (SEAN) through three audit cycles, and for an information system to allow its work to continue.

**Schizophrenia**

A key element of this work in the field of mental health has been the reviews of the implementation of standards for the management of schizophrenia. A report into the second phase of the standards was published in June 2004. It found that progress is being made in a number of areas and there are many examples of good practice and innovative developments across Scotland.

However, service development continues to be held back in many cases by:

- a lack of accurate record keeping
- poor continuity of care
- incomplete care planning
- a lack of data

- insufficient support for carers.

The report also found wide variations across Scotland in the composition of community-based mental health teams and the range of skills they require to meet the assessed needs of service users.

Detailed performance against many of the standards was difficult to assess because of the lack of reliable, standardised information and fragmented systems of clinical recording. Another disappointment was the lack of priority given to the findings of the first schizophrenia overview in the accountability reviews of NHS Boards carried out by the SEHD. This resulted in a missed opportunity to focus attention on the action needed to address issues raised in the report.

It is important to learn from five years experience in developing and implementing a standards-based approach in mental health before embarking on any new initiative to take them forward. For sustained quality improvement, local systems need to become more responsive. That will require a national quality improvement approach that fosters the development of local initiatives – balancing a "top-down" (national) with a "bottom-up" (local) approach.

In addition, to the work with the Schizophrenia standards, we have funded the SSOS to look at ways of assessing the outcome of care for individuals with schizophrenia. One way was to look at an assessment of needs using the AVON Mental Health Measure (AVON), which was designed by service users. This comprehensively examined all the areas of an individual's life which could have an effect on mental wellbeing.

SSOS has demonstrated that the use of an assessment tool in this national project involving several hundred staff and service users, has enabled staff to have a better understanding of the needs of the people that they care for. This has led to continuous quality improvement of care for the service users. It has shown that service users, with a condition such as schizophrenia, can be involved, playing a full part in the process.

The key principles of the SSOS methodology are a sound base on which to build:

- **Understanding** – it was essential that key-worker clinicians understood the key aims of the study
- **Nurturing -** a culture of quality improvement with a multidisciplinary team approach to the care process
- **Explicit -** what clinicians were asked to do had to be seen to make a difference to care planning
- **Relevant** – only clinically relevant information was collected
- **Achievable -** it had to be able to be done within routine daily practice without too much disruption

- **Involvement** – service users were given the opportunity to express their views on their needs and have them taken account of. It was also important that staff felt involved and valued within the process.
- **Education** – the process was rigorously underpinned by continuing support, education and training
- **Benchmarking** – clinicians had to understand the importance of benchmarking between local, regional and national practice
- **Dissemination -** regional and national meetings were a focus for information sharing and networking

This project included incorporating a process focused on determining the needs of service users within a minimum data set, and has been supported by education and training. The process has been nurtured, driven forward, and sustained through the means of a central support function.

This culture of working can be generalised locally throughout mental health services and form part of an ICP process that can ensure continuous quality improvement.

**Adult Mental Health In-Patient Services**

In April 2004, a *Best Practice Statement for Admissions to Adult Mental Health In-Patient Services* was produced. The statement offers guidance to nurses within adult mental health acute in-patient services, the emphasis throughout is on multiprofessional working and collaboration. The importance of communication, access to and the sharing of information across services and disciplines is crucial in attaining best practice for patients entering these services and is echoed throughout the statement.

**Postnatal Depression**

Following production of the SIGN Guideline for *Postnatal Depression and Puerperal Psychosis*, a project was carried out to investigate current policy and practice relating to the detection and management of postnatal depression across Scotland. This project set out to establish the extent to which current policies and 'front-line' practice follow the recommendations detailed in the SIGN Guideline.  Through the process, the project aimed to establish the minimum standard for ICPs in postnatal depression. (The existence of the project has helped to stimulate the development of ICPs across Scotland for the management of perinatal mental health problems).  The final report of this project will be published in winter 2005.

**Alcohol**

Following the production of the HTA, *Prevention of relapse in alcohol dependence* and the SIGN Guideline, *The management of harmful drinking and alcohol dependence in primary care,* NHS QIS continued its commitment to this

earlier work on alcohol by forming a small working group to look at the need for an NHS QIS approach to quality improvement for alcohol services.

This group organised a successful conference in December 2004 to discuss the pressing quality improvement issues for alcohol problem treatment services. As a consequence of the event and subsequent discussions with the working group, several recommendations were made. Including the inclusion of alcohol related problems to the next NHS QIS Clinical Outcome Indicators and the identification of training needs to implement the HTA and SIGN Guidelines.

Meanwhile advantage has been taken of an opportunity to conduct a survey which will quantify the current impact of people with alcohol problems on accident and emergency (A&E) departments in Scotland, and to relate existing practice to what is known to be effective. This will show how links with other services, statutory and non-statutory may be improved.

**Attention Deficit and Hyperkinetic Disorders (ADHD) Audit**

Following the publication of the SIGN Guideline, *Attention deficit and hyperkinetic disorders in children and young people*, June 2001, and the *Health Indicators Report – A Focus on Children*. An audit, using the SIGN Guidelines as a benchmark, of the care and treatment provided throughout Scotland for children with ADHD will be carried out in the next two years.

**Clinical Indicators in Mental Health**

Mental health has been a topic in a number of our Clinical Outcome Indicators and Health Indicators reports. Examples of areas covered include anxiety and depression in the postnatal period, prescribing rates for ADHD (as described above) and the number of inpatient psychiatric (and non-psychiatric) episodes due to alcohol abuse.

## Appendix 5

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# Appendix 6

## Glossary

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| **A&E** | Accident and Emergency Department. |
| **accountability review** | The method by which NHSScotland can systematically demonstrate to the Scottish Executive its performance locally, and as a whole. |
| **acute care** | Where a patient is treated for an acute (immediate and severe) episode of illness, injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually given in a hospital by specialised personnel using complex and sophisticated technical equipment and materials. Acute care is often necessary for only a short time. |
| **Attention Deficit and Hyperkinetic Disorder (ADHD)** | ADHD is a clinical syndrome, characterised by difficulty in sustaining concentration, hyperactivity and impulsiveness. |
| **acute sector** | Hospital-based health services which are provided on an inpatient or outpatient basis. |
| **AVON** | AVON Mental Health Measure. |
| **benchmarking** | Use of a standard or point of reference for the purpose of comparison, usually in the context of improving performance. |
| **best practice statements** | Statements of best practice focus on specific aspects of care. They are usually developed after wide consultation, taking into account a broad range of views from health professionals. |

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| **Clinical Standards Board for Scotland (CSBS)** | The Clinical Standards Board for Scotland was a statutory body, established as a Special Health Board in April 1999. Its role was to develop and run a system of quality control of clinical services designed to promote public confidence that the services provided by the NHS met nationally agreed standards, and to demonstrate that, within the resources available, the NHS was delivering the highest possible standards of care. On 1 January 2003, CSBS was merged, along with four other clinical effectiveness bodies, to form NHS Quality Improvement Scotland (NHS QIS). See NHS Quality Improvement Scotland. |
| **Community Health Partnerships (CHPs)** | These seek to integrate the work of primary and secondary care and integrate health and social care services. Resources and decision making are devolved to frontline health and social care professionals with the aim of their working jointly with a picture of care recognisable from the patient's point of view.<br><br>Website: www.show.scot.nhs.uk/sehd/chp/index.htm |
| **Confidentiality and Security Advisory Group for Scotland (CSAGS)** | A group consisting of members from various professional bodies whose remit is "to provide advice on the confidentiality and security of personal health-related information to the Scottish Executive, the public and to health care professionals".<br><br>Website: www.show.scot.nhs.uk/csags/ |
| **data set** | A list of required and specific information. |
| **diagnostic** | The process of determining the nature of a disorder by considering signs and symptoms. |
| **Electroconvulsive Therapy (ECT)** | Electroconvulsive Therapy is a physical treatment for depressive illness, during which a brief electrical stimulus is given to the brain. |
| **Health Technology Assessment (HTA)** | Health Technology Assessment is a process used by NHS QIS to advise NHSScotland about a specific health intervention (eg medicine, equipment or diagnostic test). |

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| **Improving Mental Health Information Programme (iMHIP)** | The programme supports the development and implementation of mental health policy in Scotland. Its main tasks are to: make current data and resources more accessible; prepare a mental health information strategy for Scotland and an implementation plan; to build an information culture by involving service users, carers and professionals who are interested in information; to agree minimal information sets (information bundles) to be shared to support joined-up care for individuals; and review and make recommendations on the information systems required (including mobile access).<br><br>Website: http://www.isdscotland.org/imhip |
| **Information Services – NHS National Services Scotland** | Information Services is part of NHS National Services Scotland. Health service activity, manpower and finance data are collected, validated, interpreted and disseminated by the Division. This data is received from NHS Boards, NHS Trusts and general practices.<br><br>Website: www.isdscotland.org |
| **Integrated Care Pathways Users Scotland (ICPUS)** | An established network of NHS staff from all over Scotland, who are using integrated care pathways in many different clinical areas.<br><br>Website: www.icpus.ukprofessionals.com |
| **integrated care pathway (ICP)** | An integrated care pathway is an explicit agreement by a local group, both multidisciplinary and multi-agency, of staff and workers to provide a comprehensive service to a clinical or care group on the basis of current views of good practice and any available evidence or guideline. It is important that the group agree on communication, record keeping and audit. There should be a mechanism to pick up when a patient has not received any care input specified by the pathway so that the omission can be remedied. The local group should be committed to continuous improvement of the integrated care pathway on the basis of new evidence of service developments or of problems in implementation. |
| **intervention** | Healthcare action intended to benefit the patient. |
| **ISD** | See Information Services – NHS National Services Scotland |

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| **managed care network (MCN)** | Similar to managed clinical network but involving health, local authorities and other staff. See managed clinical network. |
| **managed clinical network** | A formally organised network of clinicians. The main function is to audit performance on the basis of standards and guidelines, with the aim of improving healthcare across a wide geographic area, or for specific conditions. Each managed clinical network is required to have a Quality Assurance Framework describing the standards the service will meet. The Framework has to be accredited by NHS QIS, and an annual report on progress is also required. |
| **Management Executive Letter (MEL)** | Management Executive Letter (now known as Health Department Letter (HDL)) |
| **Mental Health (Care and Treatment) (Scotland) Act 2003** | A major overhaul of mental health legislation designed to bring improved rights for users of mental health and learning disability services and their carers in Scotland.<br><br>The new Act provides:<br><br>1 New rights and safeguards for people with mental disorders and new and extended duties on NHS boards and local authorities providing services to them.<br><br>2 New, fairer procedures for the compulsory treatment of people with mental disorders.<br><br>3 Fairer and safer procedures in relation to people with mental disorder within the criminal justice system. The Act is due for implementation in October 2005.<br><br>Website: www. scotland-legislation.hmso.gov.uk/ legislation/scotland/acts2003/20030013.htm |
| **Mental Health and Well Being Support Group (MHWBSG)** | The Mental Health and Well Being Support Group was formed on 31 March 2000. The Group's aim is to support service users, carers and organisations to advance strategic developments that will help improve the nation's mental wellbeing and mental health services.<br><br>Website: www.show.scot.nhs.uk/mhwbsg |

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| **Mental Welfare Commission (MWC)** | An independent organisation set up by Parliament with the responsibility of protecting the welfare of people with mental disorder (including learning disabilities and dementia) in Scotland. The Commission has a duty to anyone with a mental disorder whether they are in hospital, local authority, voluntary run or private accommodation or in their own homes. The Commission's work includes visiting people in hospital and in the community, investigating cases of deficiency in care or treatment, and providing information and advice.<br><br>Website: www.mwcscot.org.uk |
| **Millan principles** | In 1999, a Committee chaired by the Rt Hon Bruce Millan was asked to review the Mental Health (Scotland) Act 1984. Its comprehensive report, New Directions, was published in 2001, and included a framework of principles to underpin metal health law.<br><br>Website: www.scotland.gov.uk/health/mentalhealthlaw/millan/Report/rnhs-08.asp |
| **minimum data set (MDS)** | A minimum set of information related to a specific medical condition - may include demographic, clinical management and outcome data. |
| **National Assessment of Mental Health Services (2004)** | A Scottish Executive assessment of the current ability and readiness of the partner agencies to implement the new provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003. The report was published after wide-ranging consultation.<br><br>Website:<br>www.scotland.gov.uk/library5/health/mnhsaf01.asp |
| **NHS Board** | NHS Boards are responsible for the strategic planning, service delivery, performance management and governance of each of Scotland's 15 local health systems. |

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| **NHS Education for Scotland (NES)** | NHS Education for Scotland is a Special Health Board, whose role is to help provide better patient care by designing, commissioning, quality assuring and, where appropriate, providing education, training and lifelong learning for the NHS workforce in Scotland.<br><br>Website: www.nes.scot.nhs.uk |
| **NHS Quality Improvement Scotland (NHS QIS)** | NHS Quality Improvement Scotland is a statutory body, established as a Special Health Board in January 2003. Its role is to focus on improving the quality of patient care and the health of patients. It has a particular emphasis on the quality of care and the patient journey for vulnerable groups.<br><br>Website: www.nhshealthquality.org |
| **outcome** | The end result of care and treatment and/or rehabilitation. In other words, the change in health, functional ability, symptoms or situation of a person which can be used to measure the effectiveness of care and treatment, and/or rehabilitation. |
| **patient journey** | The pathway through the health services taken by the person who is receiving treatment, and as viewed by that person. |
| **pharmacological** | Relating to the properties of drugs and their effects on the body. |
| **primary care** | The first point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively, delivered through general practices. Primary care services are the most frequently used of all services provided by the NHS. Primary care encompasses a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners. |
| **psychological** | Relating to human behaviour. |
| **psychosocial** | Involving both psychological and social aspects. |

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| **reciprocity** | One of the Millan principles. Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion. |
| **risk assessment** | A systematic process to determine risk management priorities through finding out the frequency of an outcome, and its consequences. |
| **Scottish Executive Health Department (SEHD)** | The Scottish Executive Health Department is responsible for health policy and the administration of NHSScotland.<br><br>Website: www.show.scot.nhs.uk/sehd |
| **Scottish Mental Health Information Strategy** | See entry for Improving Mental Health Information Programme (iMHIP) |
| **Scottish Schizophrenia Outcomes Study (SSOS)** | The Scottish Schizophrenia Outcomes Study is a national study which aims to monitor the outcomes of care for service users with schizophrenia.<br><br>Website: www.schizophrenia-outcomes.org |
| **Scottish Electroconvulsive Therapy (ECT) Audit Network (SEAN)** | A network of healthcare professionals with an interest in audit of ECT.<br><br>Website: www.sean.org.uk |
| **secondary care** | Care provided in an acute sector setting. See acute sector. |
| **social work services** | Social work services provide advice and practical help for problems resulting from social circumstances. A social worker is a person who has obtained a professional qualification in social work. A social worker supports vulnerable people and their carers, including people who have mental health problems, with the aim of enhancing the quality of all aspects of their daily lives. |

| **Social Work Inspection Agency (SWIA)** | The Social Work Inspection Agency is an independent Executive agency, whose role is to inspect all social work services in Scotland, and report publicly and to Parliament on the quality of these services, locally and nationally.<br><br>Website: www.swia.gov.uk |
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