Mental Health Project
Final Report
November 2007

National Benchmarking Project
Report 2
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# Contents

1. Foreword .......................................................... 3

2. Executive Summary ............................................. 4

3. Principal Recommendations ................................. 5

4. Strategic Overview .................................................. 6

5. Project Principles, Objectives and Approach ............ 7
   5.1 Performance Measures for Delivery of Mental Health Services ................. 8
   5.2 Mental Health Service Definitions ........................................ 9
   5.3 Existing Data ......................................................... 9
   5.4 Costing .......................................................... 16
   5.5 Capability Scoping .................................................... 17
   5.6 Information Systems and Information Sharing ................................. 18

6. Findings and Recommendations ............................ 19

7. Acknowledgements .............................................. 22

8. Bibliography ..................................................... 23
1. Foreword

Over the past eighteen months many people involved in using and delivering mental health services have worked together to decide what is needed to measure and compare in order to achieve better patient/client experience of care, better outcomes from the care received and best value for the tax payer. This work has not only enabled the development of a shared vision, but more importantly allowed us to determine how we will start to develop a picture of what is working and what is not based on information and evidence to achieve improvement. I would like to thank all those who have taken the time and effort to contribute to this work.

This report will be of interest to everyone working in mental health services and to those who use mental health services. The work to date has been frontline led and going forward will be managed locally and supported nationally. The report explains what benchmarking mental health services hopes to achieve, how it will go about it, and how we will know if it has succeeded. Our approach is a long-term strategy requiring the support and involvement of patients, clients, carers and health and social care professionals. Over the course of the next three to four years we all will be refining and developing this work through the implementation of the recommendations described in the report. I commend this report to you.

Shona Robison MSP
Minister for Public Health
2. Executive Summary

The objective of the Mental Health Benchmarking Project is to support the improvement of mental health services from a basis of a common understanding of the current position. Our approach is to use a range of comparative information to:

- compare key aspects of performance:

<table>
<thead>
<tr>
<th>Quality</th>
<th>patient experience and health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency</td>
<td>how resources are used and managed</td>
</tr>
<tr>
<td>Sustainability</td>
<td>whether the functions provided by services are appropriate, sufficiently sized and appropriately positioned to meet the needs of local communities in the medium and longer term</td>
</tr>
<tr>
<td>Cost</td>
<td>resources are limited and so best value must be achieved from current investment.</td>
</tr>
</tbody>
</table>

- identify gaps in performance
- identify how improvement can be achieved
- implement improvement
- monitor progress and review benefits.

It is estimated that one in four adults in Scotland will experience some form of mental health problem in any given year. Depression, anxiety and stress are together the single largest reason for presenting to health services. Twenty-five to thirty percent of all General Practitioner consultations involve depression, stress or anxiety. Mental health services are delivered through the NHS and local authorities in partnership with the voluntary sector and independent sector. NHS Boards are responsible for those with health problems either in community or acute settings, whilst local authorities are responsible for securing social care and support and other mainstream services supporting recovery in the community.

There are just over 6,000 mental health beds provided for a range of functions (acute, rehabilitation etc.) and age groups in Scotland, but this is reducing annually. Mental health services are delivered by approximately 7,000 registered nurses working in both primary and acute care, just over 1,152 psychiatrists (including consultants and doctors in training) and around 1,098 psychologists. Social workers, voluntary sector personnel and other allied healthcare professions also make up a significant part of the workforce. Informal carers contribute a wide range of support in addition to the identified workforce.

Expenditure on mental health services was in the region of £660.9 million for Health and £84.7 million for local authorities during 2005/06. We want to look at where efficiency change could be made, that could be re-directed back into other aspects of the mental health service. For example, if we were to agree to achieve a 5% efficiency change across the NHS spend this would be in the region of £35 million. We could work towards this over a 3 to 5 year timeframe.

This benchmarking work is aligned to the high level generic outcomes framework for primary and community care being developed by The Joint Future Implementation Advisory Group. The two work streams are complementary to each other and supported by the Mental Health Outcomes Costing Pilot work described in this report.
3. Principal Recommendations

Improving mental health services successfully is dependant on staff and stakeholders owning, understanding and using mental health information to deliver improvement. From the work we have done, we conclude our challenge is to develop ‘good enough’ recording and reporting systems in the first instance that may only partially meet the needs of all the stakeholders (Government, Health Boards, staff, service users, general public), whilst developing a clear vision of the final shape of what is needed to support benchmarking and continuous improvement.

In order to deliver valid and effective measurable improvement, a range of preparatory work is required to achieve meaningful comparisons. **We recommend:**

1. **Implementation is achieved through the funded National Mental Health Improvement Programme and governed through a Mental Health Benchmarking Implementation Group (MHBIG) that would work with NHS Boards and stakeholders to deliver the actions detailed in the table on page 19 of this report.**

2. **The implementation of the draft service definitions detailed in the Technical Appendix to this report with all partners working to develop and agree joint definitions for mental health services and functions.**

3. **Boards and partners work to align costs with the service definitions and functions.**

4. **The adoption and development of the draft mandatory measures based on a balanced scorecard approach to performance improvement. To achieve this Boards with partners should:**
   - undertake a systematic review of information systems and their use locally giving an initial priority to mandatory measures that focus on national priorities via the national commitments and targets for mental health
   - draw up an implementation plan to address the gaps
   - develop local scorecards with partners to address local needs and priorities.

**Note:** the scorecard measures may need refinement for specific mental health services e.g. children and young people.

5. **Boards focus on measurable improvement for example by reducing antidepressant prescribing, changing the pattern of antidepressant prescribing and reinvesting savings in psychological therapies, moving the balance of care from inpatient to community, and reducing the level of hospital readmissions as we believe there is scope nationally, to achieve more efficient and focused use of mental health resources of up to 5% over 3 to 5 years. The potential for improvement in any particular area will vary from Board to Board.**

Details of findings and the supporting recommendations can be found in the table on page 19.
4. Strategic Overview

Mental Health is one of the three national priorities for the NHS in Scotland. The direction of travel and the need for change for mental health are exactly the same as for physical health.

Specifically we would like to see:

- better anticipation and delivery of care for those who are ‘at risk’ of mental illness
- increased appropriate mental health services for those living in the most disadvantaged communities
- increased support for self care
- better management of admission to, and discharge from, hospital
- full utilisation of the skills and expertise of those who work in our mental health services to deliver better care.

The Mental Health (Care and Treatment) (Scotland) Act 2003 became effective on 5th October 2005. In addition to providing three main compulsory powers of detention, the Act legislates on the following principles:

- non-discrimination, respect for diversity, equality, reciprocity, child welfare, respect for carers, least restrictive alternative, ensuring benefits, and an informal, participatory approach.

To comply with the Act and legislation around discrimination, robust patient centred data and information that cuts across professional and organisational boundaries, particularly health and social services is required. Benchmarking data can inform and support effective efficient compliance with the law.

This strategy map shows an overview of the key components for effective delivery of mental health objectives.
5. Project Principles, Objectives and Approach

The principle objective of the Mental Health Benchmarking project is to improve mental health services by using benchmarking to understand and compare services and their outcomes and to promote best practice.

The Mental Health Benchmarking and Measurement Group through a core team undertook the following in conjunction with partners involved in the delivery of mental health services:

- assessment of the availability and use of mental health information
- developing a common set of mental health service definitions
- developing a Balanced Scorecard Approach to performance
- evaluation of current mental health information system implementations
- evaluation of the role of information in joint mental health planning.

These actions were set out to ensure continuous improvement in mental health services by identifying and quantifying the steps required to phase the implementation of a fit for purpose benchmarking approach and infrastructure that would:

- enable the identification of the cause and effect behind significant performance variances
- establish a common understanding of how change can be achieved
- establish pathways to achieve practical improvements.

A Balanced Scorecard Approach was adopted as this is an inclusive approach that aligns and channels the energy, ability and specific know-how held by staff in the organisation towards achieving strategic goals. Balanced scorecards comprise a suite of measures across different domains (e.g. Quality, Efficiency, Finance, Future) in order to provide a balanced overall view of performance.

Principles of the balanced scorecard

- a strategic management and measurement system that links strategic objectives to comprehensive indicators
- a unified, integrated set of indicators that measure key activities and processes at the core of an organisation’s operational environment
- takes into account a combination of “hard” financial measures and “soft” quantifiable operational measures
- these can include: patient, internal, and innovation and learning perspectives
- using the different categories provides a rounded balanced scorecard that reflects organisation performance more accurately ...
- helps managers focus on their mission ...
- and helps motivate staff to achieve the strategic objectives.
5.1 Performance Measures for Delivery of Mental Health Services

Two stakeholder days were held to determine the measures required to manage mental health services effectively. A balanced scorecard of measures was produced and refined through consultation over the period of the project:

**Mental Health Overview Whole System Scorecard**

<table>
<thead>
<tr>
<th>Cost</th>
<th>Patient Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total spend for mental health per 1,000 population</td>
<td>Use of the AVON validated tool to measure patient needs and promote recovery oriented practice</td>
</tr>
<tr>
<td>% community spend/Total spend</td>
<td>Mortality rates for severe and enduring mentally ill population per 1,000 population</td>
</tr>
<tr>
<td>Total mental health drug costs per 1,000 population</td>
<td>% re-admissions &gt; 7 days/total admissions</td>
</tr>
<tr>
<td>Persons on incapacity benefit/severe disablement allowance with a mental health diagnosis per 1,000 population</td>
<td>% delayed discharges</td>
</tr>
<tr>
<td></td>
<td>Suicide rates per 1,000 population</td>
</tr>
<tr>
<td></td>
<td>% carer involvement/those who have a carer</td>
</tr>
<tr>
<td></td>
<td>% of voluntary inpatient/inpatients subject to compulsory treatment by Board</td>
</tr>
<tr>
<td></td>
<td>% of people on community CTOs/total known to the Community Mental Health services</td>
</tr>
<tr>
<td></td>
<td>Patient safety and risk management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total psychiatric beds per 1,000 population</td>
<td>Training/supervision index</td>
</tr>
<tr>
<td>% A&amp;E presentations with a mental health and/or substance misuse diagnosis/total A&amp;E presentations</td>
<td>Information quality and capture</td>
</tr>
<tr>
<td>Average time to assessment and time to intervention</td>
<td>Use of mental health information</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>Number of accredited Integrated Care Pathway (ICP) standards implemented with 100% collection of prescribed datapoints</td>
</tr>
<tr>
<td>Total mental health staff numbers per 1,000 population by psychiatrists, AHPs, nurses, psychologists, social workers, MHOs</td>
<td></td>
</tr>
</tbody>
</table>
5.2 Mental Health Service Definitions

A draft glossary of definitions for mental health services has been developed in conjunction with all partners and has undergone wide consultation. These definitions will form the first step in achieving a consistent picture of what services are currently delivered and are framed around what a comprehensive mental health service might look like in terms of primary care mental health, early intervention, crisis, assertive outreach, and voluntary sector provision as well as in-patient services. Further work will be undertaken to develop full joint definitions with Local Authority and other partners.

This service level information can then be disclosed at various meaningful levels, e.g. Community Health Partnership (CHP), Board and national level and is vital to support consistent and meaningful comparisons.

5.3 Existing Data

Data is available at national level but is of insufficient coverage, relevance and reliability to provide an accurate picture of mental health services across Scotland. High level metrics derived from this data shows variability across Scotland but there are gaps in terms of what we need to know to measure and manage performance effectively. Examples of currently available data matched to the balanced scorecard are shown in the following table (see Technical Appendix for further details).
### Mental Health Project

#### Cost

<table>
<thead>
<tr>
<th>NHS Board Area</th>
<th>Total expenditure (£) per 1,000 population (Arbuthnott) for General Psychiatry Services</th>
<th>Community spend as a percentage of total spend for General Psychiatry Services</th>
<th>Total Gross Ingredient Cost (£) per 1,000 population (Arbuthnott) for Medicines used in Mental Health (BNF categories)</th>
<th>Incapacity Benefit/ Severe Disablement Allowance claimants with a mental health diagnosis per 1,000 population (Arbuthnott)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Argyll &amp; Clyde</td>
<td>153,923</td>
<td>22.79</td>
<td>21,283</td>
<td>-</td>
</tr>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>126,629</td>
<td>29.89</td>
<td>17,032</td>
<td>23.56</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>140,552</td>
<td>31.83</td>
<td>15,617</td>
<td>17.11</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>117,812</td>
<td>33.65</td>
<td>17,036</td>
<td>16.63</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>108,991</td>
<td>22.44</td>
<td>18,105</td>
<td>23.53</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>134,119</td>
<td>32.61</td>
<td>18,286</td>
<td>24.00</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>157,909</td>
<td>33.65</td>
<td>19,122</td>
<td>23.42</td>
</tr>
<tr>
<td>NHS Greater Glasgow</td>
<td>150,044</td>
<td>31.80</td>
<td>17,793</td>
<td>35.04</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>126,695</td>
<td>23.04</td>
<td>15,901</td>
<td>16.62</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>97,894</td>
<td>29.14</td>
<td>20,789</td>
<td>30.22</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>164,080</td>
<td>24.37</td>
<td>18,252</td>
<td>27.32</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>72,640</td>
<td>60.11</td>
<td>13,517</td>
<td>9.85</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>36,015</td>
<td>87.44</td>
<td>11,294</td>
<td>12.93</td>
</tr>
<tr>
<td>NHS Taylorside</td>
<td>159,922</td>
<td>32.30</td>
<td>19,062</td>
<td>22.77</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>125,437</td>
<td>6.42</td>
<td>10,026</td>
<td>9.20</td>
</tr>
<tr>
<td>Scotland</td>
<td>139,435</td>
<td>31.91</td>
<td>18,516</td>
<td>26.68</td>
</tr>
</tbody>
</table>

#### Patient Quality

<table>
<thead>
<tr>
<th>NHS Board Area</th>
<th>Re-admissions (%)</th>
<th>Delayed Discharges (&gt;= 6 weeks) (%)</th>
<th>Crude suicide rate per 1,000 population (Arbuthnott)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Argyll &amp; Clyde</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>31.80</td>
<td>4.63</td>
<td>7.95</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>33.43</td>
<td>6.95</td>
<td>9.76</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>30.38</td>
<td>0.55</td>
<td>4.26</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>30.54</td>
<td>1.09</td>
<td>11.81</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>27.51</td>
<td>3.87</td>
<td>10.81</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>30.02</td>
<td>6.93</td>
<td>8.84</td>
</tr>
<tr>
<td>NHS Greater Glasgow</td>
<td>32.15</td>
<td>2.02</td>
<td>12.63</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>33.40</td>
<td>5.80</td>
<td>5.51</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>31.08</td>
<td>1.34</td>
<td>4.20</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>35.38</td>
<td>2.47</td>
<td>9.29</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>29.03</td>
<td>-</td>
<td>0.19</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>19.05</td>
<td>-</td>
<td>0.10</td>
</tr>
<tr>
<td>NHS Taylorside</td>
<td>27.19</td>
<td>3.23</td>
<td>5.33</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>34.19</td>
<td>12.39</td>
<td>9.00</td>
</tr>
<tr>
<td>Scotland</td>
<td>31.81</td>
<td>3.15</td>
<td>9.00</td>
</tr>
</tbody>
</table>

#### Efficiency

<table>
<thead>
<tr>
<th>NHS Board Area</th>
<th>Total beds per 1,000 population (Arbuthnott) for Mental Health Specialties (adjusted for cross-boundary flow)</th>
<th>Average length of stay (days)</th>
<th>Nurses per 1,000 population (Arbuthnott) for Mental Illness</th>
<th>Psychologists per 1,000 population (Arbuthnott) within Mental Health</th>
<th>Mental Health Officers per 1,000 population (Arbuthnott) within Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Argyll &amp; Clyde</td>
<td>1.64</td>
<td>83.38</td>
<td>2.16</td>
<td>0.04</td>
<td>-</td>
</tr>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>0.92</td>
<td>108.40</td>
<td>2.16</td>
<td>0.03</td>
<td>0.16</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>1.17</td>
<td>34.49</td>
<td>2.16</td>
<td>0.06</td>
<td>0.17</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>1.06</td>
<td>52.86</td>
<td>2.16</td>
<td>0.04</td>
<td>0.12</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>1.27</td>
<td>127.87</td>
<td>2.16</td>
<td>0.03</td>
<td>0.13</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>1.22</td>
<td>83.85</td>
<td>2.07</td>
<td>0.03</td>
<td>0.08</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>1.23</td>
<td>114.37</td>
<td>2.07</td>
<td>0.03</td>
<td>0.15</td>
</tr>
<tr>
<td>NHS Greater Glasgow</td>
<td>1.14</td>
<td>78.74</td>
<td>2.07</td>
<td>0.03</td>
<td>0.10</td>
</tr>
<tr>
<td>NHS Highland</td>
<td>0.92</td>
<td>61.59</td>
<td>2.07</td>
<td>0.03</td>
<td>0.17</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>1.15</td>
<td>71.90</td>
<td>2.07</td>
<td>0.03</td>
<td>0.10</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>1.41</td>
<td>66.81</td>
<td>2.07</td>
<td>0.03</td>
<td>0.13</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>-</td>
<td>-</td>
<td>2.07</td>
<td>0.03</td>
<td>-</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>-</td>
<td>-</td>
<td>2.07</td>
<td>0.03</td>
<td>-</td>
</tr>
<tr>
<td>NHS Taylorside</td>
<td>1.17</td>
<td>110.72</td>
<td>2.07</td>
<td>0.03</td>
<td>0.11</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>1.00</td>
<td>96.10</td>
<td>2.07</td>
<td>0.03</td>
<td>0.10</td>
</tr>
<tr>
<td>Scotland</td>
<td>1.21</td>
<td>85.34</td>
<td>2.01</td>
<td>0.05</td>
<td>0.12</td>
</tr>
</tbody>
</table>
Deprivation and urbanisation/rurality are key drivers of the need, configuration and mix of mental health services. The following maps reflect these drivers against which the metrics on page 10 can be considered.
Within Scotland, total expenditure for General Psychiatry Services was £139,435 per 1,000 population. Lothian experienced the highest rate and Shetland the lowest at £164,080 and £36,015 per 1,000 population respectively. Community spend ranged from £8,057 per 1,000 population in the Western Isles to £67,623 per 1,000 population in Greater Glasgow.

Medicines used in Mental Health: Prescribing rates for Scotland and England during the financial period 2003/04 to 2005/06

This graph presents the prescription rates for selected drugs used in mental health from 2003/04 to 2005/06. The use of anti-depressants and hypnotics/anxiolitics is significantly higher in Scotland when compared to England. However, over the years, the use of anti-psychotics in Scotland has declined by nearly 4%, whilst England has increased by 4%.
Scotland has 2.01 nurses per 1,000 population. Orkney and Shetland have the lowest levels at 0.22 and 0.30 per 1,000 population. Figures for psychologists and mental health officers (MHOs) are at a much lower rate compared to nurses. Scotland has 0.05 psychologists and 0.12 MHOs per 1,000 population.

Note: MHO figures are the responsibility and control of the local authorities and are shown against Boards for information purposes only.

### Consultant Psychiatrists split by post and NHS Board Area as at April 2007

This graph illustrates consultant psychiatrists per 100,000 population by post and Board Area. Overall, 2005/06 has witnessed a small increase in consultant establishment. Grampian has the highest establishment figures, equating to 12.20 consultants per 100,000 population.
Consultant Psychiatrists split by Speciality as at April 2007

Looking at consultant psychiatrists by speciality shows us that overall, there were more consultants working within the specialties when comparing 2005 and 2006. The General Adult specialty is the highest at 211.8 WTE, a 4.3% increase on last year.

Staff Grade and Associate Specialists split by post and NHS Board Area as at April 2007

This graph displays staff grade and associate specialists per 100,000 population by post and Board area. Lanarkshire and Borders show the highest establishment rates at 4.87 and 4.46 per 100,000 population respectively.
This graph illustrates the percentage of readmissions by Board area. Across Scotland, readmissions were 31.8%, with the highest percentage in Lothian (35.4%) and the lowest in Shetland (19.1%).

The average length of stay in Scotland was 85.3 days. Fife had the highest average length of stay at 127.9 days, which is 50% greater than the Scotland figure. Delayed discharges were 3.2% for Scotland. Dumfries & Galloway had the lowest percentage at 0.55%, whilst the Western Isles figure was 12.4%.
5.4 Costing

Costs and activities are not meaningfully matched for mental health services, which results in difficulty in making accurate judgements about best value of services. Non-financial information will need to be developed and aligned with financial data. This is likely to require commitment and investment by local and national partners and the development of a clear framework around which this information can be developed.

Costing information is required to: inform leaders, managers, employees, patients and the public about the financial implications of re-designed services, new investment and their relationship with measurable user outcomes. It will become increasingly important in the field of public performance reporting.

The diagram below shows how service definitions, service functions and outcome measures will be aligned with costing information.

NHS Greater Glasgow and Clyde and NHS Forth Valley with partners are undertaking an exercise to match financial information to the work done on service definitions and the non-financial measures.
5.5 Capability Scoping

During April to July 2007 visits were made to all mainland Boards and associated local authority partners and a video conference held with one Island Board. The purpose of the exercise was to:

- communicate the purpose and objectives of the Mental Health Benchmarking and Measurement Project
- seek Board input to current activities
- assess locally available mental health information
- evaluate mental health system implementations
- evaluate the role of information in joint mental health planning.

Key issues which emerged were as follows:

Approach to Performance Improvement

There was strong support for a Balanced Scorecard Approach to comparative performance in mental health services. Boards and partners have expressed an interest in developing multi-partner balanced scorecard approaches to performance in mental health services.

Consistent Definitions

There was broad consensus on the draft service definitions with the main areas requiring further clarification around the specific functions carried out in these areas.

Responsibility and Accountability for Improvement

Boards and local authorities do not collect and report data in a consistent manner, e.g. health and local authorities categorise differently. In addition, information/data gaps also exist, e.g. community activity.

There was consistent understanding around the beneficial role of reporting to achieve improvement but in general the approach was ad hoc and the credibility of the exercise undermined by weaknesses in the data integrity.

Generally, there were few high level management reports available at frontline/client facing functions, with a broad range of approaches to management reporting at local level for mental health services both for NHS Boards and NHS Boards and partners. There are incomplete and inconsistent approaches to the provision of feedback on improvement activities.

Many Boards and local authorities however, are able to produce a wide range of local reports, including both some standard reporting and a wide variety of ad hoc reports. Reports generated include information about:

- Waited and Waiting Times
- Bed management/utilisation
- Admissions/Discharges
- Contacts
- Referrals
- Occupancy
- Risk Assessments
- Critical Incidents
- Team/Community Activity
- Joint reporting – Single Shared Assessment, Joint Performance Framework
- Clinical/Staff Governance reports

In one Board, six localities/joint teams provide information on activity every six weeks to the Mental Health Partnership Board, which is used to look at training and local issues.

Mental health services across Scotland are delivered through a range of management and accountability structures with some undergoing change over the period of the visits. These structures are major influencing factors on the range and level of reports in use.
There was wide variability in the amount, purpose and focus of information used in the planning and delivery of mental health services.

Further information regarding good practice can be found in the Technical Appendix.

**National Information**

There were concerns from those delivering mental health services that the Scottish Health Services Cost Book does not encompass all the relevant, direct, indirect, resource transfer and community costs and that the data is not comparable.

There was a lack of national information on quality and patient satisfaction.

**Data Quality**

We found that data quality is varied across the service and that this is related in part to individual practice and recording. Some of the issues with respect to data quality are as follows:

- **Provisional Status of National Returns**
  Problems of validating and returning records locally on a timely basis leads to incompleteness of the national returns. This impacts on the time period, which can be selected for analytical purposes.

  Further information regarding the status of national returns can be found in the Technical Appendix.

- **Data Validation**
  The level of data validation varies between Boards and partners. Most Boards use a mixture of systems such as PCSMR and PiMS to validate data, however, other additional checking/validation is inconsistent. Quality issues arise from the conflict between the actual inputting of data into the mandatory fields by clinicians and the need to perform other duties i.e. clinical/workload priorities.

  - **CHI Compliance**
    Most Boards have good CHI compliance but none achieve 100%.

    Further information regarding CHI compliance can be found in the Technical Appendix.

- **Timeliness**
  The timeliness of updating information varies between Boards and local authorities. Common themes that have emerged relate to:
  - Capacity issues
  - Clinical commitments
  - Lack of mobile technology
  - Dual records, i.e. electronic and paper based
  - Individual practice and recording
  - System limitations/difficulties.

  Competing clinical pressures on frontline staff were cited as the major barrier to timely updating of information for mental health services.

**5.6 Information Systems and Information Sharing**

A multitude of systems (information and IT) exist within and between Health Boards and local authorities. These systems have different levels of functionality and are used by various members of staff. The systems range from paper based manual systems, computerised real time/other systems and a variety of ad hoc databases.

There are system limitations that constrain the sharing of health and social care information between Boards and local authorities. This issue is further compounded by incompatibility of IT systems, i.e. they do not link with each other.

No Board or partnership has a fully integrated comprehensive system.
6. Findings and Recommendations

The following table details these findings, the required actions and timescales for completion.

<table>
<thead>
<tr>
<th>Findings</th>
<th>Recommendations</th>
<th>Responsibility</th>
<th>Timescale</th>
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<tr>
<td>National Data</td>
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<td><strong>F1</strong> Classification and description of current mental health services is patchy and suffers from a lack of common definitions of similar types of services making it difficult to make meaningful comparisons. There is strong support from Boards and partners for the adoption of common definitions for mental health services.</td>
<td><strong>R1</strong> NHS Boards classify and quantify their services using the service definitions detailed in the Technical Appendix to this report. <strong>R2</strong> Local Authority, social work, and voluntary organisations are equal partners with the NHS in contributing to the wellbeing, health and services provided to individuals with mental health problems. We recommend the work on service definitions and functions be extended into a comprehensive joint social work, health and partners listing.</td>
<td>NHS Boards</td>
<td>April 2008</td>
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<td><strong>F2</strong> Nationally available data does not currently reflect the way in which the service is delivered. The majority of mental health services are delivered in the community but the national data does not fairly reflect this.</td>
<td><strong>R3</strong> Core definitions of mental health service functions are developed and mapped to the range of services and associated resources being delivered and planned across Scotland. The new national clinical/social data standards developed and piloted to cover community encounters/interventions (ICIC) would provide the basis for the work.</td>
<td>MHBIG</td>
<td>April 2009</td>
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<td><strong>F3</strong> The Scottish Health Services Cost Book does not encompass all the relevant direct, indirect, resource transfer and community costs and the data is not comparable, as services are described and managed differently in each Board with their respective partners from local authorities and other organisations.</td>
<td><strong>R4</strong> Boards and partners align costs with mental health activities using a consistent methodology across all NHS Boards and partners through the recommendations of the Mental Health Costing Pilots in Greater Glasgow and Clyde and Forth Valley, which are being undertaken in conjunction with partners. <strong>R5</strong> MHBIG update the presentation and disclosure of mental health activities and costs in the Scottish Health Services Cost Book to fully reflect mental health service delivery and outcomes from the work undertaken in the costing pilots.</td>
<td>MHBIG</td>
<td>April 2009</td>
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## Findings

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<td><strong>F4</strong> There are gaps in the areas of quality and patient satisfaction, which are critical areas for service improvement.</td>
<td><strong>R6</strong> The quality and patient satisfaction measures in the mandatory scorecard are developed and adopted.</td>
<td>MHBIG</td>
<td>April 2009</td>
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<td><strong>F5</strong> There is wide variability as to the completeness and timeliness of the submission of national data by Boards, which results in relatively out of date comparisons.</td>
<td><strong>R7</strong> We recommend NHS data is sent timeously to ISD, analysed and reported on and social work data sets from supporting people, and local areas (e.g. Care First) are analysed and reported on in conjunction with NHS data by MHBIG.</td>
<td>NHS Boards and MHBIG</td>
<td>April 2008</td>
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<td><strong>F6</strong> There is also variation as to the completeness and timeliness of local data at partnership level, which results in inconsistency between parts of the system and long lead times before a meaningful review of information can be undertaken locally. A combination of competing clinical commitments, lack of streamlining and integration of information systems were found to be constraining factors at local level.</td>
<td><strong>R8</strong> Adoption of the draft definitions for health and development of joint definitions for health and partners will support integrated planning, reporting and performance management as will recommendation R7.</td>
<td>Boards and partners</td>
<td>September 2008</td>
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<td><strong>F7</strong> Boards demonstrated differences in the capability of local information systems in terms of capture and reporting of information across partners, which meets users needs. There is currently no information system, which is considered fully fit for purpose.</td>
<td><strong>R9</strong> Coding of the datasets, which will flow from work on definitions and functions into systems currently in use and those undergoing development, will allow extraction and presentation of data on an integrated basis. Our work on the capability visits has confirmed that some systems do have the capability of supporting the necessary dataset. Some Boards are already creating joint data warehouses and/or joint systems to allow information sharing and enhance the integrated approach.</td>
<td>Boards and partners</td>
<td>To be confirmed</td>
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<td><strong>F8</strong></td>
<td><strong>R10</strong> In the medium to long term, existing systems should be improved or new systems developed in line with the National IM&amp;T strategy, that will adopt a whole system approach and to allow systems to link into each other.</td>
<td>MHBIG</td>
<td>To be confirmed</td>
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### Findings and Recommendations

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<th>Reporting and Improvement</th>
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<td><strong>F8</strong> We found that data quality is varied across the service and that this related in part to individual practice and recording. Boards highlighted that information in support of the Mental Health Act should be improved and streamlined.</td>
<td><strong>R11</strong> While it is recognised that regular dissemination and review of information will lead to improvement in the quality of the data, all Boards should achieve a focus on improving data quality by undertaking an audit to identify gaps in data quality and implementing an action plan to address the gaps. The requirements from all areas of relevant legislation should be specifically addressed. It is expected that a systematic transparent approach to data quality checks and use of exception reporting highlighting missing codes, outliers, and shifts in activity etc. would form part of the plan.</td>
<td>NHS Boards</td>
<td>September 2008</td>
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<td><strong>F9</strong> Generally there were few management reports available at frontline/ client facing functions, with a broad range of approaches to management reporting at local level for mental health services both for NHS Boards and joint reporting for NHS Boards and partners. There are incomplete and inconsistent approaches to the provision of feedback on improvement activities.</td>
<td><strong>R12</strong> Boards should adopt a local reporting framework using the Balanced Scorecard Approach in support of accountability frameworks where performance is reported at Board, CHP, joint team and individual practitioner level. MHBIG will support Boards in developing the mandatory national indicators shown (see page 8). This approach will also support the performance management structure that has been put in place by the Mental Health Delivery Plan Implementation Board and will feed into the reviews that are undertaken with Boards, local authorities and others twice a year and the annual accountability reviews that Ministers undertake each summer. Boards should develop local reporting frameworks using the same approach to focus on local priorities. Suggested measures, which can be used, are shown in the Technical Appendix, Appendix C.</td>
<td>NHS Boards and MHBIG</td>
<td>April 2009</td>
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<td><strong>F10</strong> Boards and partners have expressed an interest in developing multi-partner balanced scorecard approaches to performance in mental health services.</td>
<td><strong>R13</strong> It is recognised that the scope of mental health services is very wide and so, specific scorecards developed in the context of the high level mental health scorecard may be required for specific aspects of the service e.g. perinatal services.</td>
<td>MHBIG</td>
<td>As required</td>
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7. Acknowledgements

The Mental Health Benchmarking Core Steering Group would like to thank the many individuals within NHSScotland, the local authorities and the voluntary and independent sectors who have supported and contributed to this piece of work.

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