



## What?

The fourth annual meeting of the Improving Mental Health Information Programme<sup>1</sup> (iMHIP) was held in Glasgow on 15 Nov 2005.

## Why?

The meeting was arranged to allow delegates to:

- Understand why improving mental health information is so important.
- Share experience and hear about each other's progress.
- Discuss how to implement the Mental Health Information Strategy for Scotland.

## Who?

130 delegates attended from a range of backgrounds (including service users, informal carers, care professionals, managers and policymakers), and from across Scotland.

## To learn more

- For a summary of key points raised at the meeting please see the next page.
- A fuller report follows on the succeeding 12 pages.
- The PowerPoint presentation slides shown at the conference are available at the iMHIP website (see <http://www.isdscotland.org/imhip05>).

*Karen Brown and Alastair Valentine Philp, Improving Mental Health Information Programme, 4 April 2006*

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<sup>1</sup> See <http://www.isdscotland.org/imhip>

## Summary of key points

- Service users would like to participate more actively in their own treatment and recovery, and feel that the information held is aiming at and encouraging recovery.
- The role of significant people looking after the patient should be taken into account as they require information and support.
- The introduction of a useful clinical information system in mental health will require training to support a change of culture in most organisations.
- Having access to information by both care providers and users fosters a culture of transparency – people have less to fear if they can see what information is being held about them.
- In a more ideal world there would be ready access to reliable, quality, information to plan individual care.
- Using record linkage to join up existing data streams adds value to existing data.
- Electronic shared care records should offer tangible benefits to care practitioners. For example they should make it easier for care professionals to do a better job by making sure information is to hand.
- Information to support care should be person-centred, support team-based care, referrals and transfers of care, and only be available to those who need-to-know.
- Unless information is seen to be useful locally and therefore has local ownership, collecting it will be an uphill struggle and it won't be used to support quality improvement.
- Give service users adequate information and support to identify their own needs and help. Ownership of information allows empowerment and recovery.
- There's a need for continual training and user education (for those who require access to the evidence) in the use of e-library and other relevant databases, and lots more publicity regarding existing sources of evidence/training courses.
- Establishing a set of mental health and well-being indicators for Scotland will be important for monitoring the state of mental health and well-being of the population, and assessing trends.
- Delivering for Health can only be realized with the support of solid information. The eHealth Agenda is designed to provide robust IT for NHSScotland but the main challenge will be to change the culture so that all professionals feel confident in capturing and sharing clinical information in a secure electronic environment. We all have a role in this endeavour.
- To change services for the better we must value information and have a desire to collect, use and share it. We must recognise how vital it is to recognise the importance of outcomes and measure them.

## Opening Remarks

Rod Muir opened the meeting with a few introductory remarks welcoming delegates and setting the conference in context.

## Reminder - Why we need to do this and what'll it be like if we succeed

Six presentations were given in this session. Each was a personal perspective of how things are, with the information we have got, and how they could be, if we had better information. The hyperlinks are to their slide presentations on our website (<http://www.isdscotland.org/imhip05>)

- Service user - [Trish Burnet](#) – Service User Involvement Coordinator, SAMH
- Informal carer - Carol Gortmans - NSF Scotland
- Consultant psychiatrist - [James Hendry](#), NHS Lothian
- Voluntary agency - [Charlie McMillan](#) - Director of Policy, SAMH
- Local service manager - [Christina Naismith](#) - Joint Programme Manager, Mental Health, City of Edinburgh Council/ NHS Lothian
- Public health and planning - [Cameron Stark](#) - NHS Highland

### Trish Burnett – Service User Involvement Coordinator

Trish opened by saying that there is a need for a shift in the way we view mental health information: how might we change this in a way desired by service users?

Current experience of information by service users includes:

- Stigma of a 'psychiatric' label. They feel they are treated less equitably for physical health issues, as their symptoms are not taken seriously. A mental health 'label' also affects other aspects of life including insurance, driving, and employment opportunities.
- Diagnosis may not convey the affects a condition has on everyday life.
- Fears for confidentiality and an uncomfortable feeling sometimes that information has been shared inappropriately. There is a high turnover of staff and thus a lot of people accessing records. Over a 10-year period, patients will be seen by hundreds or even thousands of staff.
- Feeling of little/no involvement in what information is held and how to change any incorrect information.

In order to change this situation, service users would like to participate more actively in their own treatment and recovery, and feel that the information held is aiming at, and encouraging, recovery. Users would benefit from more information on access to services and an increased level of clarity on who needs to see what information and why.

Recovery should be promoted, and this should be reflected in the definitions used for outcome measures, e.g. living well despite symptoms.

It is important to build a culture of person-centred care planning.

### Carol Gortmans – informal carer – NSF Scotland

From the initial diagnosis, whether the role of the carer is short-lived or long-term, it is vital for the carer to understand what is going on. Useful information includes that on diagnosis and medication and this can be accessed, for example, through leaflets. Hospital and community service information is also useful but how access for carers to this can be problematic. For example, when searching for information on mental health on the internet, information on the history of hospitals and new parliamentary bills may be found, but not the relationship between services and people, which is what is important for the carers to know. The role of significant people looking after the patient should be taken into account, as they require information and support.

People's views on how good mental health services are varies across Scotland. There have been developments of improved services through advances in technology, and the new Mental Health Act should further enhance services. The National Programme for Improving Mental Health and Well-Being and the anti-stigma campaign are seen as positive by carers in Scotland and there are some areas where integrated care pathways are in place at a local level. For the carer it is necessary to access a number of strands of information and multi-layered information.

### **James Hendry - Psychiatrist, NHS Lothian**

James Hendry's presentation was about emphasising the need to improve the records held about patients: from paper to electronic; from incomplete to complete; and from inaccessible to accessible. He began by outlining the current situation: case records are rarely complete or up to date; it is difficult to find either the record or information in it; and as a paper record they are difficult to communicate and bulky. Integrated care pathways are also incomplete and are separate from the record, requiring extra time for 'double entry'. He noted that (the rare) electronic records have mandatory fields, which do not allow omissions.

Management information he said exists in a parallel universe and is also inaccurate and incomplete. This leads to poor planning. Although clinical information is the most vital priority this must be put together to form the management information.

The 'brave new world' future is to have up to date electronic patient records, easily accessible and not requiring duplication; and automatic recording of clinical information, with audit at the touch of a button.

The introduction of a useful clinical information system in mental health will require training to support a change of culture in most organisations.

### **Charlie McMillan – Director of Policy – SAMH: Voluntary sector**

Charlie opened by stating, "information is power". If information is power, and if users have access to information held about them, it can help to foster hope and recovery. He went on to say that

- Confidentiality is of paramount importance, but is often used as an excuse to withhold information when it would be more beneficial to be shared.
- Having access to information by both care providers and users fosters a culture of transparency – people have less to fear if they can see what information is being held about them.
- Sharing information with other agencies and providers improves partnership working and understanding.
- Access to good quality information challenges current practice and promotes equality and diversity. For example, having information about sexual orientation and ethnicity enables resources to be targeted appropriately and challenges public perceptions.
- Access to good quality information also enables services to set current and future priorities.

### **Christina Naismith – Joint Programme Manager, Mental Health Edinburgh Council/ NHS Lothian**

Christina started by considering how things are now:

- Patchy local and national information.
- Overemphasis on inpatient activity and quantitative data.
- Poor links with social care data – do not support integrated working.
- Management information is variable and time consuming.
- Poor record keeping and poor sharing of information.
- Limited IT equipment and skills despite a lot of training.
- Lack of shared definitions and methods of collecting data.
- Still no agreement on core national indicators.
- New demands stretch existing systems and staff, e.g. advance statement requirements for mental health act.
- Different local and incompatible systems resulting in lack of consistency, little robust aggregated information and poor service user involvement.

She then went on to consider how things would be in a (more) ideal world.

- Ready access to reliable quality information.
- Good information available for planning individual care 24/7.
- Agreed national datasets across health and social care
- eHealth and eGovernment integrated national approach.

- Ongoing investment in up-to-date software and training.
- Patient/ service-user-held records so people would have control over their information.
- People need to be clear why they are providing information and the care professionals need to be clear why they are asking for information.
- Sharing information and improving information across agencies.
- A culture that values information.

### **Cameron Stark – Consultant in Public Health Medicine, NHS Highland: Public health and planning**

Cameron's aims were to discuss:

- What information is currently available
- How we can add value to the current data
- How this can be done

He opened by presenting examples of current data on inpatient episodes of alcohol misuse, depression, dementia, and schizophrenia. From these data it could be seen that alcohol misuse and schizophrenia had a low number of admissions but a high number of bed days. However, from the data it is not possible to see the information on patient history, information about people identified in primary care or outcomes.

In a second example, Cameron showed that, using a specialised graph called a control chart, it is possible for NHS Highland to view variations of mental health out-patient referral rates by practice size across Highland. This is helping planning for Community Health Partnerships.

Cameron suggested three things to improve current data so that patterns of service use can be assessed:

- Using record linkage to join up existing data streams. This adds value to existing data.
- Develop additional common datasets, including outcomes.
- Collect community well-being information.

Incentives may be needed for clinicians to improve the quality of data recording.

### **Discussion**

Questions were invited and a GP asked if we should be moving to all patients having ownership of their own records. Charlie McMillan replied that we should be moving away from paternalism and think about why we want the information. Christina Naismith agreed that we have to move away from paternalism but pointed out that as organisations we have to be accountable and so are required to collate information on what we are doing. This, though, cannot be separated from knowing why we are doing it.

Carol Gortmans suggested that there is a weakness on general information on hospital services. However, there are pockets where the information required is available.

Jean Johnston (former carer) commented that there needs to be continuity within cases. Attention needs to be directed to both the patient and the carer. Carers can provide important information.

### **Update on iMHIP actions**

#### **Alastair Philp, Improving Mental Health Information Programme (iMHIP)**

Alastair opened by acknowledging the many contributions of members of the iMHIP programme team and then described the aims and strands of the programme. Over summer 2005 a consultation had taken place on a draft Mental Health Information Strategy for Scotland<sup>2</sup>. Alastair spoke briefly about the vision and components of that strategy and summarised feedback from the consultation that encouraged us to:

- Develop local leadership and ownership. Draft an implementation plan setting priorities, and committing resources.

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<sup>2</sup> See [http://www.isdscotland.org/imhip\\_MHIS](http://www.isdscotland.org/imhip_MHIS)

- Concentrate on information to allow integrated individual's care, and data derived from this to support quality improvement, planning and service management.
- Maintain close links with eHealth to deliver information systems.
- Facilitate public debate on the balance between confidentiality and security, and information to improve the connectedness of care.
- Emphasise the multi-agency context within which mental health operates, with clear links with eCare.

We continue to raise awareness of the importance of an information-valuing culture where care providers are persuaded of the need to collect share and use information. Information sets<sup>3</sup> such as the Information Core for Integrated Care (ICIC; to allow collection and sharing of patient data on encounters and interventions among members of a community specialist team) and a psychiatric inpatient discharge summary are being developed and tested. And work continues with the eHealth programme<sup>4</sup> to ensure that mental health benefits from work to design and procure information technology systems across all client groups in NHS Scotland.

Alastair's slides are available at <http://www.isdscotland.org/imhip05>.

## Workshops

A series of parallel workshops followed to allow delegates to explore who needs to do what next-

1. Developing an information culture: leadership and ownership
2. Building standard information sets and systems to support joined-up care
3. Information to support quality improvement
4. Information for users, carers and care providers on conditions/interventions and services
5. Aiding access to the evidence base

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<sup>3</sup> See [http://www.isdscotland.org/imhip\\_icic](http://www.isdscotland.org/imhip_icic).

<sup>4</sup> See <http://www.ehealth.scot.nhs.uk>

## **Workshop 1: Developing an information culture: leadership and ownership**

Two groups discussed this topic. This report incorporates strands of both discussions.

In pondering how to develop an information culture - one where there is a desire to collect, share and use information to deliver better services - a number of organisational levels were considered and recommendations made:

### ***Front-line care-delivery***

What would encourage people to collect, share and use information?

- Develop IT skills and confidence to use systems by training and improving access for all to IT.
- Avoid duplication of data entry.
- Ensure people who are delivering and documenting care value the information they are responsible for providing to colleagues. They need to understand what the data is for, the aims of the data collection and the benefits of the data collection to their own service. Such ownership is vital.
- Electronic shared care records should offer tangible benefits to care practitioners. For example they should make it easier for care professionals to do a better job by making sure information is to hand along with contact details. They should work to support practitioner/patient interaction and be intuitive, for example look like a case note.
- Development of systems should involve those who will use them. Current tools are widely viewed as inadequate to the core task of supporting individual practitioners in their task of interacting with people (clients and colleagues).
- Use technology appropriately and yet in novel ways, i.e. texting reminders.
- Systems should be simple and effective. It should be easy to collect data and get data out as reports.
- Present information as a core component of continuously improving care delivery
- Compel data collection.

### ***Local Service Management Level***

What needs to be in place?

- Effective change management is needed across all levels.
- Local champions of data needed.
- Management time and support is needed to support this culture shift.
- Investment in the infrastructure.
- A belief that most management planning, reporting and public health information can be derived from aggregated information from anonymised individual records.

### ***National Level***

What solutions should be taken forward? How can we inform and influence the decisions at national level?

- Investment of staff time and money is needed to ensure good quality information is held and kept up to date.
- Resources are needed for training and IT skills development.
- We need agreement of what data should be collected for national purposes and clear understanding of how this will be derived from local data without duplication. We require to shift the balance from gathering data for national reporting to collecting information to support individualised care.
- Consistency of what is collected across Scotland is needed. If possible data should be gathered using unified systems across social work, health and local government and using single specifications for information systems and standardised all-Scotland datasets.

## **Workshop 2: Building standard information sets and systems to support joined up care**

The group explored this topic under three main headings.

### ***What information should we gather and share with whom and when?***

Information to support care should:

- Be person centred.
- Contain likes/ dislikes, and advance statement.
- Identify partners/ protocols to sharing information.
- Be collected once, and used many times.
- Support referrals and other transfers of care.
- Be up to date.
- Only be available to those who need-to-know.
- Document patient consent (informed) and capacity to give consent.
- Be separated into different levels, with different levels of access.
- Only be derived from valid and reliable tools.
- Be valued as a way of supporting team-based care.

### ***Barriers to implementation***

- Change and resistance to change.
- Lack of clear guidance and protocols.
- Infrastructure and IT.
- Lack of time and perceived benefits for individual practitioners.
- Unconverted leadership.
- Lack of IT skills/ training and access to training.
- Concern about erosion of roles / professional rivalry/ lack of trust.
- Money.
- Getting mental health voice heard at the top table.

### ***How can we overcome barriers?***

- Clear guidance on information sharing/ access to records - where do we draw the line in what should be shared?
- Local ownership of information.
- Training issues (local training if possible).
- Local champions (buy-in for care practitioners).
- Flexibility in tackling knock-on effects.
- Progress in information sets/ standards/ culture at same time.
- Appropriate technology (e.g. mobile devices like personal digital assistants (PDAs)/ palmtops that suit mobile working patterns.
- Adequate hardware/ infrastructure.
- Money.
- Pro-active change management.
- Modernisation.

### **Workshop 3: Information to support quality improvement**

The group raised a number of issues, which we have grouped under three headings as follows:

#### ***Local focus and ownership***

- Unless information is seen to be useful locally, and therefore has local ownership, collecting it will be an uphill struggle and it won't be used to support quality improvement.
- We need to be clear about whether we are aiming for local responsiveness (ownership/ making a difference to our service) or standardisation (imposed values/ theirs, not ours). Different NHS boards and different professions have different cultures and histories. Unnecessary standardisation may threaten their autonomy.
- Need to involve a wide range of participants.
- National definitions for some information, to allow local benchmarking.

#### ***What does 'better' look like: what information do we need***

- What should we measure?
- How will we recognise better?
- How will we know a change is an improvement?
- What information do we need to collect to show things are better?
  - Social data
  - Easy-to-collect data
  - Information for patients
  - Service users views: is their experience better?
- Where are the current gaps in information? How do we join information streams up?
- There is a temptation to do nothing because we don't yet have a perfect system. However we never will. We need to make a start and improve as we go.

#### ***Supporting people to improve quality***

- People need to want to improve.
- We must manage anxiety about change
- Investment in baseline assessments is required.
- We need clinical leadership (and clinical leaders).
- Staff training and consistency of approach are important.
- Conclusions from studies must lead to action.
- Learning must be shared.

## **Workshop 4: Information for users, carers and care providers on conditions/ interventions and services**

Two groups discussed this topic. This report incorporates strands of both discussions.

### ***Topics for information***

- People often have other needs as well as mental health problems, e.g. special needs or learning difficulties. There is often a lack of information for these groups of people.
- Information must recognise service users as people rather than diagnoses or statistics. Mass media (TV, radio, newspapers) can be used to reduce the stigma of people trying to obtain information.
- Consultation with carers is important – in particular when patients are being discharged. Carers are placed at the sharp end of trying to obtain information, which is not always accessible.
- Hospitals need to pass on information on medication/ways of supporting patients.
- People need differing types of information, and at different levels, depending on their circumstances.
- The Mental Health Information Strategy has been discussed and consulted upon but who is to do what to implement it?
- We need to increase the skills of GPs for signposting to self-help websites

### ***Accessibility, reliability and co-ordination***

- Users need to know where to go for help – not just GP.
- Information needs to be clear and not use jargon.
- Information on where to go for help must be kept up to date.
- A good combination of types of information should be available e.g. paper, internet, in person, at the hospital.
- Carers feel overlooked in mental health - they can provide info to service users too
- Information for users, carers and professionals on conditions and services should be coordinated. In order to improve practice we should look at existing models that work i.e. communication between hospitals and community voluntary services.
- Accessing information can be troublesome, if people do not know how to do this or where to get the information from.
- We should look at ways of making information as accessible as possible. For example some people may not be able to leave their homes.
- The internet should be used more in the provision of information. For example:
  - Message boards
  - Localised information
- More joint working is needed.

### ***Empowerment***

- Service users should be given adequate information and support to identify their own needs and help. Ownership of information allows empowerment and recovery.
- Users needs are key – all other professionals need to share their language. There are too many differences in language across different professions.
- Patients should be seen as partners, and important sources, in preparing information. How can resources be coordinated? Involvement of service users and carers needs to be consistent.
- Examples of good practice exist, including Breathing Space and the Lanarkshire website.
- Successful projects should be rolled out to other areas.

## **Workshop 5: Aiding access to the evidence base**

The group discussed a wide variety of issues. These are summarised under three main headings.

### ***Information sources***

A wide variety of sources were mentioned. These included:

- SIGN
- Hospital Library
- NHS e-library and managed clinical / knowledge networks
- Mental welfare commission
- Search engines e.g. Google
- ISD
- Other databases i.e. Cochrane Collaboration
- Practice based evidence

### ***Reasons people are searching for evidence?***

- Current value placed on evidence base.
- Onus on professionals to be more knowledgeable.
- Degree courses.
- Mentoring students on placement.

### ***Information challenges in looking for evidence***

- Information is rarely presented in ways that make it easy to access and use. Quick answers are often required because of time constraints.
- It can be hard to get to a computer with internet access to access eLibrary and other electronic ways of searching the evidence base.
- Time, away from patients, to look things up is severely constrained. Often people are searching for information in their own time, at home. While this is appropriate if they are undertaking further study or education, it isn't for routine decision support.
- The masses of information retrieved can be hard to make sense of. Teaching in critical appraisal skills is considered essential to make sense of the literature. Lack of knowledge in information retrieval skills is a barrier to retrieving meaningful results.
- More databases which aid the practitioner in evaluating the evidence are needed e.g. Cochrane, clinical evidence, evidence-based-medicine journals etc.
- We often over-estimate computer skills possessed by staff.
- How can we recognise which information is bad or wrong? Some information is not trusted, e.g. from drug companies.
- There's a need for continual training and user education (for those who require access to the evidence) in the use of e-library and other relevant databases, and lots more publicity regarding existing sources of evidence/training courses.

## National progress

### Mental well-being indicators,

#### **Jane Parkinson, Public Health Adviser, NHS Health Scotland**

Jane's work is a support activity of the Scottish Executive's Programme for Improving National Health and Well-Being<sup>5</sup> and she began by laying out that programme's aims. As part of their current work they wish to develop a set of defined, national, sustainable mental health and well-being indicators for Scotland. These will be used to provide a summary mental health profile for Scotland, to monitor trends in Scotland's mental health and well-being, to inform decision-making and to compare Scotland with other countries.

The stages of the mental well-being indicators work are:

1. To determine a desirable set of defined indicators.
2. To review data currently held nationally e.g. routine data collections and national surveys.
3. To identify a set of practical indicators that are currently collectable.
4. To recommend new data to fill information gaps.
5. To explore and develop data collection systems for desired indicators where they do not currently exist and to ensure the sustainable collection of both current and new data

Jane has already reviewed data collected nationally, which includes; other indicator sets in existence and being developed to measure for example quality of life and well-being; data from routine administrative sources; 4 large national surveys (Scottish Health Survey, Scottish Household Survey, Scottish Crime & Victimization Survey, and Scottish House Condition Survey); and a public attitudes to mental health survey. She then spoke in more depth about useful data for the indicators available from each of the four large national surveys (see her slides<sup>6</sup> for details).

She went on to discuss how we can better measure mental health and well-being. There are a number of already-existing positive mental health and well-being scales but one that adequately captures positive mental health is needed. A promising one is the Affectometer 2, which is currently being validated for UK use. Affectometer 2 is a 40-item positive mental well-being scale developed in New Zealand. It covers 10 areas: confluence, optimism, self-esteem, self-efficacy, social support, social interest, freedom, energy, cheerfulness, and thought clarity.

Other areas which are being considered for development of indicators include: emotional intelligence, healthy living, positive relationships, spirituality, skills & learning, mental health problems, social support, working life, mental health promoting environment and violence.

The main challenges for the future of this programme of work are to find ways of filling gaps between the data currently collected and the data which is required for the full indicator set. And to work on how to build data collection methods that are sustainable (to allow us to track trends across the years) and allow data to be disaggregated to small enough local areas. Attention is also being given to special sampling to allow analysis of effects of cultural diversity.

### **New eHealth strategy – what does it mean for Mental Health**

#### **Kenneth Robertson, Clinical lead for eHealth, Scottish Executive**

Kenneth opened by saying that no aspect of care is possible without reliable, robust information. The report from the Kerr committee – *Building a Health Service fit for the future*<sup>7</sup> – strongly endorses that view but was critical of the speed of implementation of information systems to support care. Ken strongly recommended the recently published strategy for the future of NHS Scotland - *Delivering for Health*<sup>8</sup> produced in response to *Fit for the future*. He continued by commenting that while other clinical areas get IT money, mental health does not always. He said that because of this the mental health community were lucky to have the Improving Mental Health Information programme led by Alastair Philp.

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<sup>5</sup> See <http://www.wellscotland.info>

<sup>6</sup> See <http://www.isdscotland.org/isd/files/Parkinson.ppt>

<sup>7</sup> See <http://www.scottishexecutive.gov.uk/Publications/2005/05/23141307/13104>

<sup>8</sup> See <http://www.scotland.gov.uk/Publications/2005/11/02102635/26356>

We are on the way, in Scotland, to a single patient record. This is defined as being one record per patient covering all medical details, and not the ability for all database users to see all a person's details at once. The 'generic clinical system toolkit'<sup>9</sup> is a step towards this.

It will be impossible to guarantee complete confidentiality in this system, but we should continue to punish those who transgress. It can be difficult to pin down exactly who will need access to the data, as we don't always know who requires information to support their care of a patient. Apart from the registered NHS users there are also voluntary groups, who might legitimately need access to some of the information. We should beware of over-complex models of restricting access for these reasons. We should however restrict information as far as possible and we will need a secure sign-in system.

Although there are risks, the benefits to joined-up patient care of such information systems outweigh them. The use of aggregated and non-identifiable data for secondary purposes of service management and planning will also be a benefit. We need to work to persuade service users and care providers that this vision deserves their support. Alastair Philp and colleagues have already been very active in exploring this

In response to questions the following points were made:

- Historically, not all the money earmarked for information systems was actually spent on them.
- To support multi-disciplinary working, organisations have been given guidance on how to share data between them.
- Guidance from the General Medical Council has sometimes appeared more of an obstruction to achieving these aims than the Data Protection Act.

### **Improving Mental Health Information: links with national mental health policy?**

#### ***Geoff Huggins, Head of Mental Health Division, Scottish Executive Health Department***

Geoff described the commitments made in *Delivering for Health* in relation to mental health. These will be taken forward by a National Delivery Plan for Mental Health, which will be published by the end of 2006. In preparing that plan we need to:

- Ensure commitments are deliverable with the resources we have.
- Not just concentrate on services.
- Focus on improving physical health and well-being of those with mental illness through work on smoking cessation, diet and physical activity (anticipatory care).
- Take forward work in primary care and produce an evidence-based practice guide on depression.
- Learn from work in respect to crisis pilots and work on out-of-hours services to develop a national standard for services in 2006.
- Develop national and regular analysis of specialised service needs and the action required to meet those needs, including implications for service redesign.
- Develop national standards for Integrated Care Pathways for main diagnoses by late 2007.
- Continue to support the developing work of Forensic Managed Care Network to put in place delivery of new medium secure units in Western and North-Eastern Scotland, with redevelopment of the State Hospital by 2009.

#### ***The key messages coming from Delivering for Health are that we need to focus on:***

- Unscheduled care
- Managed care networks
- Anticipatory care
- Improving diagnoses
- Primary more than secondary care
- Chronic disease management

This is no less true for mental health than for other client groups. To support this new strategic approach we need information. This will include:

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<sup>9</sup> See <http://www.show.scot.nhs.uk/GCS>

1. Information to support teams in the care of individual patients
2. Information on the quality of the care delivered - from carers, clinicians and consumers
3. Information to ensure public value, accountability, auditing, and national statistics

The main way that information will be collected on the quality of care delivered is through work on Integrated Care Pathways. This will allow us to tell whether care-needs that were identified have been met.

Other work envisaged includes development of a counterpart for mental health, of the community care knowledge exchange. This is probably best done on a UK-wide basis. Public sector benchmarking work will also be tapped in to, at a UK level. There are plans for increased use of care matching in 2006 with experts from the U.S. They have a scheme where 4 chief executives look at a particular group of services and each writes a confidential report of what they think of each other's services over the last 7 years. Other benefits of this include providing support for each other.

Geoff concluded by emphasising that to change services for the better we need to work both through policy and through planning. This will require us to:

- Value information and have a desire to collect, use and share it.
- Work with the evidence base.
- Record and use patient information effectively.
- Satisfy standards for delivering services.
- Recognise how vital it is to recognise the importance of outcomes and measure them.

## Concluding remarks

Alastair Philp thanked the speakers and the audience and wished them a safe journey home. He acknowledged that there was work to do, but expressed confidence that the day's proceedings had shown that progress was already being made to bring the vision outlined in *A Mental Health Information Strategy for Scotland* into reality. With the support of the mental health community in Scotland there is no reason not to believe that we can benefit enormously from the renewed priority to be accorded to information systems and ehealth over the next few years by the Scottish Executive and NHS Scotland.

## Where next?

iMHIP continues (in partnership with other organisations, in particular the Scottish eHealth programme) to:

- Plan for the implementation of a Mental Health Information Strategy for Scotland.
- Test, in real life, whether the Information Core for Integrated Care and the Psychiatric In-patient Clinical Discharge Summary contain the right information to support integrated care.
- Develop a specification for joined-up systems that can exchange information to support care of those with mental ill-health.
- Organise workshops to share experience and perspectives about information sharing among service users and care professionals.
- Build a powerful mental health information interest network spanning service users, care providers, managers and policy makers.
- Ensure that lessons learned in one part of Scotland's mental health care services are shared with others as quickly and painlessly as possible.
- Provide support to national and local audits by mining national data.
- Want to hear what you think we could be doing better!

For more information please visit our web site at <http://www.isdscotland.org/imhip>.

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