MINIMUM DATASET
Expert Review Group

Report
June 2008

MDS Expert Review Group

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Background to the Review Group

The National Minimum Dataset (MDS) for Smoking Cessation has been, and will continue to be, a compromise between the need to gather anonymous, standardised data at the national level, and to provide a foundation for local services monitoring. The Expert Review Group (ERG) in its current incarnation was formed after it was recognised that the National Smoking Cessation Database Project Board (the body responsible for the administration of the database) was receiving a large number requests from services to examine in more depth particular technical or content-related issues within the dataset. The decision was taken by the Project Board to establish a review group, which should have strong representation from practitioners and services in addition to staff from Partnership Action on Tobacco and Health (PATH) and specialists in database management and statistical analysis.

The group’s aim, as defined at its conception, is to monitor, analyse, and suggest directions for development for the dataset that should strive to balance the Scottish Government’s requirements for statistically robust national level data with a structure that integrates with local cessation services. The intent was for the ERG to help ensure that the MDS:

- reflects service developments across Scotland;
- has a strong basis of monitoring and evaluation at both a local and national level;
- shows meaningful comparisons between Health Boards across Scotland;
- supports local service delivery;
- documentation reflects any changes made and enhances understanding of the rationale behind the dataset.

The ERG group convened in late April 2007, and has met five times to date, with an additional meeting in November 2007 to present and discuss the ERG’s suggestions for potential changes with the Smoking Cessation Coordinators, and a further consultation meeting with Smoking Cessation Coordinators and database users in April, 2008.

The structure of this document will reflect two areas the ERG have discussed over the past ten months – technical suggestions for the dataset, and reflections on the review process with implications for the future. The suggestions for the dataset will attempt to detail some of the ERG’s thinking and rationale behind each item, and, in instances where issues were determined to need additional examination in the future before action can be taken, a summary of the ERG’s discussions relating to the matter in hand.

Lastly, although the MDS provides core items of, but is distinct from, the MDS database – some comments relate to explicit changes in the database that go beyond the core MDS items. These were raised during the consultation over the core MDS, and were considered appropriate to be dealt with in this document as for many services, perceptions of the dataset and database are strongly linked.
Technical Suggestions for the Minimum Dataset

April 07 to June 08

This section will review each item in the current MDS, and detail the ERG’s comments relating to it. Each section will be accompanied by a relevant except from the current MDS form.

MDS Items 1-3

Item 1
Client ID

No Change Proposed.

However, discussion focusing on this item prompted the need for some clarification as to what types of client should be entered into the database. It should be noted that the MDS form and entry into the database is for specialist smoking cessation intervention only. It is not intended for ‘brief advice’ interventions.

Action recommended: Clarify in the guidance that the above is the case.

Item 2
Health Board Area

No Change Proposed.

Item 3
Clinic area /type

The current item 3 does not allow for the national analysis of the data at the level of where the intervention takes place, as at present the use of this field is subject to some variance across health boards.

The review group notes that the current item 3, though problematic for standardisation because it is utilised in multiple ways across local health boards, should nevertheless be left unchanged due to its central role in designating local permissions and access to data within certain areas. However, a complementary question alongside the current Clinic Area/Type to gather data on general Service Setting would provide the specificity
that should ideally be defined by Clinic Area/Type, but in practice has not been possible due to varying local interpretation and designation.

The purpose of this new field is to provide a list of broad service settings, detailing where the intervention took place. This would be distinct from the category of ‘intervention type’, described later in item 20, which specifies the particular nature of the intervention (e.g. specialist group, telephone support), not where it is located or delivered.

After consultation within the ERG and through meetings with smoking cessation coordinators and dataset users, the following items are proposed for inclusion into the Service Setting category.

<table>
<thead>
<tr>
<th>Please Specify the Service Setting(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary Care</td>
</tr>
<tr>
<td>• Hospital - Inpatient</td>
</tr>
<tr>
<td>• Hospital - Outpatient</td>
</tr>
<tr>
<td>• Educational Establishment</td>
</tr>
<tr>
<td>• Non-NHS community venue</td>
</tr>
<tr>
<td>• Home</td>
</tr>
<tr>
<td>• Pharmacy</td>
</tr>
<tr>
<td>• Prison</td>
</tr>
<tr>
<td>• Workplace</td>
</tr>
<tr>
<td>• Other (Please Specify)</td>
</tr>
</tbody>
</table>

Consideration was given as to whether to include services that consider themselves as offering a ‘tailored service’ to one particular target group (e.g. young people, pregnant women, and mental health service-users) as an additional MDS item following the above. The complexities in setting criteria for what constitutes a tailored service (and what criteria differentiates a tailored service from a ‘generic’ service) are numerous. It is particularly important to have clarity on this if the data is to be used for national level analysis to compare outcomes in tailored versus generic services. At present the Review Group feels that there is insufficient understanding and precision in defining what makes an effective ‘tailored’ service, that the inclusion of further service specialisms would be problematic in terms of comparing outcomes nationally.

The utility in being able to compare outcomes between tailored and generic services is recognised however, and the inclusion of a non-mandatory item in the database, to allow services to designate this locally, could be a useful first step.

*Action recommended:* Current item 3 to remain unchanged, but to be supplemented by the addition of a ‘Service Setting’ category, with the items listed above.
MDS Items 4-10

Item 4
Full Postcode

No Change Proposed.

However an addition should be made to the guidelines to emphasise that it is the responsibility of each board to obtain complete data for these fields and signpost resources that may aid them (e.g. Royal Mail's Postcode finder - [postcode.royalmail.com](http://postcode.royalmail.com)).

*Action recommended:* Revise guidelines.
Having the conditional ‘and/or’ statement offering an option as to whether users of the MDS record present age or date of birth would seem to be overly complicating this item. The ERG would suggest that just the date of birth is retained here, with the current ‘and/or Age’ statement being removed. Age is easily calculable from date of birth and this figure will remain correct over time, whereas age alone clearly will not. Date of birth is also essential in instances where client identification is required in a large practice.

*Action recommended:* Remove ‘and/or Age’ from this item, and retain ‘date of birth’ only.

**Item 6**
Gender

No Change Proposed.

**Item 7**
If female, pregnant?

No Change Proposed.

**Item 8**
Does the client receive free prescriptions?

No Change Proposed.

**Item 9**
Employment Status

Some background discussion may be helpful here. It was brought to the ERG’s attention that the Scottish Government are moving to harmonize a core set of socioeconomic questions, including employment status. It is suspected that the current wording of this item in the MDS may over-report those who are unemployed when they should more accurately be identified as economically inactive – that is, not in work and not actively seeking work or unable to take up a job in the short term. The suggestion of revising the categories that appear in item
9 to that which appears below was discussed (proposed changes in *italics*).

**Employment Status? (Please tick one box)**
- in paid employment *of one hour or more a week*
- homemaker / full-time parent or carer
- retired
- full-time student
- unemployed, *actively seeking work and able to start work immediately*
- permanently sick or disabled
- not known/missing
- other (please specify)

This was considered by the ERG, but a recommendation of no change was decided upon. The rationale behind this decision comes from the need to build relationships between the practitioner and service-user. It was felt that this additional detail may be seen by some clients, particularly those in disadvantages circumstances, or those who mistrust Health Services, as 'prying' or suspicion-generating and liable to harm this relationship. A consequence of this decision not to adopt these changes, care will need to be taken (e.g. caveats about potential overstatement of unemployment given) when reporting employment-related statistics from the MDS in the future.

**Item 10 Ethnicity**

The Scottish Government’s Analytical Services Division are producing a new official ethnicity classification (due for publication on 21st May), which is expected to provide a new recommended template for all national data gathering in Scotland. It is recommended that, pending publication and review of these new standards, they are incorporated into the MDS.

**Action recommended:** Pending publication and review of the new Scottish Government ethnicity standards, replace the existing section on ethnicity with its update.
MDS Items 11-14

**Item 11**
How many cigarettes per day?

No Change Proposed.

**Item 12**
How soon after waking does the client smoke?

No Change Proposed.

**Item 13**
How easy or difficult is not smoking for a whole day?

Remove item. It was felt that this item involved a sometimes challenging subjective judgement on the part of the practitioner/client, and that if it could be removed - whilst still maintaining a robust measure of nicotine addiction within the MDS – then it should be.

Research (de Leon et al, 2003) suggests that items 11 and 12 are reliable core elements of the Fagerstrom Test for Nicotine Dependence, and can in combination be used together to give the client a position on the Heavy Smoking Index (Heatherton et al, 1989). This would seem to provide a robust enough measure of nicotine dependence so that item 13 could be unproblematically removed.

*Action recommended:* Remove item.
MDS Item 15

The review group recognises that the quit date is a core component of the MDS, and integral to its central function of providing data on the number of successful ‘quitters’ as a result of service intervention. It is the start point by which this may be calculated, and the setting of a quit date is in line with many smoking cessation services in Scotland, in addition to the guidance for the use of Nicotine Replacement Therapy and Bupropion.

However, the ERG also recognises that, due to the divergent nature of service development across the country, some services find it challenging to fit the data entry of the quit date (as detailed in the MDS guidance documents) into their service model. This appears to result in some services feeling that they do not ‘get credit’ for all the clients that pass through the service, as their service delivery model is not as well placed as some to the demand of setting quit dates and adhering to set follow up points.

The ERG notes that, although the current situation is not seen as ideal by all health board areas, the current format of, and guidance instruction relating to, the quit date should be maintained (but clarified on several points, described shortly). In addition, it is suggested that two additional categories of date first contacted service, and date referred to service should be included as mandatory in the MDS (at present date referred to service is a field in the database, but not a mandatory item in the dataset). This would allow services to more easily track clients who may enter the service, but do not set a quit date. This would assist local and national reporting, and help to ensure that an accurate service usage profile is generated from entries into the database. It will also allow for an analysis that reflects waiting/referral times.

The MDS should continue to emphasise the importance of quit dates, as this is in line with an evidence-based approach to smoking cessation interventions. However it should also be noted that, during the review process, there were some services who reported a preference for quit dates to be set prior to the date a client first makes contact with the service in some instances. These were cases where clients may make an initial quit attempt unsupported by services, and then seek service help to continue the success of a quit attempt. At present, the current MDS guidelines exclude database entries of clients who have effectively set a quit date before first contact with the service.
During the course of ERG’s discussions on this matter, we received correspondence from Dr. Linda Bauld, University of Bath, who was involved in the initial development of the Scottish MDS. She suggested that it may be helpful for the group to consider what the revised monitoring guidelines for English services have to say on this matter, given below:

*Smokers who have already stopped smoking, when they first come to the attention of the service, may only be counted as having been ‘treated’ (for local accounting purposes) if they have quit within the last 14 days and attend their first session of a structured multi-session intervention within 14 days of their spontaneous quit date (which should be recorded as the designated quit date). Services should note the results of spontaneous quitters separately for local information purposes, but they should not be included in monthly or quarterly data returns, as they will have higher success rates than other service users. We do not anticipate that there will be significant numbers of such quitters but we will keep this issue under review (DH, 2007, p.18).*

By taking measures of how many service-users fall into this category locally, services can more precisely detail at a local level the scale of this issue. Whilst not being gathered into the national data-returns, this would then generate evidence for any future review of the no quit dates before first contact with service criteria. This would seem like a logical step forward, and should be considered for inclusion in the MDS guidelines.

Further amendments to the guidelines should be carried out in the case of quit date flexibility. It was noted by the ERG, that the potential exists to amend a record’s quit date at any point prior to the one month follow up (as a feature to correct any errors in data entry). Some services were reported to use this feature to change the quit date if, for example, the client was unable to commence a genuine quit attempt on the originally identified date. Reflecting upon this, it was felt that the guidelines should be revised to be more helpful regarding under what conditions it would be appropriate to change the quit date outside of an administrative error, if any. This should be discussed with the MDS Project Board, with reference to the Smoking Cessation Services in Scotland, Recommendations for the Future Development of Scottish Smoking Cessation Services: Data Collection, Monitoring & Evaluating, Information Management and Essential Resources document to ensure that all services are aware what degree of flexibility is allowed regarding quit dates.

*Action recommended: Retain item. Add additional date first contacted service, and date referred to service mandatory fields. Encourage services to gather local data on clients who quit prior to entering into service, and review these figures nationally. Clarify conditions under which it is permissible to amend quit dates (if any).*
Prior to the follow up section, there should be a mandatory client consents to follow up option (the existing item should also be made mandatory in the database). This will prevent the small number of instances where services may contact a client for follow up and that contact is considered unwanted or intrusive.

The wording on this MDS item should be amended to read ‘Client successfully contacted for follow up’ – as is the wording on the database currently – to prevent misinterpretation that the meaning is ‘tried to contact’ rather than ‘actually contacted’.

A key concern for the ERG was common understanding of language when it comes to the ways in which clients can be categorised as 'lost to follow up'; when using the term ‘lost to follow up’ all services should be clear that it means the client was lost to the service despite effort to contact, not that no attempt was made to contact the client by the service (all services should attempt to contact for follow up, as detailed in the guidelines).

In combination with the above, it is suggested that an additional item is added to the follow up section to capture information on clients who are no longer in the service at the time of 1 month follow up. The wording for this item could be a simple tick-box with the instruction to tick if ‘Client has withdrawn from service at time of follow up’. This does not imply that the client should not be followed up, but instead should provide extra utility in the data national reporting is able to produce.

Another issue to be clarified and reinforced is whether recommended practice is to follow up all clients, even
those who have attended sessions but subsequently left the service, or if they are exempt from standard follow up practice.

This is an area where the guidelines could also be clarified – in terms of specifying precisely who should be followed up. At present, the direction to follow up ‘all clients setting a quit date’, as given the guidelines, is still resulting in variable practice in data gathering. The English guidelines are more specific regarding who should be followed up, stating:

‘… a smoker who has received at least one session of a structured, multi-session intervention on or prior to the quit date and sets a quit date with their adviser. Smokers who participate in an assessment session but fail to attend for treatment should not be counted but those who have consented to a programme of treatment, attended their first session and have set a quit date should be included.’ (DH, 2007, p.17)

It is worth considering if Scotland should adopt a more substantive, complete definition as to who should be followed up, as above, in combination with additional list items in this MDS question to specify reasons for lack of follow up.

**Action recommended:** Addition of a mandatory Client consents to follow up – yes/no item prior to this one. Amend the language of the MDS question to read ‘Client successfully contacted for follow up’. Include a check box for services to indicate if the ‘Client has withdrawn from service at time of follow up’ (though this should not affect whether the client is followed up or not).

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**Item 17**  
*Date follow up carried out*

No Change Proposed.

**Item 18**  
*Smoked in the last 2 weeks?*

No Change Proposed.

It was the review group’s original suggestion to revise the criteria for whether or not a client gets followed up at three months from the ‘not smoked in the last 2 weeks’ criteria, to the ‘smoked less than 5 cigarettes’ criteria. The ERG has since been advised against that course of action by some of the experts familiar with the original development of the dataset. The ‘not smoked in the last 2 weeks criteria’ is one which is based upon a body of evidence in smoking cessation research and is employed internationally. To deviate from this may result in Scotland’s data being less robust (and hence more open to criticism). The ERG’s consensus is that the current 1 month measure of successful abstinence should be maintained.

The ERG discussed feedback from services on the perceived ‘fairness’ of this criteria and heard from some services’ experiences of clients who are classified as smokers by this item at the 1 month point (and are thus ineligible for follow up at 3- and 12- months), but at some later stage are successful in their quit attempt (and hence will not be picked up by the current MDS follow up arrangements). It is suggested that this situation is monitored locally by services, and the frequency of this ‘early lapse, later success’ phenomenon is noted for future consideration.
Item 19
CO reading confirms quit?

No Change Proposed.

Item 20
Interventions used in this quit attempt

The ERG suggests that this item be removed from the section dealing with follow ups and dealt with in a separate section, after the quit date, and prior to the 1 month follow up. This section could be labelled *Interventions Used*, and should also be made mandatory on the database. It is felt that this change may improve reliability and completion rates (currently this item is often missed or left incomplete during database entry).

Following a consultation on a revision of the items that appear in this list, the Review Group would propose that the existing items are replaced with those given in the box below.

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Interventions used in this quit attempt

- One to One Sessions
- Group Support (Closed Groups)
- Group Support (Open/Rolling Groups)
- Telephone Support
- Couple/Family Based Support
- Other (Please Specify)
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This differs from the current version of the MDS in several ways, listed below:

- the existing ‘Group Support’ option is split into two to more accurately capture the nature of current practice in group-based intervention
- the existing option of ‘Buddy Scheme’ is removed, as the intervention is not one of the evidence-based strategies approved for use in Scotland’s cessation services
- the option of ‘Pharmacy Scheme incl. Support’ is removed, as this information (that the intervention takes place in a pharmacy) can be obtained by the additional service setting option described in item 3, previously, and would then be classified as a ‘one to one’ or ‘group support’ intervention as appropriate

*Action Recommended*: Remove section from current location, and reinset as an independent *Interventions Used* category after quit date, and prior to 1 month follow up. Amend the list presented to reflect the items above.
In a similar manner to Item 20, above, it is suggested that the pharmaceutical usage section under each of the 1, 3, and 12 month follow ups (Items 21, 26 and 29 respectively) be removed from their current place and re-inserted after quit date, prior to 1 month follow up, and be labelled *Pharmaceutical Usage* or similar. This may hopefully resolve some data collection consistency issues, and will avoid replication of the same information under each follow up.

In addition, the new *Pharmaceutical Usage* section should incorporate Varenicline (Champix©). As the dual use of NRT and Bupropion/Varenicline is currently not licensed as a combination therapy (but in theory one client may alternate between both products during one quit attempt), the ERG proposes the inclusion of the ‘single product/change in product’ categories. This amended section may look similar to the example given below.

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**Pharmaceutical Usage**

- NRT only (single product)
- NRT only (more than one product)
- Varenicline only
- Bupropion only
- NRT and Varenicline (change in product)
- NRT and Bupropion (change in product)
- Neither
- Unknown

**Total Number of Weeks Used:** ______________

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*Action Recommended:* Remove section from current location, and re-insert as an independent *Pharmaceuticals Used* category, in a similar manner to Item 20, above. Add Varenicline (Champix©) to the list of options, as appears in the example given above.
**Item 22**
Was the client contacted for 3 month follow up?

*Action recommended:* Reflect any changes made to 1 month follow up here.

**Item 23**
Date follow up carried out

No Change Proposed.
Items 24 & 25
Has the client smoked at all in the last two weeks?

Has the client smoked at all since the one-month follow up?

These items are intended to assess the smoking status of the client, and are both recommended in the Smoking Cessation Guidelines for Scotland (2004 update). However the instructions, as given in the MDS guidance documents may lead to some inconsistencies and confusion in this area. For the point-prevalence measurement (Item 24: Has the client smoked at all (even a puff) in the last two weeks) the guidance instructs that… the answer given to item 24 shows if the 12 month follow up needs to be attempted or not.

In Item 25, offering a longer term measurement of any lapses, the guidelines direct that… if the client answers ‘no’ or ‘less than 5 cigarettes in total’ then attempts should be made to follow them up at 12 months.

Essentially, the guidance states that both of these items must classify the client as a non-smoker for them to be considered abstinent and eligible for 12 month follow up. However, how valid is this assertion? Is a client that has smoked less than five cigarettes since the 1 month follow up (smoking two in the weekend three weeks prior to the 3 month follow up) to be classified as abstinent, whilst a client that has smoked less than five cigarettes in total since the 1 month follow up (but has smoked two cigarettes in the weekend immediately prior to the 3 month follow up) to be classified as a smoker? This situation seems anomalous.

Hence it is recommended that item 24 be removed, and item 25 retained as the sole measurement by which clients’ smoking status is determined at the 3 month period.

Further, the current phrasing of item 25 is incorrect, as it does not allow for the situation where the client has smoked five cigarettes exactly (only less than five and more than five). The item should be rephrased.

Action Recommended: Remove item 24, and update guidance accordingly. Amend the options in item 25 to read Yes, between 1 and 5 cigarettes in total and Yes, more than 5 cigarettes.

Item 26
Pharmaceutical Usage

Action Recommended: Remove item. This will now be covered by a separate Pharmaceutical Usage category, and not included as part of the 1 and 3 month follow ups, as described under item 21.
Item 27
Was the client contacted for 12 month follow up?

Any changes described in the 1 and 3 month follow ups should be reflected here also.

A change is also suggested to the item routing, which currently allows those not contactable at 3 months to be followed up at 12 months (this differs from the transition from 1 month to 3 month follow up where those not contactable at 1 month are not flagged for follow up at 3 months). For many services this is a resource issue, as there seems to be little benefit (and low rates of success) in the attempt invested to follow up at 12 months for those uncontactable at 3 months. However, this must be considered in terms of the national priorities for data gathering, and if there is a continued drive towards gathering longer-term 12-month quit data, it may be worth leaving the system intact. This should be considered with the Project Board in combination with examination of existing 12-month follow up data to ascertain its utility.

Action Recommended: Reflect any changes made to the 1 and 3 month follow up here. Clients who are uncontactable for follow up at 3 months should not be flagged for follow up at 12, though this must be discussed with ISD and the MDS Project Board before final decisions are made.

Item 28
Date follow up carried out

No Change Proposed.

Items 29 & 30
Has the client smoked at all in the last two weeks?

Has the client smoked at all since the one-month follow up?

In a similar manner to items 24 & 25, the need to ask both of these items to ascertain smoking status is questioned.

Action Recommended: Remove item 29, and update guidance accordingly.
Reflections on the Review Process and Implications for the Future

In addition to the technical suggestions for the dataset described in the preceding section, the ERG felt it was important to feed back their reflections on the review process, and also describe the implications of what the ERG has, and has not yet, been able to achieve in its present incarnation.

Reflections on the Review

The process the current ERG has been through over the past months has been one which has been of value for those involved in the review group, and has resulted in the output detailed in the previous section. Evidently some of these items require ongoing work and investigation, and it is the ERG’s opinion that review of these items should continue. For items where there is an immediately actionable suggestion, there should be a clear conversation between the administration and MDS users detailing the reasoning behind changes to the core dataset items, and the circulation of a timetable for implementation.

The current members of the ERG agreed that, if it was deemed appropriate by the MDS Project Board, they could continue to play a role in:

- furthering the work on items identified as needing continued investigation;
- communicating with services why changes are being made, and facilitating adoption of the revised MDS;
- playing some part in the implementation of the changes proposed in this document, but recognising this as a large commitment, which would need to be carefully defined.

Composition of Future Review Groups

The emphasis on any MDS review group having representation across different levels was seen to be an important feature – however, in the future, having members of the group who are more deeply familiar with the research base and rationale behind the original development of the MDS would also be extremely useful. The ERG spent considerable time questioning some of the fundamental features of the dataset (for instance, the MDS criteria for a successful 1 month quitter); this discussion would have been illuminated greatly by the presence or input of some of the original researchers/developers of the items, to prevent too many attempts to ‘reinvent the wheel’.

Feedback from Practitioners

It is clear that the MDS, as a relatively new development in a relatively new field, can only benefit from continued feedback from practitioners. This is not to say that the MDS should be frequently changed as and when feedback comes in; in fact, one of the principles underlying the ERG is the recognition that changes should not be made on an _ad hoc_ basis, rather they should occur only at set points - no more than once or twice throughout the year. This is the only practicable model of revision given a system in constant use. Relating to this, a feature that would benefit future work in reviewing the MDS would be the production of a timetable for MDS revisions – that is, providing set points throughout the year (e.g. the end of a calendar or financial year) where changes to the MDS and database should be implemented.

Through consultation with smoking cessation coordinators during the review process, it was noted how contact
with this group was seen as valuable from both the coordinators’, and the ERG’s, perspectives. For the future of MDS review, it is suggested that this work continues and expansion into receiving feedback from more smoking cessation practitioners (other than those who are also coordinators) be investigated. This feedback may be facilitated by the inclusion of a web-based feedback form for MDS content-related inquiry. Whilst ISD receives feedback and requests for assistance regarding the MDS and database, these are predominantly concerning the technical implementation rather than MDS content - a accessible online feedback form (clearly identifiable from any feedback form relating to technical issues) delivered with the database (e.g through a web link) could go some way to resolve this.

Training, Learning, and Sharing of Practice

This work would also be enhanced by an examination of the training model offered regarding the MDS. The ERG discussed the added value of mandatory induction training for new staff into the dataset; the aim being to provide new MDS users with more of an understanding as to the logic underlying the dataset, in addition to its functionality – a greater understanding of the *why* in addition to the *how*. Some means by which to foster the development of this sharing of practice are given below:

- the creation and facilitation of practitioner-driven networks or communities of practice around the MDS and database would enable services to share the methods by which they use the MDS in their own context, and may allow sharing of learning across services and/or areas;
- this may be enabled by a nominated minimum dataset ‘specialist’ in each area, who could work with others in their locality (supported by PATH and ISD), and also network with other areas and services - this work could be shared by a quarterly bulletin or similar that would highlight feedback received on the dataset, the status of the review process, and, most importantly, what services are doing with their data locally;
- Formalising coordinator responsibility in this area, so they are able to effectively lead and support this work, is vital to its success.

The need to share practice is not just a concern for practitioners who enter data, but also for coordinators and those who have access to collating and reporting functions for their area. Variation in local reporting practice is apparent, with some health board areas using data gathered from the MDS to inform their judgements locally, and others inputting the data primarily for national reporting with little apparent local utility. Facilitating the sharing of practice between those who currently utilise the local reporting aspects of the database, and those who currently do not, would benefit MDS data collection as a whole. Anecdotal evidence from services would lead us to believe that the more useful the data is seen to be locally, the higher the likelihood of data entry being completed in an accurate and timely manner. If it is not seen as something that will benefit the local area in addition to national reporting - and instead is perceived as ‘another procedure to keep the Government happy’, the efficacy of data gathering is certain to be impacted.

Suggestions for Consideration in Future Reviews

To date, the ERG has received suggestions regarding new additions to the dataset and database and novel queries regarding structure and information management which have not been given full consideration in this document. They are given below for reference, and should be included in discussion with the MDS Project Board and a focus of future work:

- inclusion of ‘number of sessions attended’ at some stage in the dataset to allow reporting on how many times the client has contacted the service and hence how much the service has invested in the client;
• investigation of an automatic default of ‘lost to follow up’ or ‘not contacted for follow up’ if the database entry is not modified within 14 days of the follow up date (as per the guidelines) – this will save data-entry time for services;
• web-based help – is it possible to have ‘mouse over’ help for the database terms to avoid referring back and forth between the database screen and guidelines?;
• investigation and research into the frequency of patient transfer across services and health boards areas – with HEAT targets it will be even more vital to correctly monitor transfer and pickup across areas (and to put measures in place to deal with potential miscounts due to duplication);
• inclusion of ‘local use’ boxes (analogous to those used in ISD’s SMR series Assessment forms) in the MDS to facilitate services gathering of data for local needs;
• a review of both the procedure and purpose of the 12 month follow up – at present response rates are low, and services question the necessity of this procedure in light of the targets set focusing on 1 month data.

Conclusions

Some issues discussed in this section call in arguments from beyond the ERG’s focus on the revision of the core dataset items. However, if the function of the review group, as stated at its conception and repeated from the start of this document, is to ensure the MDS:

• reflects service developments across Scotland;
• has a strong basis of monitoring and evaluation at both a local and national level;
• shows meaningful comparisons between Health Boards across Scotland;
• supports local service delivery;
• documentation reflects any changes made and enhances understanding of the rationale behind the dataset.

Then the review group must be mindful of local concerns and continue to keep the needs of the services responsible for the collection of the data - and the ways in which the MDS can help support these services’ delivery - at the forefront of its thinking.

References

