# Implementation Proposals for Integrated Care Pathways (ICPs) in Mental Health Partnership

**Presented by**
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**Recommendation(s)**
The SMT should progress the attached List of Actions and Questions in relation to ICP Implementation.

## Summary/Background
This report outlines the work completed by the ICP Steering Group of the Mental Health Partnership. It contains information about the development of a generic mental health pathway as well as pathways in response to the five diagnoses outlined in "Standards for Integrated Care Pathways in Mental Health" (NHS Quality Improvement Scotland (NHS QIS), 2007)

In line with “Delivering for Mental Health” and related performance management arrangements, it will be the responsibility of managers working across the Mental Health Partnership to implement these pathways. It is therefore of importance that this work is embraced and supported throughout the Partnership.

## Background/Policy/Legislative Context
The Standards for Integrated Care Pathways in Mental Health were published in response to "Delivering for Mental Health", commitment 6, that ICPs would be developed, implemented and monitored.

The standards cover the development of the following pathways:
- generic mental health pathway for everyone in specialist mental health services
- depression pathway
- bipolar disorder pathway
- borderline personality disorder pathway
- dementia pathway
- schizophrenia pathway

All of these pathways are designed specifically around the specialist mental health services, with the exception of the depression pathway. Much of this pathway lies within the primary care setting, whether this be within primary care mental health teams, or a general practice setting.

## Financial Implications
There may be some specific costs associated with use of outcome tools or assessment measures. NHS Greater Glasgow and Clyde is already committed to the routine use of the Health of the Nations Outcome Scale (HONOS). It was therefore agreed that it should be used within the new pathway developments.

## Human Resources Implications
This report identifies training issues which will have both direct and indirect implications for the implementation of the pathways. In particular, the ability to release staff to be involved in such training was an issue of concern across all of the pathway developments.
Existing ICP posts (clinical and facilitative), where secondments and sessions were allocated until March 2010 have now ceased.

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1. Introduction

This report outlines the work completed by the Integrated Care Pathways (ICP) Steering Group of the Mental Health Partnership (MHP). It contains information about the development of a generic mental health pathway as well as pathways to meet the five diagnoses outlined in the document “Standards for Integrated Care Pathways in Mental Health” (NHS QIS, 2007).

The outputs contained within this report are the product of the Steering Group and four subgroups set up to work on the development of pathways in line with the standards. (A combined subgroup, the psychosis group, was established to progress both the schizophrenia and the bipolar disorder standards.) The generic pathway developments were overseen by the Steering Group. Each subgroup has prepared a full report highlighting their main developments and issues. These reports include information about the subgroups’ roles, remits, and membership.

This report contains an outline of the pathways developed and key considerations for their implementation. It also includes recommendations as to how these proposals may be progressed and some of the key activities necessary to assure the organisation that implementation is proceeding.

In line with Delivering for Mental Health and related performance management arrangements, it will be the responsibility of managers working across the MHP to ensure and be accountable for the implementation of these pathways. It is therefore of importance that this work is embraced and supported throughout the Partnership.

2. Background

NHS QIS published ‘Standards for Integrated Care Pathways in Mental Health’ in 2007. This document outlined the required development of the following pathways for specialist mental health services:

- generic mental health pathway
- bipolar disorder pathway
- borderline personality disorder pathway
- dementia pathway
- schizophrenia pathway

It also covered a pathway for depression which will function primarily in primary care services (including general practice and primary care mental health teams), although it has implications for specialist mental health services in relation to chronic or treatment-resistant depression.

Work has already taken place across a significant part of NHS Greater Glasgow and Clyde to raise awareness of the purpose and principles of ICPs. Those services which were previously part of the Greater Glasgow PCT start in a significantly different place from those within the area formerly covered by NHS Argyll and Clyde. It should be noted that there are significant differences in the approach undertaken in the new developments which will require a degree of sharing new messages about the principles of ICPs in line with lessons learned. It would not be considered likely therefore that any area of the service is more prepared for these new developments than another.

The work undertaken by the steering group takes account of the existing ICP for Schizophrenia across services which were previously part of Greater Glasgow Primary Care Trust (PCT). A large consultation exercise included an evaluation of and feedback on the use of this existing pathway.
This work is overseen by the Medical Director of the Mental Health Partnership, who is Executive Sponsor for the ICP programme. Operational support to the programme is provided by 1.4 WTE Clinical Effectiveness / ICP Co-ordinators who works within the Clinical Governance Support Unit.

ICP Facilitators have been available locally to support the implementation of the ICP for Schizophrenia, and organisationally to assist the development of these new pathways. These seconded posts will not continue past 31st March 2010.

3. Development of ICPs for Mental Health

The development of the ICP for Schizophrenia was used as the basis for further work by the condition specific subgroups. This ICP was based on four pathway modules which covered:

- Annual Review
- Inpatient Admission and Discharge
- Inpatient Transfer; and
- Early Intervention

During a stakeholder event held in November 2008, approximately 300 people contributed their views about the ICP development work presented. This led to redevelopment of all of the then existing pathways, as well as the development of a new generic mental health pathway.

Furthermore, separate consultation with Managers working in mental health services shaped some of the emerging principles of the new ICP developments.

4. Principles of ICP Programme

- **A single pathway of care for people using mental health services**: Feedback gathered on evaluation of the ICP for Schizophrenia suggested that there were difficulties associated with the modular approach to the pathways and this should not be retained.

- **The care received by everyone in need of a comprehensive mental health assessment should follow the generic mental health pathway**: However, people attending only for maintenance reviews, or who are being seen by a single discipline, would not need to be included in the pathway. The extent to which this is likely to occur should be explored with individual teams at the time of implementation.

- **The pathway outlines the basic standards of care to be delivered throughout NHS GG & C**: This means that where existing service provision exceeds the standards outlined, this level should be sustained, where appropriate to do so.

- **There should be an annual review of care for everyone who remains in mental health services**: A review definition should be included within the local Resource Folders for implementation of the generic pathway. The review may be an existing process, such as Care Programme Approach, Supported Accommodation review or other mechanism where this exists already. However, the information required by these reviews may need to be augmented to fulfil the requirements of the pathway.

- **Condition specific pathways accompany the generic mental health pathway**: The generic mental health pathway describes the way in which services will be delivered. Additional items which assist care for a particular diagnosis will accompany the existing expected level of care across the service.

- **Performance management arrangements need to be established**: It was clearly fed back by managers within the service that unless they are asked to account for implementation of the ICP, it is likely to be superseded by other priorities. Additionally, managers should hold responsibility for implementation.

- **Pathways are developed in response to standards outlined by NHS QIS**: All members of the steering group and subgroups agreed that the pathways should revolve around the standards and associated principles. During implementation, individual teams will add detail for local guidance.
5. Generic Mental Health Pathway

The generic mental health pathway provides a breakdown of the Standards for ICPs in four main categories as outlined below:

- **Assessment**, including specialist shared assessment and clinical risk assessment
- **Planning**, including information needs and the potential to include other sources of support
- **Delivery** of the care plan, including roles, responsibilities and timescales
- **Review** of the outcome of the plan of care for an individual, using agreed measures

In relation to each of these features of care, the pathway outlines what the service is expected to provide, and describes the standards to which individuals should expect care to be delivered. It is acknowledged that not all of the features listed will be relevant to every person all of the time, but consideration of their appropriateness should be evident from the patient record.

Some areas of the service may require support to use the assessment tools outlined within the pathway, although areas currently using the ICP for Schizophrenia should already be familiar with the recommended AVON and HONOS tools.

Other features of the generic mental health pathway are being progressed through existing strategy and working groups across the partnership. For example:

- **Physical health assessment and management**: The documentation to be used, how it is shared electronically, and responsibility for administration is part of the work plan for the Primary Care Mental Health Interface Group.
- **Suitability for psychological and / or psychosocial interventions**: The Psychological Interventions Strategy group will ensure that appropriate systems are established to progress these standards.
- **A single plan of care that operates across all service care providers**: The Integrated Health Record implementation, and work on electronic document management systems will contribute to this agenda.

Resource Folders have been prepared for each of the condition specific pathways. It is a recommendation of this report that individual service areas are supported to prepare their own resource pack which reflects their current documentation and systems in relation to the generic mental health pathway. Resources to progress this should be considered by the MHP management team, particularly in light of the end of ICP Facilitator secondments.

There are some documents which would be provided as examples of good practice in relation to meeting the standards, or which may more generally support implementation of the pathway. Some core features of a generic pathway resource folder include:

- **Physical health assessment and management record**: The final version of this document will be implemented for use across all service areas and should therefore be included.
- **Pharmaceutical care plan**: The final version of this document may facilitate monitoring of standards pertaining to the recording of medication decisions but is not currently being considered for implementation across all services.
- **Annual Review checklist**: This document covers the requirements of a review of a person’s care, which should take place at least once a year. This document is not currently being considered for implementation across all services, but it is acknowledged that some areas or individuals may find it useful.
Ways in which the implementation of the ICP can be integrated with plans to establish the Scottish Patient Safety Programme (SPSP) in a mental health setting are currently being explored.

During a recent patient safety event within NHS GGC the following suggestions were made in relation to **key variances** to report as part of the implementation of the generic mental health pathway, although there may be a need to define the measurements more specifically.

- Completion of a multidisciplinary risk assessment and associated management plan.
- Completion of a physical health assessment and associated management plan.
- Undertaking regular scheduled reviews which proactively plan and consider issues of wellbeing and recovery.
- Communication within the team including active involvement of users and carers.

However, the extent of variance will not in itself establish a better understanding of its causes, and teams should consider ways in which the information is reported and reviewed to facilitate improvements over the longer term.

### 6. Depression Pathway

Throughout the development process, the Depression sub-group has retained strong links with Primary Care Mental Health Teams (PCMHTs), the Primary Care / Mental Health Interface Group, and the HEAT Antidepressant target work.

Entry to the pathway is for patients who haven’t had treatment for depression for 6 months or more. In both primary care services and specialist mental health services, the care for people who have been receiving treatment prior to implementation of the pathway should be reviewed, and consideration given to including them in the pathway.

The first element of the depression pathway is a therapeutic assessment of need, usually in the primary care setting. This determines whether talking treatment, an antidepressant, or access to specialist services is required.

The depression pathway differs from the other pathways in that much of it lies within the primary care setting. For this reason, there is particular complexity in relation to its implementation.

Entry to the generic mental health pathway would be appropriate for patients with chronic and treatment resistant depression. This would be considered an adequate care pathway for this group, with the use of specific outcome and assessment tools highlighted throughout the depression pathway.

The following summary outlines various options for progressing its implementation.

The outcome and assessment tools highlighted for use in this group are:

- Combined Patient Health Questionnaire (PHQ9) / Generalised Anxiety Disorder Scale (GAD7)
- Hospital Anxiety and Depression Scale (HADS)

The following is a summary of the key issues and likely difficulties in implementing the ICP for depression:

- Few PCMHTs have medical staff, and other staff often do not feel able, or are reluctant, to make a diagnosis.
- There are many variations between PCMHTs such as the self-help materials provided, staffing mix, and the provision (or not) of guidance around drug treatment.
- Practice amongst GPs also varies.
- Few PCMHTs meet the waiting time target for access to brief, depression-focussed psychological therapies.
The STEPS approach to stress, though well-received, does not meet the care set out in ICP

When exploring ways in which this pathway could be implemented, two main options were suggested for detailed appraisal and decision.

**Option 1**
A board-wide approach to a redesign of PCMHTs, seeking to achieve outcomes in three significant areas: ICP implementation, HEAT implementation, and delivery of savings. A team responsible for a depression “workstream” across all Board areas would be developed. This team would work collaboratively to ensure HEAT and ICP compliance, while promoting best practice and seeking to improve clinical and cost-effectiveness.

The advantages to this approach include:
- synergy of working practices,
- contribution to the savings programme whilst protecting the integrity of the core functions of PCMHTs, and
- potential to improve the quality of service provision for people with depression by taking the best of the current models in existence at present.

The risks of this approach are:
- the workstream would be significant,
- lack of agreement regarding way forward, and
- uncertainty as to whether all the required elements could be delivered on time.

**Option 2**
Maintain current approach of devolving implementation of ICP to GPs, CH(C)Ps and Mental Health Partnerships

The advantages to this approach include:
- no major service redesign, and
- maintenance of local responsibility.

The disadvantages are:
- the approach is less likely to achieve change,
- potential for duplication of effort, and
- there is a risk of continued inappropriate variation in local areas.

The subgroup identified **key monitoring data** to be:
- The use and recording of a PHQ-9 score for each patient, to indicate a baseline against which improvement or deterioration can be measured. This should be electronically stored and be readily retrievable
- The use of signposting and provision of self-help materials etc by GPs, PCMHTs
- The number of referrals for brief psychological therapies, to be captured through electronic systems.
- The prescribing of antidepressant medications to be monitored via existing prescribing mechanisms.
- Referral to specialist services through GP systems, PIMS and CONTINUUM
7. Dementia Pathway

Information about the number of people in the population with a diagnosis of dementia is collected by the HEAT group for the target relating to improving the rate of diagnosis of dementia. The number standards at 7130 at the date of this report, many of whom are managed within the primary care setting.

The group recommends using the dementia ICP in secondary and specialist mental health areas only, and would not consider its introduction within nursing or care homes unless the patient is also in contact with specialist health services.

The dementia pathway will sit alongside the generic mental health pathway and includes the following specific additions:

- **Assessment:** development of psychological or behavioural dementia symptoms should lead to a reassessment which occurs within four weeks, and consideration of end of life issues.

The outcome and assessment tools identified for use with these patients are outlined below:

- Mini Mental State Examination (MMSE)
- Addenbrooke’s Cognitive Examination (ACE-R)
- Cognitive Examination (CAMCOG)
- Neuropsychiatric Inventory Questionnaire (NPI-Q)
- Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)
- Health of the Nation Outcome Scale for over 65s (HONOS65+)

The following is a summary of the key issues in implementing the ICP for dementia:

- Assessment and outcome tools are routinely used in community settings, but less so within hospitals.
- End of life issues training is not currently on offer to staff, but should be provided.
- Many patients with dementia are in contact with both primary care and acute services, and achieving close liaison is challenging.
- Not all services are currently completing six monthly reviews and would need to be supported to achieve this.

At an early stage, the subgroup took on both the ICP development work and that of the HEAT target group for dementia. Now that the development phase of the ICP is coming to a close, the subgroup will work to progress the HEAT target.

It is felt that implementation of this pathway could take place across all services with little development work required, other than the identification and delivery of training in end of life issues.

The subgroup identified **key monitoring data** to be:

- Rate of diagnosis of dementia to be captured, as currently, as part of HEAT targets.
- Variances recorded locally in a log book, which will be reviewed by the service manager who will identify appropriate actions.
8. Borderline Personality Disorder Pathway

This group recommends application of the pathway for borderline personality disorder within mental health services for all people who have the diagnosis and fulfil the requirements for entry to the generic pathway. It would be anticipated that people entering the service would commence on the pathway, with discussion still to take place about how people already in the service are transferred to such a package or programme.

This pathway will sit alongside the generic mental health pathway and includes the following specific additions:

- **Assessment:** When considering a diagnosis of borderline personality disorder, there is a particular need to focus on issues of impulsivity, parenting issues and circumstances of children. Where reassessing an existing patient, it was acknowledged that borderline personality disorder is often a problematic diagnosis to reach. The validity of existing diagnosis and unsuccessful previous management plans may be indicators for borderline personality disorder. This is referenced in a training summary within the main subgroup report.

- **Planning:** The need for careful consideration of the length and purpose of inpatient admissions for this group was highlighted, in addition to retaining existing community links wherever possible during an admission phase.

- **Delivery:** The need for a robust, agreed plan of care with clear parameters and boundaries was expressed. This links with a consistent theme throughout this pathway about understanding the complexity of the management of these patients and a consistent and shared approach to their management plans.

This group were confident that the existing outcome tools recommended within the generic pathway (HONOS and AVON) would meet requirements for this group. (It was acknowledged that these have some limitations, but no commonly used validated tool is available for this group of patients.) Options are explored further within the main subgroup report.

The following issues were identified as potential barriers to implementing this pathway:

- There is currently a lower than anticipated rate of this diagnosis. There are issues in relation to acknowledging this diagnosis in some areas, as well as confidence to deliver appropriate information once a diagnosis is made.
- Throughout the development phase, it was difficult to achieve the engagement of general adult psychiatry and this may be indicative of likely challenges in implementing the pathway.
- There are cost implications for improving the knowledge base for borderline personality disorder, both in relation to establishing a diagnosis, and its subsequent management.
- There is a shortage of training at a national level to increase this knowledge base, and it was identified as likely that such provision would need to be managed within the NHS GGC.

Some links between the implementation of this pathway and the HEAT readmission target have been emerging, although no formal links were established during the development phase.

It was recommended by this group that implementation of this pathway should not take place before successful implementation of the generic mental health pathway.

The subgroup identified **key monitoring data** to be:

- Service user questionnaire and sample audit to determine whether appropriate information is being given to service users about their diagnosis
- HoNOS scores to be recorded for every patient
- Number of individuals with a diagnosis of Borderline Personality Disorder within services to be recorded (and compared with general population prevalence rates)
9. Psychosis Subgroup – Bipolar Disorder Pathway

This subgroup was tasked with progressing standards for both a bipolar disorder pathway, and for a schizophrenia pathway.

The bipolar disorder standards addressed the following key themes:

- Management of acute mania in accordance with the evidence base including monitoring outcomes
- Management of bipolar depression in accordance with the evidence base including monitoring outcomes
- Management of maintenance phase in accordance with the evidence base including monitoring outcomes
- Maintaining a record of medication choices

The specific outcome and assessment tools identified for use with this group are:

- Hamilton’s depression screening algorithm
- Montgomery Asperg Depression Rating Scale (MADRS)
- Young’s Mania Rating Scale (YMRS)

There are not believed to be direct costs associated with the use of these tools. However, the confidence of staff to administer them should be assessed prior to implementation of this pathway.

The ICP standards suggest that an algorithm based on medication choices, outlined in NICE guidance for Bipolar Disorder (NICE 38, July 2006) is followed. However, liaison with specialist mental health pharmacy had suggested that this would be a complex piece of work, and a suggestion was made to oversee the development of guidelines. These are not available at this stage.

This group recommends application of the pathway for bipolar disorder within mental health services for all people who have the diagnosis and fulfil the requirements for entry to the generic pathway. It is anticipated that people entering the service would commence on the pathway, with discussion still to take place about how people already in the service are transferred to such a package or programme.

The subgroup identified key monitoring data to be:

- The number of people for whom antidepressants are prescribed in conjunction with a mood stabiliser
10. Psychosis Subgroup – Schizophrenia Pathway

This sub group was tasked with progressing standards for both a bipolar disorder pathway, and for a schizophrenia pathway.

The schizophrenia pathway has two components, one of which covers the early intervention phase, whilst the other addresses ongoing care.

Within NHS GG&C there are currently variations in service provision for the early intervention phase when considering a diagnosis of schizophrenia. However, the early intervention model outlined in the pathway should be achievable across all care settings. Where a dedicated early intervention service exists, the provision of care will exceed that outlined within the pathway.

The early intervention pathway outlines the following standards of care:

- **Pre-Assessment**: Family contact prior to comprehensive assessment; assessment should include a contribution from at least two members of a multidisciplinary team where psychosis is suspected; initial contact should be made within five days of referral; and there is a need to assertively engage with this group

- **Planning**: A multidisciplinary formulation and care plan should be available within twelve weeks of initial assessment. The care plan should include family interventions, and delivery of psychoeducation, psychological, or psychosocial interventions

- **Outcomes**: The first care plan review should be undertaken within three months of formulation and individual progress in relation to psychoeducation, psychological, or psychosocial interventions is reviewed

The schizophrenia pathway reflects the ongoing care issues raised within the early intervention pathway. It does not include those areas specific to the pre-assessment process, such as establishing a diagnosis and establishing the initial involvement of family.

The original ICP for Schizophrenia introduced HONOS and AVON across the range of services for this group. It is felt that no change is required to the use of these outcome measures at this stage.

Specific issues were raised by this group in relation to the availability of psychological intervention, and in relation to the skills of staff to deliver family interventions. These issues should be benchmarked prior to implementation of this pathway.

This group recommends application of the pathway for schizophrenia within mental health services for all people who are thought to have a diagnosis of schizophrenia. It is anticipated that people entering the service would commence on the pathway. Individuals already within the service should be receiving care in accordance with the existing schizophrenia pathway.

It is further recommended that activity in relation to the current ICP for Schizophrenia ends prior to the implementation of the generic mental health pathway. This would include the removal of existing checklists that are used as part of the ICP for Schizophrenia, and their replacement with a revised set of processes for annual review.

Medical records staff compile case files for new records or episodes of care, and it is important that they are clear about the documentation that these should include.

The subgroup identified key monitoring data to be:

- Number of contacts with family of person with schizophrenia – available through PIMS / potential PsyCIS developments
- Number of assessments completed by more than one discipline (regardless of whether these professions met jointly with the person or separate assessments took place) to
provide evidence of multidisciplinary decision-making

- Number of patients for whom more than one discipline is involved in their care
- Number of patients seen within five working days of the first multidisciplinary team meeting where referral considered

11. Stakeholder Involvement

A significant amount of stakeholder involvement has taken place in relation to these pathway developments, through the Hampden consultation event described above, ongoing communication between services and the ICP Facilitators, and the contribution of individual steering group members.

Further work was undertaken with mental health service managers to understand some of the implementation barriers pertaining to the ICP for Schizophrenia.

A significant part of the role of the ICP Facilitators in relation to the existing ICP has been to share progress and developments around this work. Staff will have remained well informed throughout the development phase, both through this process, and through the sharing of information within services by members attending the various subgroup meetings.

Service user involvement was seen to be an area of some difficulty for all of the pathways, perhaps with the exception of the dementia group. It is anticipated that service users will be engaged in the process when preparing for implementation. This may include involvement, at local level, in process mapping of current service provision and work to identify any changes that may be required to meet the standards.

The continuing involvement of staff and service users in the ongoing development of the ICPs is important. Support for this work is available through ICP Co-ordinators working within the Clinical Governance Support Unit.

12. Implementation Planning

The pathways give high level outlines of the expected standards of care. It is anticipated that individual services will need to be supported to identify the ways in which their current activity meets those standards, and address any areas where it does not yet do so. Ongoing communication with ICP Facilitators has confirmed that services acknowledge that the requirements of the pathway are in line with the way in which services are delivered currently. It is therefore anticipated that there would be few significant changes required to implement the pathway in relation to current practice. Discussion did, however, include feedback that some aspects of the pathway may not currently be evident in relation to decision-making, particularly where a feature of the pathway was considered but not deemed appropriate for a particular patient.

The use of improvement methodologies such as process mapping would be beneficial in determining if and where there are areas of inefficiency in existing processes. The benefit of the process mapping technique is that it gives staff the opportunity to stand back and take a ‘whole system’ view of a process, enabling them to identify where blockages or duplication are occurring and make changes accordingly.
Benchmarking against the generic pathway should include:

- Auditing a sample of records to evidence the extent to which current practice conforms to the requirements of the pathway.
- Investigating the skills of staff to implement specific components of the pathway such as the ability to deliver standards around psychological therapies and psychosocial interventions, and the administering of agreed outcome and assessment tools.
- Exploring the suitability of existing documentation and systems to meet the standards. (Existing tools such as the Equality and Diversity Impact Assessment Tool and the Scottish Recovery Indicator Tools may provide useful in supporting this process.)
- Examining opportunities for variance management systems.

Many of these activities will need to be undertaken prior to the implementation of the other components of the pathway. Consideration should be given to the pace with which condition-specific pathways are implemented, and the support required to facilitate this.

Appendix 1 provides an example of how the implementation phase of this work may be completed in relation to the generic mental health pathway. The Management Team should reach agreement on how the other pathways may be included within this process. A range of options is included in the conclusions of this document.

Staff should utilise improvement techniques endorsed by the Mental Health Collaborative to ensure that care processes are working effectively. These include

- **Process mapping:** As described above, there are benefits to be gained from staff taking time out to consider the effectiveness of existing ways of working
- **PDSA cycles:** The Plan, Do, Study, Act approach supports the use of simple changes which can often make a significant difference to services. It includes a real-time analysis of the impact of those changes, thereby determining the suitability of any approach prior to larger service changes being progressed.

13. Monitoring and Evaluation

**Variance Management / Exception Reporting**

An ICP is defined by NHS QIS as “an agreement to provide a comprehensive service on the basis of current views of good practice and available evidence or guidelines that includes a mechanism to pick up when a patient has not received the expected care in order to remedy this”.

This places a significant emphasis on the systems for addressing exceptions to delivery of planned care, formally called variance management.

The reporting of variances is a significant feature of an ICP because it enables understanding of the reasons why the anticipated delivery of care has not been fulfilled. As well as acting as a prompt for key activities, the recording and appropriate management of variances should encourage:

- Changes to the pathway as a result of interventions being found to be unhelpful or unnecessary.
- Changes to the way that services are structured to support the delivery of better care.
- Changes to the way services are resourced to reduce unmet need.

There is an anticipation that the way in which exceptions are managed is similar in approach to the current systems for the management of risk registers. An outline of levels of variance management and reporting is provided below:
• **Informal Analysis**: Looking at exceptions recorded in a local area. Actions taken locally to tackle gaps that are identified and/or share good practice that is highlighted.

• **Formal Analysis – Level 1**: Reports for the care team locally. Issues should be acted on at that level but will reflect problems which have not been addressed through informal analysis. Good practice will also be shared.

• **Formal Analysis – Level 2**: Reported to local care governance groups and identifying problems or areas of good practice that are the responsibility of others. Will reflect issues which could not be resolved at Level 1.

• **Formal Analysis – Level 3**: Reported to NHS GGC care governance group and identifying issues that need to be addressed across the system, or areas of good practice that could be shared. Will reflect issues that could not be resolved at Level 2.

NHS QIS suggested during early discussions that exception reporting should focus on a small number of key activities which would be considered to have a significant impact if delivered appropriately. This correlates with development of links between the Scottish Patient Safety Programme approach and implementation of the ICP, considered later in this report.

**Monitoring**
NHS QIS define monitoring as ‘The systematic process of collecting information on the performance of clinical or non-clinical activities, actions or systems. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas’.

There is no expectation that monitoring would be a point of care issue and it is recommended that a regular schedule of clinical audit against agreed standards could progress this.

The existing core audit schedules are based on the Community Nursing Standards and the Standards for Ward Management. They are overseen by Ward Managers and Nurse Team Leaders. This system currently addresses key areas of record keeping and care planning, medication, and user and carer involvement which are all of relevance to the proposed generic mental health pathway.

The existing system would need to be expanded to ensure a more multidisciplinary approach to its application, and opportunities to integrate this system with the establishment of the Scottish Patient Safety Programme in mental health should be considered.

**Future Development Opportunities**

The Schizophrenia group have a considerable advantage in that there is a dedicated clinical effectiveness project in place through the PsyCIS programme for diagnoses of psychosis. This project provides support to teams throughout the area which was formerly within the Greater Glasgow Primary Care Trust in a number of ways:

- assisting the maintenance of up to date caseload and diagnostic information by reviewing the completeness of data, date of last reviews, and availability of diagnosis – this supports accurate analysis of the number of people with this diagnosis who receive care in accordance with the pathway
- recording an annual retrospective review of care which would confirm whether key indicators are met – there are opportunities to use existing PsyCIS indicators or seek adjustment to ensure that pathway issues can be measured and monitored

The Partnership should consider the potential to extend its application in any way that would increase coverage to all areas of NHS Greater Glasgow and Clyde and/or increase the range of diagnoses that it currently supports to cover the wider requirements of this programme.
14. Scottish Patient Safety Programme (SPSP)

The Mental Health Partnership is currently exploring opportunities to develop an approach to the SPSP within mental health. This is an exciting opportunity of national interest.

Patient Safety methodology, as championed by the Institute of Healthcare Improvement, has been applied to the Acute Sector with encouraging results. Complications in service delivery that have previously been accepted as the norm are now almost eradicated. The principle of the approach is to use what we know about what goes wrong to create more effective and reliable interventions.

The SPSP combines the use of leadership structures to support service improvement; brief, small scale tests of new ways of working to test potential changes; and the use of routinely monitored information to measure the impact of those changes. It encourages the sharing of good practice and learning from the experience of others.

A working group has been established to explore the potential to apply this approach to the implementation of ICPs in NHS GGC. This group will review critical incident data and consider the specific features of the ICP which could influence the likelihood of recurrence.

One feature of the SPSP is the routine collection and analysis of information. This work has already been established to some extent with the implementation of core audit schedules. As described above, this system is already managed by ward managers and team leaders at a local level, where completed data is submitted to the Clinical Governance Support Unit for collation at area and MHP levels to provide information about performance in relation to key indicators. Local data is instantly available through recording on Excel spreadsheets, and improvements are identified and progressed at a local level.

15. Proposed Next Steps

ICP Co-ordinator
- Staff survey – what supports are needed to implement this pathway?
- Patient survey – how does the service currently meet your needs in relation to key areas for monitoring / exception reporting?
- Work with pilot service area to progress ICP implementation
- Use learning from pilot experience to support Mental Health Partnership to roll out ICP implementation across all service areas

Management Team
- Agree resource for supporting services to implement pathways
- Agree models for pathway implementation
- Agree monitoring and exception reporting mechanisms
Breakdown of Actions Required – Team Level

Consideration should be given at this stage as to whether these processes take place in relation to all the pathway requirements, or commencing with the generic mental health pathway.

Consideration should also be given as to whether these processes take place within one clinical area (e.g., a ward), or whether it is extended to include all elements that could influence a person's journey of care (e.g., including community mental health team, crisis service, early intervention service, etc).

It should be acknowledged that for this process to be successful, there needs to be an opportunity for everyone involved to make their contribution. Ideally, this would be a stakeholder event/development session, but there may be difficulties in identifying time for this to take place.

Actions required:

1. Map current activities and documentation to proposed pathway
2. Audit case records in relation to pathway
3. Obtain the patient perspective on current provision of care
4. Agree where practice currently meets expected standards of care and what further actions are required
5. Agree and implement action plan to achieve expected standards of care
6. Identify opportunities for collecting, recording and monitoring variances
7. Establish local resource folder – may include support from Practice Development Nurses, Practice Education Facilitators, Clinical Tutors, etc., acknowledging the role this folder may have in inducting new staff into any clinical area
8. Agree what should be monitored locally to identify whether action plan is being implemented and compliance with expected standards are changing, and how this will be done, including reporting arrangements to management team.

Breakdown of Actions Required – Organisational Level

- Review opportunities to co-ordinate improvement strategies
  - Core audit schedule adjusted to reflect requirements of pathway implementation. Consider reporting through the Care Governance Group, with agreed summary data being reported as a performance indicator through the Performance Assurance Group
  - Leadership arrangements for Patient Safety work to be agreed and the methodology applied to the ICP implementation process and seek organisational support for ongoing monitoring
  - Maintain and enhance links with MH Collaborative in supporting change management processes and utilisation of improvement methodologies such as PDSA cycles.
- Regular reporting of variances through a structured governance route, both at a detailed local level, and in summary at a managerial level
- Review opportunities to enhance processes delivered by PsyCIS project in terms of geographical and diagnostic inclusion criteria
- Ensure appropriate use of Integrated Health Record in fulfilling pathway requirements
- Continue to include pathway requirements in development of information management systems, including current pilot being supported by Redesign Manager
- Continue to ensure pathway requirements are progressed through existing mechanisms
  - Primary Care Mental Health Interface Group
  - Psychological Interventions Strategy Group
  - relevant planning and implementation groups
## List of Actions and Questions for Presentation of Pathways work to Senior Management Team of Mental Health Partnership

<table>
<thead>
<tr>
<th>Activity</th>
<th>SMT Question</th>
<th>Response from SMT – how to progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to embarking on the implementation of a generic mental health path</td>
<td>Can existing ICP work stop and documentation removed from systems?</td>
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<tr>
<td>way for all services, and subsequent additions of condition specific pa</td>
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<td>thways, it is important to end the current ICP process. All services sh</td>
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<td>ould be advised that the historical Glasgow ICP for Schizophrenia is n</td>
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<td>o longer in use. Existing ICP checklists in use and within admission p</td>
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<td>acks should be removed, to enable the introduction of the revised appr</td>
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<td>oach to pathway developments</td>
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<td>There should be a single pathway of care for all people in mental hea</td>
<td>Is it appropriate that ICP is only for those identified as requiring a comp</td>
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<td>lth mental health services who require a comprehensive mental health as</td>
<td>rehsessment?</td>
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<td>sessment</td>
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<tr>
<td>Pathways for specific diagnoses should be used in conjunction with th</td>
<td>Is it appropriate that generic ICP acts as foundation for all services with</td>
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<td>e specific additions dependent on diagnosis?</td>
<td>specific additions dependent on diagnosis?</td>
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<td>The care record should document consideration of each feature of the p</td>
<td>Is it appropriate that staff are expected to document consideration of all</td>
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<td>athway, and the outcome of that consideration</td>
<td>outlined features of care, with no checklist to guide practice?</td>
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<tr>
<td>Existing mechanisms for annual reviews should be maintained with fur</td>
<td>This is about how implementation is communicated – services may need</td>
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<td>ther detail obtained as necessary to fulfill the requirements of the p</td>
<td>support to translate existing practice into standards and identify any fur</td>
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<td>athway</td>
<td>ther actions required</td>
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<td>Variance Management Systems should be evident in each area at ward, a</td>
<td>How do you anticipate the recording and acting on variances in your area? W</td>
<td></td>
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<td>rea, and service levels</td>
<td>ho is responsible?</td>
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<tr>
<td>Options for ensuring depression standards are met should be considered</td>
<td>Specific considerations on page 8 of report – which approach? How to pr</td>
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<tr>
<td>Activity</td>
<td>SMT Question</td>
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<tr>
<td>Implementation of the ICP will be part of performance management reporting for managers – it is suggested that the Core Audit Schedules are developed to support this function</td>
<td>Is it appropriate that implementation of the ICP is performance managed? How will this work in practice?</td>
<td></td>
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<tr>
<td>In each area, staff time should be identified for work with Clinical Governance Support Unit to support benchmarking, implementation, and evaluation arrangements</td>
<td>How will implementation take place in individual wards, teams and services?</td>
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<tr>
<td>Benchmarking</td>
<td>Can this be facilitated locally? By whom? Is support required from the ICP Co-ordinator, or should services be issued a benchmarking tool and associated audit and evaluation tools to undertake within own service areas? Examples will be available from pilot area</td>
<td></td>
</tr>
<tr>
<td>Work should be undertaken in local teams (including all care settings) to identify current practice in relation to standards A case file audit should be undertaken Service users’ perspectives on key features of care should be obtained</td>
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<tr>
<td>Implementation</td>
<td>Is it appropriate to ensure generic pathway completes implementation before incorporating other diagnoses?</td>
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<tr>
<td>The generic mental health pathway should be implemented prior to the introduction of other condition specific pathways</td>
<td>Who will undertake this? What support is expected from ICP Co-ordinator?</td>
<td></td>
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<tr>
<td>Current systems and documentation should be mapped initially against the generic mental health pathway</td>
<td>Pilot underway in one area (generic only) – will be written up and made available when seeking implementation in other areas</td>
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<tr>
<td>Support should be provided to establish a local resource folder in one area to act as a model / pilot for other areas</td>
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<tr>
<td>This process should thereafter be completed for condition specific pathway additions</td>
<td>Is it appropriate that work is secured in relation to generic pathway implementation first? Revisit for implementation of other pathways will also help to measure extent of implementation of generic pathway and emerging issues.</td>
<td></td>
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<tr>
<td>Evaluation</td>
<td>Where and how will information be reported? And actioned?</td>
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<tr>
<td>Activity</td>
<td>SMT Question</td>
<td>Response from SMT – how to progress</td>
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<tr>
<td>Where appropriate, there should be a co-ordinated approach and integration with existing methodologies</td>
<td>Is it appropriate that existing mechanisms are established to support monitoring and evaluation wherever possible? This may require modification of some existing systems.</td>
<td></td>
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<tr>
<td>Core audit schedules should be used</td>
<td>Is it appropriate that core audit schedules be redesigned to work around standards of care as outlined in ICP, in a multidisciplinary way?</td>
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<tr>
<td>The ICP implementation process itself should be evaluated</td>
<td>Pilot will be written up and feedback gained from staff about the process, and how it may be improved for subsequent implementation. Ongoing process thereafter – ICP Service Standards.</td>
<td></td>
</tr>
<tr>
<td>Links should be made and maintained with the Mental Health Collaborative and potentially the Scottish Patient Safety Programme</td>
<td>Does the current structure support this collaborative working? Are more systems required?</td>
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<tr>
<td>Indirect Activity Impacting on ICP Potential</td>
<td></td>
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<tr>
<td>The current scope of the PsyCIS project should be reviewed in relation to geographical spread and diagnostic inclusion – potential to contribute to ongoing monitoring of ICP with development</td>
<td>Would it be useful to review current scope (geographic and diagnostic inclusion) of PsyCIS to support information management</td>
<td></td>
</tr>
<tr>
<td>Ensure that Information Strategy continues to make reference to ICP requirements. Over longer term this should tie in with not only mental health partnership, but wider Board and CH(C)P objectives (including links to hospital patient administration systems, primary care administration and decision support systems)</td>
<td>Where is this link made between MHP Information / Information Technology Strategy and NHSGGC-wide?</td>
<td></td>
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<tr>
<td>Progress development of Integrated Health Record towards single live record of care</td>
<td>Who should be responsible for ensuring this happens? How?</td>
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<tr>
<td>Progress Interface issues between primary and secondary care services, particularly in relation to assessment and management of physical health</td>
<td>None – action ongoing.</td>
<td></td>
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<tr>
<td>Activities Taken from NHS QIS / NHS GGC Action Plan following foundation level accreditation</td>
<td>Action Required</td>
<td>Route for delivery</td>
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<tr>
<td>Named Leads</td>
<td>None. ICP Co-ordinator – Margo Pratt / Karen Jenkins ICP Service Lead – Dr Linda Watt</td>
<td>Maintain existing</td>
</tr>
<tr>
<td>Stakeholder involvement</td>
<td>Continue to engage with range of stakeholders</td>
<td>Mental Health PFPI Group PCMH Interface Group Care Governance Group Mental Health Partnership Senior Management Team</td>
</tr>
<tr>
<td>Process Mapping</td>
<td>Progress mapping of individual services as part of implementation, encouraging use of SRI Tool and EQIA tool. Potential also to implement Admissions to Mental Health Best Practice Statement</td>
<td>Supporting implementation</td>
</tr>
<tr>
<td>Links to local care governance system</td>
<td>Kept advised during development phase Systems for variance management to be introduced</td>
<td>MHP Care Governance Group</td>
</tr>
<tr>
<td>Information Management</td>
<td>Systems for establishing numbers with each of the diagnoses outlined in the Standards IT Infrastructure Strategy</td>
<td>Maintain links with IT Strategy Group of MHP Links between this group and overall NHSGGC IT / Information Strategy Group</td>
</tr>
<tr>
<td>Activity Number</td>
<td>Description</td>
<td>Feb-10</td>
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<tr>
<td>1</td>
<td>Presentation to Senior Management Team of Mental Health Partnership</td>
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<tr>
<td>2</td>
<td>Identify resource within locality to support implementation of generic mental health pathway in pilot area</td>
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<td>3</td>
<td>Identify one CMHT for intensive support to inform process</td>
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<tr>
<td>4</td>
<td>Pilot area - Support within one CMHT and one ward to translate current activities to practice</td>
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<tr>
<td>5</td>
<td>Pilot area - Undertake analysis of existing systems and agree next steps</td>
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<td>6</td>
<td>Pilot area - Establish whether changes have led to improvements</td>
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<td>7</td>
<td>Pilot area - Develop guidance based on experience gained to develop a template / guidance to use when roll out to other service</td>
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<td>8</td>
<td>Agreement to progress approach by SMT of MHP</td>
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<tr>
<td>9</td>
<td>Progress implementation across all areas*</td>
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<td>10</td>
<td>Establish whether changes made successful and commence routine reporting of monitoring information</td>
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