In this issue:

03 / **Dementia**
Workstream Update

08 / **Depression**
Workstream Update

13 / **Readmissions**
Workstream Update

19 / **Events**

22 / **National Team**
Contact Information
Welcome to the latest edition of the Mental Health Collaborative Newsletter. Thanks to everyone who took the time to comment on our last edition – it was great to get so much positive feedback about it.

The Mental Health Collaborative is set up to support NHS Boards and key partners to deliver four HEAT targets: one associated with reducing psychiatric readmissions, one associated with improving the early diagnosis and management of those with Dementia, one associated with reducing the increase in amount of antidepressants prescribed and one that runs through everything we do – improving the quality of the healthcare experienced.

HEAT targets are the measures against which NHS Boards are publically monitored and evaluated. They reflect the Ministers’ priorities for the Health portfolio and are called HEAT targets as each one sits under one of the following key objectives:

- **Health Improvement for the people of Scotland** – improving life expectancy and health life expectancy
- **Efficiency and Governance Improvements** – continually improving the efficiency and effectiveness of the NHS
- **Access to Services** – recognising patients’ need for quicker and easier use of NHS services and;
- **Treatment Appropriate to Individuals** – ensuring patients receive high quality services that meet their needs

This quarter’s newsletter includes information on each of these targets and data on how each Board is doing.

We hope you find this edition of the newsletter useful – and as always – if you read about something that interests you - do follow it up.

Part of the aim of the Mental Health Collaborative is to support better ‘collaboration’ between all of those who are interested in improving the quality of Mental Health services. So encouraging direct contact to share ideas and good practice is a vital part of our work.

Our next newsletter will be March 10. If you want to highlight work you are doing locally, please send information to Rachna Dheer by the 31st January 2010 stating ‘Newsletter’ in the subject field

rachna.dheer@scotland.gsi.gov.uk
Dementia

Workstream Overview

Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.

This is measured by setting each Board a target number of people for GPs to have registered with a diagnosis of Dementia. This target equates to approximately 61% of those predicted to have Dementia using Eurodem prevalence data.

There are different ways of predicting how many people in a given area will have dementia. However, all of the methods use data which estimates how many people of a given age and gender are likely to have Dementia. These estimates are based on research and at the time of setting the target, the two most common prevalence rates were Eurodem and Dementia UK. So for instance, Eurodem says that 7 out of 10,000 females between the ages of 60 and 64 will have Dementia. However at the age of 85-89 the number increases to a 23 out of 100 females having Dementia. Applying all of these figures to a GP practice population will tell you how many people registered with that practice are expected to have Dementia.

Since setting the target new prevalence estimates have been produced – EuroCoDe - however, as the actual target is a number (overall Scotland needs to have 39,582 people with a diagnosis of dementia recorded by GPs), these new prevalence rates don’t change the target. For those who are interested – the target equates to 52% of those predicted to have Dementia using EuroCoDe. You can access a summary of all three sets of prevalence rates at http://www.nodelaysscotland.scot.nhs.uk/Pages/default.aspx

The following graph shows how well Boards are currently doing against the target. This shows that, though improvement is being made in the number of people being diagnosed, there is still some way to go. However, most NHS Boards are confident that, with the work they now have in place, they will deliver the required improvements in the number of people being diagnosed with Dementia. The Mental Health Collaborative will work...
closely with those Boards who are not as confident to provide additional support and guidance to enable them to also deliver the increases in the number of people being diagnosed.

But increasing the number of people who get a diagnosis is only part of the improvement story. We also need to improve the support that they receive post diagnosis. One way of doing this is by increasing the number of people who are getting their care reviewed.

Once an individual has a diagnosis recorded in primary care, they then become eligible for a 15 month review of their care. This review should be face to face and include:

01. An appropriate physical and mental health review for the patient
02. If applicable, the carer’s needs for information commensurate with the stage of the illness and his/her and the patient’s health and social care needs
03. If applicable, the impact of caring on the care-giver
04. Communication and co-ordination arrangements with secondary care (if applicable).

The following graph shows what percentage of people diagnosed with Dementia have received this 15 month review.

In addition to trying to increase the number of people who receive this 15 month review, Boards are also taking a range of other actions to improve the early management and support of those with Dementia. Please see the next section for an example of work being taken forward within a Board.
NHS AYRSHIRE & ARRAN - CARE HOME AUDIT

NHS Ayrshire & Arran conducted an initial audit of 3 care homes during May to June this year to establish a baseline position reflecting a range of issues for Care Home Staff re “diagnosis” and management of people with dementia. The aim was to use the information gleaned to inform the wider CMHT review, current partnership working arrangements and support a wider “Service Improvement Plan” for Older Peoples Services. Based on the overall evaluation a further 2 Care Homes were audited to capture a wider sample of smaller independent Care Home Providers. All residents within the 5 Care Homes were registered with a General Practitioner.

The first stage of the audit looked at:

- Residents’ profile
- Residents’ source of admission
- Support arrangements available to residents, their relatives and Care Home Staff

The second stage accessed 56 randomly chosen care records to identify aspects of care arrangements and management about how people with dementia are diagnosed and subsequently supported within care homes.

The areas covered included:

- Medical Involvement
- Assessment and Care
- Support arrangements, including the involvement of relatives

Amongst a number of findings a significant one was that none of the Care Homes could confirm which of their residents with a diagnosis of dementia were included on their GP’s register.

Specific actions identified were:

- Develop and support a clearer pathway for people with a dementia being transferred to a Care Home from each of the four General Hospitals
- Ensure a training/support framework is available as part of identifying priorities for improvement
- CMHTS to further develop interface arrangements with locality based Care Homes and other health colleagues.
- Ensure liaison with Care Homes in providing support and advice on a range of mental health issues, including the management of behaviour difficulties
- Develop enhanced links between CMHTs and District Nursing Service as part of jointly supporting anticipatory/end of life care arrangements for people within Care Homes
- Review the use of psycho-tropic medication within Care Homes by conducting an audit into referrals to CMHTs from Care Homes
- Ensure Care Homes are involved and appropriately informed of the ongoing work relating to the Dementia HEAT Target

Further details are available from Anne Gerard
Anne.Gerard@aapct.scot.nhs.uk

The following is an example of work going on in a Board around these themes. We know there is much more happening out there – so if you have a piece of work you want featured, drop Rachna a line at rachna.dheer@scotland.gsi.gov.uk
The first part of the Dementia HEAT target states that Boards must achieve approximately 61% of the expected level of dementia prevalence within their population by March 2011 (with GP dementia registers used as the data source).

To supplement this the Collaborative Dementia Reference Group was keen to measure improvement across the wider pathway of care, including timely diagnostic assessment and the quality of early management and support. Figure 1 below details the key parts of the pathway and the corresponding measure that can be used by Boards to drive improvement:

After consultation with a wide range of stakeholder groups, greater local autonomy has been agreed and Boards will report on the measures within the parameters set out below.

- All Boards will continue to report on DEMM1 & DEMM2.
- Boards will select at least one additional measure from DEMM3 and DEMM5.
- For DEMM3 and DEMM5, Boards can choose to follow the examples set out above or decide on a local definition (subject to approval from the Regional team).
- Boards are requested to discuss and agree with their Regional Team by 27th November which of DEMM3 or DEMM5 they are progressing.
- The target date for commencing monthly reporting on DEMM3 and/or DEMM5 is January 10.
- For DEMM4, we agreed with the feedback from Boards, that further work at this stage on a nationally defined measure is not the best use of the MHC improvement resources. DEMM4 is optional and should only be developed locally where Boards have particular issues around access to specialist mental health services.

Boards are requested to discuss and agree with their Regional Team by 27th November whether they are going to report on DEMM4. Support is available from the Regional Teams for those Boards who decide to develop a local access times measure.
Dementia: Publications of Interest

Developing Nursing Practice: a counselling approach to delivering post diagnostic dementia support

Weaks, D., Johansen, R., Wilkinson, H., and McLeod J. (2009),

This report looks at the impact of equipping Community Mental Health Nurses with person centred psychosocial counselling skills and highlights a positive impact in working with the painful emotions that were triggered by a diagnosis and in enabling clients to make better use of their existing relationships and support networks to organise effective selfcare.

http://www.nodelaysscotland.scot.nhs.uk/Pages/default.aspx

Using electronic assistive technology to support people with Dementia


The Joint Improvement Team (JIT) are pleased to support the launch of the ‘Using electronic assistive technology to support people with dementia’, by funding 400 free downloads of this practice guide. This publication is aimed at practitioners supporting the delivery of technology based support services to people with dementia. It seeks to inform the reader about the context in which technology can support a person with dementia and provide an education framework to train staff delivering these services.

The JIT is supporting this publication as part of the Scottish National Telecare Strategy to inform and develop practice in the delivery of technology.

The book is made up of two parts. The first section gives an overview of the role of assistive technologies in supporting people with dementia. The second section contains the resources you need to deliver a one-day training programme on assistive technology. This resource can be accessed at http://www.dementiashop.co.uk/?q=node/264

Early Interventions in Dementia

Centre for Ageing and Mental Health, Beeston D

The Centre for Ageing and Mental Health has used a range of research methods to examine the evidence base across 9 key themes regarding early interventions in dementia. The key themes include Epidemiology of Dementia, Screening for Dementia, Drug Treatments, Psychosocial Interventions, Carer perspectives and Risks/ Ethical/Legal Aspects. The paper can be accessed at http://www.nodelaysscotland.scot.nhs.uk/Pages/default.aspx

Annual Evidence Update on Alzheimer’s Disease and Dementia

The Annual Evidence Update aims to highlight the best current evidence for selected healthcare topics and includes user-friendly summaries written by relevant experts, and links to guidelines, secondary research and primary research, if applicable. All information included in Annual Evidence Updates has been subject to rigorous selection criteria.

The evidence update on Alzheimers disease and Dementia covers

* Alzheimer’s
* Vascular Dementia
* Dementia with Lewy Bodies
* Frontotemporal Dementia
* Mixed Dementia

and can be accessed at www.library.nhs.uk/laterlife
**Depression**

**Workstream Overview**

NHS Boards to reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years

“Defined Daily Dose” (DDD) is an internationally recognised unit given to a drug by the World Health Organisation. It enables some comparison of quantities of drugs which have different therapeutic dose values.

For instance the DDD for Citalopram is currently 20mg whilst that for Lofepramine is 105mg. The use of DDD partially controls for changes to prescription levels caused by moving from one drug to another (e.g. 20mg of Citalopram = 1DDD = 105mg of Loprefamine).

It is important to note that the target measures Defined Daily Doses not the number of people on antidepressants. We do not know how many people are on antidepressants as the prescribing data only tells us how much of the drug has been dispensed. Hence, we do not know whether the numbers of people on antidepressants have been increasing or decreasing over recent years. All we know is that the numbers of DDDs have been increasing – but this could be associated with a range of factors.

We know that some aspects of good practice will increase the levels of DDDs, and that some good practice will act to decrease the level of DDDs (see table below). A growing research consensus suggests that most of the increase in DDDs is caused by a relatively small group of people taking

---

**Latest News**

The Antidepressant HEAT target is being replaced from April 2010 with an access to psychological therapies HEAT target. The antidepressant HEAT target has always been acknowledged as a proxy measure for improved access to psychological therapies, the proposal is to now measure this directly.

The new HEAT target says:

During 2010/11 the Scottish Government will work with NHS Boards to develop an access target for psychological therapies for inclusion in HEAT in 2011/12.

The supporting guidance says:

NHS Boards required to deliver milestones on defined pathways for psychological therapies and new data sources during 2010/11 to allow specific target on psychological therapies to be included in HEAT 2011/12. Target to set access standard for those requiring access to named psychological therapies.

The MHC Depression Workstream has concentrated on improving both evidence based prescribing of antidepressants and improving access to non-drug treatments for depression – so this will not have a major impact on our work. We will continue to work with NHS Boards and their key partners, to deliver improvements in these two areas.
their medicines for a longer period, rather than an increase in people starting a drug for the first time. Improved long-term concordance with antidepressants is likely to be clinically appropriate for most people (see New Publications Section for link to new research around this).

The following table highlights aspects of good practice that may lead to elevated or reduced levels of DDDs.

<table>
<thead>
<tr>
<th>Factors which impact levels of DDDs</th>
<th>Good practice interventions that will reduce DDDs</th>
<th>Good practice interventions that will increase DDDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision to Prescribe</td>
<td>GPs may sometimes use antidepressants to manage low mood for want of access to more appropriate treatment options (like psychological therapies). Improving access to psychological therapies and other non-drug treatments may act to reduce DDDs.</td>
<td>There is evidence to suggest that depression may be underdiagnosed and undertreated, particularly in some groups (elderly people, those with chronic physical illness and perhaps in some ethnic minority populations). Improved case finding and concordance with treatment guidelines may result in an increase in DDDs.</td>
</tr>
<tr>
<td>Duration</td>
<td>NICE guidelines indicate that patients should be supported to stay on the antidepressant for a minimum of 6 months post recovery. Improving concordance with NICE guidelines will increase DDDs.</td>
<td></td>
</tr>
<tr>
<td>Dosage</td>
<td>Dose-response curve for SSRIs is probably flat, yet many people take two or three times the “usual” dose. Prescribing only the minimum effective dose may reduce DDDs.</td>
<td>Some antidepressants (particularly tricyclic drugs) may be prescribed at sub-therapeutic levels. Addressing sub-therapeutic prescribing will increase DDDs.</td>
</tr>
</tbody>
</table>
What's happening

The following is an example of work going on in a Board around these themes. We know there is much more happening out there – so if you have a piece of work you want featured, drop Rachna a line at rachna.dheer@scotland.gsi.gov.uk

NHS HIGHLAND VALUE STREAM MAPPING IN CLINICAL PSYCHOLOGY

What we were trying to achieve
To distribute the available staffing to best effect the team wanted to find out what areas of clinical work used the highest volume of department resources.

What we did
At the time of the exercise (Feb 2009) NHS Highland had 2200 clinical psychology patient records for the time period of interest.

Information was extracted from 175 case notes using an electronic proforma, and the data was collated and analysed by gender, age, referrer and main complaint at point of referral.

Measurable outcomes:
The data retrieved provided information about waiting times, number of appointments, number of attendances, days in treatment; condition and type of treatment as follows:

- 30% of patients in the sample did not attend a first appointment
- 50% (approximately) of referrals were for depression, anxiety or mixed states
- CBT was the intervention offered most often
- 88% of patients attended 10 times or less
- 56% of patients attended 5 times or less.
- A few individuals had considerably more appointments and constituted a substantial proportion of the activity
- There were some instances of lengthy delays between discharge and issue of discharge letter

Potential Service Improvements
Using the above information the department will be able to re-focus existing resources to maximise efficiency in delivering services to this population.

Plans for Spread
We are sharing the ideas behind this process with other departments and other boards who have experienced a similar lack of available information and data.

Key Contacts
Cameron Stark
› Cameron.Stark@nhs.net
01463-704996

Lynda Forrest
› Lynda.Forrest@nhs.net
01408-664079
The MHC conducted a consultation with Boards on proposed Improvement Measures for the Depression Workstream. As a result of this the following decisions were taken:

- Progressing with a locally defined improvement measure for evidence based prescribing. All Boards are asked to set their own local measure, with the aim of reporting on this by January 2010. Support is available from the MHC Regional Teams to do this.
- We have produced guidance on potential measures to help boards in setting a local measure and this can be accessed at http://www.nodelaysscotland.scot.nhs.uk Pages/default.aspx Boards are able to set a local measure that is not included in this summary.
- MHC National Team will start with 1 GP practice, their local MHC Team and relevant system suppliers to develop changes to GP systems that enable practices to report and analyse Dep 2 and Dep 3 at a population level.
- We will evaluate the usefulness of setting local measures to measure improvement, at the end of 2010.

Co-Creating Health – one of The Health Foundation’s Demonstration Sites

Co-creating Health is a self-management scheme that aims to transform healthcare for people with long-term conditions. Studies have shown that supporting self-management can lead to dramatically improved outcomes for patients. Despite this, it remains at the periphery of most health services.

Defining ‘co-creating health’ - providing responsive, effective services for people with long-term conditions creates enormous challenges for health services. Many people are ready to take a more active role in their own care, but they need to work in partnership with their clinicians to achieve lasting improvements in their health. This is what is meant by ‘co-creating health’.

The Health Foundation believes that to take a more active role in their health, people need self-management skills and easier access to information about their conditions. They also need skilled support and motivation from their clinicians and healthcare systems that operate very differently from those we have today.

The approaches being used are:
- an advanced development programme for clinicians. This will help them develop the skills required to support and motivate their patients to take an active role in their own health
- a self-management course for people with long-term conditions. This will help them develop the knowledge and skills they require in order to manage their long-term condition and work in effective partnership with their clinicians
- an organisational development programme. This will support patients and healthcare professionals, working together, to identify and implement new approaches to health service delivery which enable patients to take a more active role in their own health.

The sites working on Co-creating Health with a Depression focus are:
- South West London & St George’s Mental Health NHS Trust, Wandsworth Teaching PCT
- Devon Partnership Trust, Torbay Care Trust

The MHC has met with representatives from the two sites and plans to organise an event with them in Scotland in Spring 2010. If you want to find out more about this work please go to: http://www.health.org.uk/current_work/demonstration_projects/cocreating_health.htm
The Primary Care Clinical Informatics Unit database sits with Aberdeen University and is funded by ISD/Scottish Government. It currently uploads anonymised GPASS practices data from across Scotland and therefore covers approx 1/3 of the Scottish population. The Mental Health Collaborative has commissioned work to interrogate this database to answer a range of research questions around antidepressant prescribing trends across Scotland including:

- the proportion of patients in a representative sample of Scottish practices who start taking an antidepressant over a year;
- the dose and duration of that treatment;
- the proportion of antidepressant prescribing accounted for by medium and longer term prescribing;
- the influence of the following factors in prescribing practice: patient age, sex, physical co-morbidity, deprivation and GP practice;
- the duration of treatment for those patients stopping antidepressants;
- the proportion of patients taking antidepressants for conditions other than depression and anxiety.
- The proportion of amitriptyline prescribing accounted.

This work will report in Spring 2010.

Depression: Publications of Interest

Newly updated NICE Depression Guidelines
NICE have just published an updated guideline on the treatment and management of depression in adults (Oct 09) and this can be accessed at http://guidance.nice.org.uk/CG90. It has also published an updated version of the guideline on the treatment and management of depression in adults with chronic physical health problems which can be accessed at http://www.nice.org.uk/CG91

Explaining the Rise in Antidepressant Prescribing: A descriptive study using the General Practice Research Database

This paper presents evidence for the rise in antidepressant prescribing being mainly explained by small changes in the proportion of patients receiving long term treatment. It can be accessed at http://www.bmj.com/cgi/content/abstract/339/oct15_2/b3999

Annual Evidence Update on Depression
The Annual Evidence Update aims to highlight the best current evidence for selected healthcare topics and includes user-friendly summaries written by relevant experts, and links to guidelines, secondary research and primary research, if applicable. All information included in Annual Evidence Updates has been subject to rigorous selection criteria.

The Depression Annual Evidence Update (AEU) for 2009 contains the best available evidence published on depression since January 2008 and can be accessed at www.library.nhs.uk/mentalhealth. It covers:

- Incidence and Prevalence
- Diagnosis, Prevention and Screening
- Pharmacological Treatments
- Psychological Therapies
- Transcranial Magnetic Stimulation
- Complementary and Alternative Treatments
- Populations and Settings
- Genetics

The Primary Care Clinical Informatics Unit database sits with Aberdeen University and is funded by ISD/Scottish Government.

It currently uploads anonymised GPASS practices data from across Scotland and therefore covers approx 1/3 of the Scottish population. The Mental Health Collaborative has commissioned work to interrogate this database to answer a range of research questions around antidepressant prescribing trends across Scotland including:
Readmissions

Workstream Overview

NHS Boards to reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of at least 7 days) by 10% by the end of December 2009

There has been some confusion over this target. The following highlights the key points around how the target is calculated:

• The initial admission should be at least 7 days as should any readmission.
• The readmission needs to fall within one year of the initial discharge. For example, patients discharged in January 2004 would be ‘tracked’ until January 2005 to determine whether they were readmitted; similarly patients discharged in February 2004 would be tracked until February 2005.
• The target counts the number of individuals who have been readmitted – not the total number of readmissions. So a patient who was readmitted 4 times during the year only counts as 1 individual who was readmitted.
• It includes all psychiatric specialties except learning disabilities
• Transfers between mental health inpatient wards or units do not count as a readmission.
• Year ending December 2009 is the period for the initial discharge – so individuals are then tracked for a further 365 days following discharge. This means we won’t have a complete data set until the end of December 2010 for this target.
• The target uses year ending December 2004 as the baseline from which to calculate the 10% reduction.

Though this target is not part of the 2010/11 HEAT set – it is a live target until December 2010. Boards delivery against this target will continue to be tracked under the 2009/10 HEAT system through to December 2010.

The following graph shows that most Boards have already met this target and across Scotland a reduction of 26% had been achieved at year ending June 08 (which tracks readmissions within 365 days through to June 09). The Mental Health Collaborative always advises caution with just looking at one data point in systems where there is natural variation. However, it also tracks the ongoing trends and the majority of Boards are on a consistent downward trajectory for readmissions.
The following graph shows the HEAT readmission rates per 100,000 population. This shows that Shetland and Orkney have the lowest rates in Scotland so a 10% reduction for them was particularly challenging. Further, their numbers are so small (less than 10 a year) that a change of just one readmission can be the difference between meeting the target or not.

In addition to looking at readmissions as defined by HEAT, the Mental Health Collaborative also looks at all readmissions within 133 days. 133 days was picked as this was the point where the rate of readmission started to level out. The following graph shows the Scotland wide position. This shows that, if you are admitted to a psychiatric inpatient unit, there is about a one in four chance of being readmitted within 133 days of being discharged. Through the readmissions workstream, there is a lot of work going on in Boards to look at the reasons for readmissions and whether improvements can be made so that we help more people to stay out of hospital.
what's happening

The following is an example of work going on in a Board around these themes. We know there is much more happening out there – so if you have a piece of work you want featured, drop Rachna a line at rachna.dheer@scotland.gsi.gov.uk

READMISSIONS - EXAMPLE OF BOARD IMPROVEMENT WORK

The Mental Health Collaborative places a lot of emphasis on making better use of data to drive improvement and to assess whether a change has actually led to an improvement. However, for data to be meaningful and useful for improvement work, it needs to be up to date. One of the problems with the readmissions data (SMR04s) was that, for some Boards, there was a very long time lag between a patient being discharged and the data being entered into the system. So, one of the early aims of the Readmissions Workstream was to support Boards to redesign their processes so that data was quickly updated. The target was for data to be 95% complete within 8 weeks of month close. The following table shows the improvements that have been made over the last year. In particular Greater Glasgow and Clyde, Forth Valley and Western Isles have made significant improvements. Well done to everyone in these Boards that has worked so hard to deliver this. Having accurate data opens the door for clinicians and managers to now start making much better use of the data to inform improvement work.

Please see the next section for more information on how NHS Forth Valley used improvement techniques such as process mapping and PDSAs to deliver more timely data.

<table>
<thead>
<tr>
<th>Historic SMR04</th>
<th>Jul’07- Jan’08</th>
<th>Oct’07- Sep’08</th>
<th>Jan’08- Dec’08</th>
<th>Apr’08- Mar’09</th>
<th>Jul’08- Jun’09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>97%</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Borders</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Fife</td>
<td>74%</td>
<td>51%</td>
<td>74%</td>
<td>80%</td>
<td>68%</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>62%</td>
<td>37%</td>
<td>17%</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>Grampian</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>48%</td>
<td>66%</td>
<td>67%</td>
<td>51%</td>
<td>100%</td>
</tr>
<tr>
<td>Highland</td>
<td>98%</td>
<td>95%</td>
<td>93%</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Lothian</td>
<td>72%</td>
<td>85%</td>
<td>98%</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>Tayside</td>
<td>95%</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>78%</td>
<td>50%</td>
<td>27%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>All NHS Boards</td>
<td>75%</td>
<td>82%</td>
<td>84%</td>
<td>82%</td>
<td>96%</td>
</tr>
</tbody>
</table>

FORTH VALLEY IMPROVING THE COMPLETION OF PSYCHIATRIC INPATIENT DATA RETURNS (SMR04S)

The completion rate of SMR04 returns in Forth Valley was well below the agreed target of 95% completion within 8 weeks of month end. The local Mental Health Collaborative Programme Manager contacted key people who could influence change and improvement. A short-life multi-disciplinary group was established involving Health Records, PIMS administrator, Ward Admin Managers, a Charge Nurse, Information analyst and a Consultant Psychiatrist.
The group was made aware of the problem and carried out a current state Process Mapping exercise. This was followed by a Process Map of the ideal state which enabled the identification of problem areas. A PDSA plan was devised by the group with key actions agreed for a test of the revised process over a two month period. The test involved nursing staff in 2 acute admission wards and relevant Medical Secretaries. Health Records sent out monthly highlight reports detailing SMR04 data missing from discharge letters and the secretaries and Charge Nurses responded appropriately.

As a direct result of this improvement action, completion rates rose to 100%. The SMR04 data has also been included in a revised Initial Assessment Form and a new Discharge Care Planning Form to sustain the improvement. Discussions are underway, as part of a system-wide Admin Review, for further improvement involving ward admin staff completing the data on PIMS at source and to support Consultants to complete discharge letters to a standard of within 2 weeks of discharge.

Graham McLaren, Program Manager, NHS Forth Valley.
graham.mclaren@fvpc.scot.nhs.uk

READMISSIONS UPDATE ON NATIONAL WORK

Readmissions Improvement Measures
Supporting Improvement in the Patient Experience

The Readmissions Stakeholder Reference Group identified four key areas of work to reduce readmissions. These were:

- Improve delivery and outcomes of assessments for admission
- Improve the Inpatient Experience
- Improve Discharge Planning
- Ensure all services are focused on sustaining wellbeing and recovery

The group went on to identify Improvement Measures that would drive and evidence improvement across these four key areas. These measures included one that would support improvements in the patient experience.

Consultation on the patient experience measure attracted mixed views but, there was support for a nationally defined measure aimed at core and universal improvement to the experience of people receiving mental health services.

A Task and Finish Group was formed in response to that consultation and representatives were invited from across Boards, voluntary organisations and service user groups.

The Task and Finish Group proposed and consulted on four potential measures reaching approximately 439 individuals. The outcome of this exercise demonstrated little, definitive support for any of the measures. However, there was a groundswell of opinion around capturing work relating to the patient experience being undertaken through other programmes and helping to ensure that:

- Work related to the four Readmissions key areas of work
- The impact of changes made to processes aimed at improving the patient experience was actually considered

To achieve this the group agreed that Boards should report on the following:

- Which key areas they are focusing on with respect to patients’ experiences of care
- What methods they are using to obtain information about that experience
- What actions they are taking in response to feedback from the methods applied
- When they will review and assess the impact of any actions taken

This information will be gathered using the Mental Health Collaborative Reporting Tool that Boards are already using and returning monthly. The work required to adapt the tool for this function will be undertaken over the next few weeks. The aim is to achieve monthly reporting by Boards by the end of February 2010.

The final report with the detail of this work has been issued to Executive Sponsors, Key Contacts and Programme Managers during November. Copies are available from rachna.dheer@scotland.gsi.gov.uk

In the meantime, should you have any queries about the work please contact either David Hall on dhall2@nhs.net, frances.wiseman@Scotland.gsi.gov.uk or vijay.gill@Scotland.gsi.gov.uk
Improvement & Support Team Mental Health Demand Capacity Action Queue (DCAQ) & Wiseman Workload Management (WWM) e-Tool

The Mental Health Collaborative is pleased to announce the roll out of two tools to help services better manage their demand and make the best use of current capacity. IST Mental Health DCAQ Tool and Wiseman Workload Management e – Tool. The two tools are complementary, though each tool can be used independently of the other.

The IST MH DCAQ Tool helps teams to analyse their demand and capacity – and mismatches between the two. It enables teams to model the impact of changes at a team level such as sickness levels, DNA rates, how often clients are followed up and how much work is seen individually or in groups. It can be used by any community mental health service which has a reasonable throughput of work (CMHTs, Primary Care Mental Health Teams, Older Adult (CMHTs, CAMHS). It is not appropriate for community teams with reasonably static caseloads i.e. Assertive Outreach and Rehabilitation Teams.

The Wiseman Workload Management tool is already used in a paper format across a range of mental health services in Scotland. It is now available in an electronic format. This tool is focused at an individual practitioner level and enables individual staff to analyse their current workload. It is designed to be used within the context of individual line management supervision. Tool can be used within any community mental health service.

How can we access them?

Testing of the IST MH DCAQ tool has highlighted that it may need to be customised to your local service set up. The Wiseman Workload Management Tool requires training before use. Therefore access to both tools is through the local MHC Programme Manager who will then liaise with the Regional MHC Teams to agree a plan for roll out. If you are uncertain who your MHC Programme Manager is, check our contacts page at the back to obtain a name to for your region.

Contacts: Please see contacts section on page 22
Institute for Health Improvement Online Tutorials

There are several useful online tutorials available from IHI, which include sessions from Bob Lloyd on using run charts and building skills for data collection and understanding variation. These are free and can be accessed at:

http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/

Readmissions: Publications of Interest

MENTAL HEALTH IMPROVEMENT GAME

What is it?
This is a fun way to learn how the design of processes impacts on the flow of work through a community mental health service. It will help you to see first hand how the design of your processes can result in queues and waiting lists.

During the day you will be involved in a process simulation exercise – we start you off with a pretty messy process and the game simulates how service users progress through it (or perhaps we should say, don’t progress through it!). You will work in a team and will get regular opportunities to make improvements to your process. You spend the morning playing the game and we then use the afternoon to debrief, go through the relevant theory and help services to think about practical application locally.

How was it developed?
This is a ‘mental health’ version of a game that has been successfully used for many years around A&E improvement work. We’ve worked with the designer of the A&E game to completely overhaul it for Mental Health. We’ve already tested the game twice and had extremely positive feedback from our most recent test run.

Who is it aimed at?
The game is designed to help clinicians and managers think through the application of demand, capacity and flow improvement theory to community mental health services. It applies equally to adult, older adult and child and adolescent mental health services. It enables those playing it to experience first hand the potential benefits of a range of improvement tools and their application to community mental health services.

How can I access it?
At the moment the game is only available through the National Mental Health Collaborative Team, though we will be supporting improvement staff within Boards to run it in the longer term. The Mental Health Collaborative Team will prioritise running the game with clinicians and managers tasked with delivering improved access to psychological therapies, or improved running of adult and older adult CMHTs. Boards may also find it beneficial to include staff from CAMHS and Drug & Alcohol services in any local event.

If you are interested in this game being delivered locally, please contact your local Mental Health Collaborative Programme Manager in the first instance. If you are uncertain who this is, please contact your Regional Manager (contact details at end of newsletter) and they will put you in contact.
The Mental Health Collaborative runs a wide range of events to support staff to develop their skills in using improvement techniques. Increasingly we are delivering training on improvement techniques within the Boards. However, we also run events to encourage the sharing of practice between different areas – both what has worked well and what hasn’t worked so well.

National Network of Crisis Resolution & Home Treatment services
19th February 2010 / Park Suite / The Park Hotel Kilmarnock
This network is open to anyone who is involved in delivering or receiving crisis services. This meeting is being hosted by NHS Ayrshire & Arran. For further details & to confirm attendance please contact Rachna.dheer@scotland.gsi.gov.uk

MHC Clinical Leads Network
26th February 2010 / Scottish Health Services Centre
This event is aimed at the Mental Health Collaborative Clinical Leads within Boards. The morning session will cover training on managing resistance to change and the afternoon session will split into a workstream focus. To register for this event please go to www.shsceventsbookings.co.uk and click on ‘Mental Health Collaborative, Clinical Leads Networking event’

Improving Mental Health Services in a Mutual NHS
“working together for improvement - learn nationally, use locally”
The Mental Health Collaborative (MHC) hosted a national Service User and Carer event in the Tollbooth, Stirling on the 25th August 2009. The event was well supported by delegates from all over the country and was fully booked with 60 people attending on the day.
The day went well with delegates engaging readily and developing their understanding of what the MHC was all about. Most people reported on their evaluations that they were going back to their local areas to get involved – which was the main aim of the day.

Clinical Leads Networking Event
An event was held in August for Mental Health Collaborative Clinical Leads. The purpose of the day was to bring Clinical Leads together to share and discuss issues that they would find helpful in carrying out their role. In order to make the day as relevant as possible, people were asked in advance what they wanted to focus on and the programme formed on their feedback.
The event was attended by 35 people and the sessions covered:
• The role and responsibilities of Clinical Leads in Collaboratives
• Using Information for Improvement
• Engaging with Primary Care - case study example of work in Dumfries & Galloway to improve the number of people on the Dementia registers

The majority of participants fed back that they had found the content of the sessions good or excellent. Those attending agreed to hold quarterly Clinical Leads’ meetings as it had been a useful forum for sharing ideas and providing peer support.

The next Clinical Leads meeting will be held on 26th February 2010. Please see Forthcoming Events Section for further information.

National Learning Event - Working Together to Deliver Improvement

Our annual National Learning Event was held in October 2009 and was aimed at anyone involved in delivering improvements across Mental Health Services.

The majority of the day was spent in workshops which were themed around each of the three workstreams – Dementia, Depression and Readmissions. We also offered workshops on Reliability Theory, Managing Resistance to Change and Measuring for Improvement. Copies of all of the presentations for the day can be accessed at http://www.nodelaysscotland.scot.nhs.uk/Pages/default.aspx

The following sessions were also webcast:
• Opening Plenary Session
• Introduction to Reliability Theory Workshop
• Improving the mental health of people with long term conditions: lessons from the Living Better Project
• Dementia – Early Support & Management
• Question Time meets in the Psychiatrists Chair

So you can watch these at any time by going to http://www.video3uk.com/mhc

There was also an area for NHS Boards to put up a poster to share an example of local improvement work. This gave an opportunity for NHS Boards to showcase their work and also a for others to network and share ideas. Copies of these posters can be found at http://www.nodelaysscotland.scot.nhs.uk/ImprovementSupport/Pages/MentalHealthCollaborative.aspx

The day evaluated extremely well with feedback that the majority of delegates had found the content of the sessions good or excellent. Our thanks go to everyone who helped us to deliver such a successful national event.
MHC Depression Network - Focus on Prescribing

3rd December 2009 / Scottish Health Services Centre

The aim of this event was to bring interested parties together nationally to share experiences and learning around key issues relating to the prescribing aspects of this workstream. The agenda for the day included:

- **Focus on Improvement Measures** – Discussion about how Boards are progressing with the development of a local measure to monitor improvements in the evidence based prescribing of antidepressants.

- **Focus on Formularies** – Included feedback on a piece of work to draw together information from all NHS Boards about their formularies for antidepressant prescribing. It also included the opportunity to see a demonstration of ScriptSwitch, a software product that supports GPs to adhere to local formularies.

- **Focus on Audit** – Finally, several Boards are undertaking audit work to better understand antidepressant prescribing in their areas. Information was pulled together and shared at the event on these audits - as well as giving attendees the opportunity to discuss what they are doing and what they have learned as a result.

There was a case study presentation from NHS Ayrshire & Arran on their work. And another on some early findings from Chris Buston and Colin Simpson from the University of Edinburgh on an examination of antidepressant prescribing with the PCCIU data set, work commissioned by the MHC.

Feedback from those at the event was very positive and a more detailed write up will be available shortly on the MHC pages at No Delays Scotland together with slides from the presentations [http://www.nodelaysscotland.scot.nhs.uk/ImprovementSupport/Pages/MentalHealthCollaborative.aspx](http://www.nodelaysscotland.scot.nhs.uk/ImprovementSupport/Pages/MentalHealthCollaborative.aspx).

There was a general consensus to run approx 3 Depression Network events a year, with each one focusing on a different topic. The next event will focus on the self management of depression and further details will be circulated shortly.
Contacts

North Regional Team

Frances Wiseman
Regional Manager
mobile: 07500 126190
frances.wiseman@scotland.gsi.gov.uk

Caroline Paterson
Service Improvement Manager
mobile: 07799 056922
caroline.paterson2@scotland.gsi.gov.uk

Frances Matthewson
Information Manager
mobile: 07919 298121
frances.matthewson@scotland.gsi.gov.uk

South & East Regional Team

David McClay
Regional Manager
mobile: 07500 126191
david.mcclay@scotland.gsi.gov.uk

Jennifer Russell
Service Improvement Manager
mobile: 07554 332345
jennifer.russell@scotland.gsi.gov.uk

Paul Arbuckle
Information Manager
mobile: 07833 047294
paul.arbuckle@scotland.gsi.gov.uk

West Regional Team

Alana Atkinson
Regional Manager
mobile: 07500 126193
alana.atkinson@scotland.gsi.gov.uk

David Law
Service Improvement Manager
mobile: 07799 063719
david.law@scotland.gsi.gov.uk

Vijay Gill
Information Manager
mobile: 07500 606686
vijay.gill@scotland.gsi.gov.uk

Clinical Leads

DEMENTIA
Dr Gary Morrison
gary.morrison@nhs.net

DEPRESSION
Dr Michael Smith
michael.smith3@nhs.net

READMISSIONS
Dr David Hall
dhall2@nhs.net
We are keen to use this newsletter to spread information about the practical actions that NHS Boards and their key partners are taking to improve their mental health services. If you have an article you want included in the next edition of the newsletter then please send it to Rachna Dheer by 31st January, stating ‘Newsletter’ in the subject field.

In the spirit of Continuous Improvement, we are also keen to get your views on this newsletter. If you have any comments or ideas for how we could make it better then please do feed back to Rachna.

Subscribe by emailing ‘Please add me to MHC Newsletter mailing list’ in the subject box.

Unsubscribe by emailing ‘Unsubscribe MHC Newsletter’ in the subject box.

rachna.dheer@scotland.gsi.gov.uk