Mental Health Collaborative
April 08 – March 11
Programme Closure Report
June 2011
Introduction

Aim of Report
The Mental Health Collaborative was a three year improvement programme running from April 2008 to March 2011. The aim of this report is to:

• Summarise the high level outcomes achieved against the main programme aims.
• Summarise in one document the key resources produced to support the delivery of these aims and provide either direct links or contact details for further information.
• Summarise the key issues that need to be addressed locally and nationally to ensure NHS Boards build on the work to date.

It is not intended to describe the vast amount of work that has taken place across Scotland, as to do so would result in a lengthy document; and the problem with lengthy documents is that few people read them. Instead it seeks to identify the high level outcomes and signpost on to more detailed information about the actual work undertaken.

Aims of the Mental Health Collaborative
The Mental Health Collaborative was set up to support NHS Boards and their key partners to use improvement approaches and techniques to deliver the underpinning improvements to enable delivery of three HEAT targets. These targets were to:

• increase the number of people diagnosed with dementia and their early management and support by March 2011.
• reduce the number of psychiatric readmissions (within one year) for those that have had a psychiatric admission of at least 7 days by December 09.
• reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by March 2010. In 2010/11 the depression work re-focussed to support NHS Boards and their key partners to prepare for the new access to psychological therapies HEAT target.

It delivered this role through:
1 Supporting staff working across mental health services to develop the knowledge and skills required to use improvement approaches and techniques.
2 Supporting the application of these techniques to deliver Mental Health HEAT targets.
3 Supporting staff to share their experiences of using these techniques to deliver improvement through a variety of methods including events, networks, case studies, websites and newsletters.


The next section outlines the high level outcomes against each of these three deliverables and provides a summary of the key national resources that supported delivery of these outcomes, together with links to these resources where appropriate.
Outcome One - Supported staff working across mental health services to develop the knowledge and skills to use improvement approaches and techniques

Evidence that we delivered this outcome

At the end of our second year we conducted an evaluation into the effectiveness of the Mental Health Collaborative. The evaluation was conducted at the end of the second year to enable us to ensure best use of resources over the final year of the programme. In reality, most local teams had only been fully functioning for a year at this point, due to considerable delays in programme set up.

This evaluation highlighted that one of the most positive impacts of the programme to date, had been an improvement in the use of methods and tools to drive improvement and an increased ability to use improvement approaches.

At the end of year two, of 15 programme managers and 14 executive sponsors:

- 24 (82%) thought the MHC had helped to improve the use of data locally to inform and drive improvement
- 23 (79%) thought the MHC had improved the skills of managerial staff to make improvements in services
- 21 (72%) thought the MHC had improved the skills of clinical staff to make improvements in services

However, one of the outcomes of this evaluation was a request for the national team to spend more time training. Therefore, during our third year, in addition to the ongoing training provided through regional meetings, we ran the Mental Health Improvement Game with 19 different services. Through this training we developed the understanding of over 400 staff (including psychologists, nurses, psychiatrists, GPs, AHPs, administrators and managers) in service improvement theory. Just as importantly, the vast majority left believing that their service would make positive changes as a result of the training received.

Our programme closure event in March 2011 reinforced consistent feedback that the Mental Health Collaborative has developed skills in using data to drive improvement. For instance, we produced summary reports for each NHS Board to inform the 6-monthly Scottish Government
Mental Health Implementation Reviews. These reports included comparative data, so NHS Boards could see how their current position against HEAT targets compared with other areas. For the spring 2011 visits, the agenda was built around data, with the focus being on using the data as a launch pad to better understand current key service issues.

Finally, in addition to the training provided by the national team, a vast amount of training was conducted by local Mental Health Collaborative teams. Conservative estimates indicate that over 2,000 staff working in mental health have had some form of training in service improvement techniques over the last 3 years. Of particular note is the work across 10 Health Boards to roll out of Releasing Time to Care Mental Health Ward. At December 2010, 78 wards representing over 1,000 ward staff had been involved in this initiative.

**Links to resources which supported delivery of outcome**

The following training resources were developed by the Mental Health Collaborative and have been delivered with excellent evaluations.

- **Mental Health Improvement Game**
  This was developed in partnership with Paul Walley from Warwick Business School and has been tailored for mental health from a game he originally developed for A&E services. The game is a fun way to learn how the design of processes impacts on the flow through a community mental health service and how poor design can lead to unnecessary waiting and a poor quality service. The event runs for a day. The morning consists of a simulation of a poorly designed community mental health system through which teams have to process service users. There are regular time-outs during the game where teams get to make improvements. During the afternoon, the theory behind the game is explained and teams get to think about and plan how they might apply those concepts to their own area of work.

  A full training pack has been developed which includes the actual game materials, facilitator guidance, debrief slides, presentation notes and delegate handouts. This material is not openly available due to the need for those delivering the training to first be appropriately trained. However, if you are interested in finding out more please view the [MHIG Handout](mailto:MHIG Handout) or contact [QuEST@scotland.gsi.gov.uk](mailto:QuEST@scotland.gsi.gov.uk).

- **Resistance Matrix and Training**
  Recognising the importance of the Human Dimensions of Change when doing improvement work, a two hour training session on responding to resistance was developed. This training has evaluated extremely well. The training pack includes presenter’s slides and facilitation notes and a range of handouts including a diagnostic matrix for resistance and a summary of the different methods available for responding to resistance. The latter two are available on the website: [Resistance Matrix](mailto:Resistance Matrix) and [Methods for Responding to Resistance](mailto:Methods for Responding to Resistance). Facilitator’s slides and notes can be requested from [QuEST@scotland.gsi.gov.uk](mailto:QuEST@scotland.gsi.gov.uk).
Outcome Two - Supported the application of these techniques to deliver Mental Health HEAT targets

Evidence we delivered this outcome

The evaluation highlighted that, by the end of year two, **100% of Executive Sponsors believed that that the MHC had helped their NHS Board to deliver the relevant HEAT targets**. The following sections outline the actual outcomes for each target and then summarises key resources that supported delivery.

**Dementia HEAT Target – Outcome Delivered**

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

On the basis of un-validated QOF data, we expect that the Dementia HEAT target will be delivered Scotland wide. The validated data, which will include performance by NHS Board, will be available in Sept 2011. The following chart shows the considerable increase in case finding rates once local mental health collaborative times started focusing on this area of work.

![Dementia Register: Net case-finding rate per month for Scotland Actual Mar 08 to Mar 10 and Number required to achieve Mar 11 Target](chart)

But it hasn’t just been about delivering increases in the number of people diagnosed. We’ve also seen significant improvements in the early management and support provided to people and the following list highlights just some of the work that was completed by local MHC teams:

- delivered training to GPs, general hospital staff and care home staff on how to recognise symptoms of dementia and how to provide dementia friendly care.
- guidelines and algorithms for diagnosis developed and implemented
- development and implementation of advanced care plans
- development of post diagnostic information packs and clear mechanisms for distribution
- reviews of antipsychotic drug prescribing in care homes.
- improved working relationships between primary and secondary care services in the delivery of care to people with dementia.
**Readmission HEAT Target - Outcome Delivered**

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

This target had already been delivered across the majority of NHS Boards prior to the start of the MHC. However, the reduction had levelled off and the MHC bought a renewed focus to this work which resulted in a further downward trend in readmissions as highlighted by the following graphs.
**Depression HEAT Target – Outcome Target Revised**

This workstream previously supported the delivery of the Antidepressant HEAT target which states:

*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.*

This target was replaced in April 2010 with an access to psychological therapies HEAT target which states:

*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.*

As a result of the HEAT target to reduce the level of increase of prescription of anti-depressants, we have significantly developed our understanding of how anti-depressants are prescribed. There is now a growing research consensus that most of the increase in antidepressant prescribing is accounted for by a relatively small group of people taking their medicine for a longer period. Further, there is growing evidence that increasing access to psychological therapies does not necessarily lead to a reduction in antidepressant prescribing.

This increased understanding, together with the growing capacity within NHS Boards to measure access to psychological therapies directly, led to the decision to replace the antidepressant prescribing target with a target that directly measures access to psychological therapies.

**Links to tools developed that supported delivery**

The Mental Health Collaborative developed a wide range of tools to support the delivery of these HEAT targets including:

- **Dementia** and **Psychological Therapies** Driver Diagrams – A driver diagram is a method for identifying the key parts of a system that need to be improved to deliver the overall aim (Primary Drivers) and then, for each part of the system, identifying the specific changes that can be made to improve that aspect of the system. Driver diagrams were developed for both the Dementia and Psychological Therapies targets.
- Why diagnose **Benefits of Diagnosing Dementia** – a summary of the benefits of diagnosing someone with dementia in response the typical reasons being given for with-holding a diagnosis
- A suite of tools was developed to support the application of Demand, Capacity, Activity and Queue work to mental health. These can be accessed via the Psychological Therapies Driver Diagram or via the Resources page on the Mental Health Collaborative website.
- NHS Ayrshire and Arran’s local Mental Health Collaborative team developed the Prescribing Audit Tool – which automates the extraction and reporting of data around antidepressant prescribing from GP systems. Further information on this is available by emailing QuEST@scotland.gsi.gov.uk. The possibility of supporting this as a national tool is currently being scoped.
- The Mental Health Collaborative commissioned research to analyse new courses of antidepressant prescribing in Scotland. This highlighted that, when compared to published data from other healthcare systems, our data – which are validated and nationally
representative – suggest that the duration of new antidepressant treatment in Scotland is as good as, or better than, that from areas of England, Spain and the USA. Further details about this research can be accessed via the following links for the Newly initiated antidepressant treatment in Scotland: a database study and Executive Summary.

- We completed a mapping of the current provision of Crisis Resolution and Home Treatment Services across Scotland. The aim of this work was to map the current configuration of services, identify any plans to develop the services, identify any current evaluations of the impact of the services. Additionally, it sought to provide a baseline to aid future analysis of the impact of such services/functions on inpatient bed use. This can be accessed at SCRHTT Network Service Mapping Report.
Outcome Three – Supported staff to share their experiences of using these techniques to deliver improvement

Evidence that we delivered this outcome

The year two evaluation highlighted that 100% of Executive Sponsors believed that the MHC had helped their NHS Board to get useful information about what other Boards were doing.

In terms of the approaches used:

- The majority of programme managers thought that regional meetings were one of the three most effective ways of sharing practice with other NHS Boards.
- National events, informal networking and one to one meetings with regional manager were considered as effective by 6 out of 13 programme managers.
- Every programme manager had contacted someone from another NHS Board to learn more about their improvement practice.

The third year of the programme saw a range of additional methods developed for sharing learning across the system. Whilst there has been no formal evaluation of the techniques developed in year three, anecdotal feedback has all been extremely positive.

- In the third year the programme started to use web-ex sessions for sharing information. Two web-ex sessions around delivering the dementia target were delivered and these are still accessible by following these links: Dementia and the General Practitioner, Dr K O’Neill and Achieving and Sustaining Dementia Diagnostic Registers, Dr D Kennedy, Dr D Mowat and Mr W Cowling.
- There was also a much greater emphasis on those struggling with target delivery visiting and contacting services making good progress.
- In addition, the driver diagrams with hyperlinks to support resources, were developed as a way of sharing information in a structured manner.
- Finally, in response to requests from the year two evaluation, national meetings for programme managers were instituted. These evaluated very positively.

Links to tools developed that supported sharing of information

- Workstream Summaries were produced in Oct 09, Mar 10 and Oct 10. These provided a concise summary of current work in each NHS Board area for each of the targets.
- Quarterly newsletters were produced which included case studies from Board areas and updates from relevant national programmes.
- The MHC website was a source of information and included links to the various tools that were developed over the life of the programme.
- During the last year – the MHC started to webcast events. Recordings of the Dementia Networking Event, 24\textsuperscript{th} June 2010 and Working Together to Deliver Improvement, 27\textsuperscript{th} October 2009, are still accessible at Video3 eventcasts.
- As already stated, a year two evaluation was produced that summarised key information on the progress of the programme to date. This is available via the following link MHC Mid Programme Evaluation Report.
Going forward – building on the work to date

Summary of key messages from MHC Programme Closure Event

The key messages received from the MHC Programme Closure event about building on the work to date were:

- Nationally we need to find a way to continue to enable networking opportunities across services.
- Ongoing training in improvement approaches is key – with a number of individuals raising the need to make training mandatory and include as part of local NHS Boards induction procedures.
- At a local level, there is a need to ensure that mental health services continue to receive meaningful reports using relevant data. One of the continued pieces of feedback over the last two years of the MHC has been the significant impact it has made on the use of data in mental health and that the information analyst roles funded by the MHC have been key to this. However, there is also a recognised need to continue to build the skills to present data in a way that is meaningful and easily understood by front line clinicians.
- At a local level, a number of Boards also identified the need for ongoing input from service improvement facilitators.
- A key reflection at the event was the importance of the human dimensions of change and there is a need to ensure that, within mental health systems improvement work, appropriate recognition is given to the importance of relationships across the system.

Recommendations for building on the work to date nationally

Going forward, there are a number of national programmes that will continue to use and promote system improvement techniques in mental health including: Releasing Time to Care, Mental Health Patient Safety Programme and the work to deliver the psychological therapies HEAT target. Nationally work is in place to look at the interface between these programmes and what needs to be put in place to ensure a consistent and linked approach across these programmes and the following key issues have been identified:

- ensuring there is clarity on the commonalities and differences between the key national improvement programmes
- ensuring a consistent use of terminology across the programmes
- ensuring a consistent approach to skills development and integrating training resources where possible
- when working on a similar issue, referencing the same support resources/tools across wherever possible.

To deliver the above, we need to ensure there is effective co-ordination across all relevant national programmes and to this end the Mental Health Delivery Team (which includes representatives from HIS, NES, ISD, Health Scotland and relevant Scottish Government Departments) will oversee the implementation of an integrated approach to improvement in mental health. **Over 2011/12, this group will ensure work is taken forward across the relevant national programmes to ensure that the aforementioned key issues are addressed.**
Further, we need to find ways to enable the ongoing networking and sharing of information across NHS Boards. The Mental Health Patient Safety programme will have a key focus on the networking and sharing of information built into programme delivery. However, further consideration needs to be given to how to enable appropriate sharing of information and learning around the delivering of the Psychological Therapies HEAT target.

Finally, though the MHC has had considerable impact on the use of data to drive improvement, there is still much more that needs to be done. This includes:

- the ongoing development of the skills within NHS Boards to both present and interpret information. This is an issue held in common across all improvement work within NHS Scotland and is a key focus of the Quality Improvement HUB. Appropriate links need to be made to the work of the HUB to ensure effective integration with the improvement work in mental health.
- the ongoing work to develop user friendly reporting of the mental health benchmarking data – as presenting data in an accessible and user friendly format aids considerably the actual use of information locally. This work is already in progress.
- The Scottish Government Mental Health Implementation Reviews should continue to be built around data with ISD producing the relevant reports. This has already been actioned.

**Recommendations for building on the work to date locally**

We recognise that the decision of the Quality and Efficiency Support Team (replacing the Improvement and Support Team nationally) to make generic allocations to NHS Boards for improvement work has left some mental health services concerned that they won’t now have access to key improvement and data expertise locally. However, one of the disadvantages of ring-fenced funding for national programmes is that all too easily the skills become focused within one or two key people in each NHS Board. It also means that the work can exist in a vacuum without the appropriate NHS Board level support. There is some evidence of this happening in some NHS Boards over the work of the Mental Health Collaborative. One of the advantages of the new generic allocations is that it makes the prioritisation of improvement expertise and attention more explicit and enables NHS Boards to consider an ongoing improvement infrastructure, rather than depending on time limited posts.

The new psychological therapies HEAT target presents considerable challenges to NHS Boards and it is unlikely that any area will be able to deliver this without paying considerable attention to:

- local data systems and whether they are collecting and producing meaningful information that will enable effective management of psychological therapy services. This must include a focus on collecting and reporting on clinical outcomes data.
- process design issues – including ensuring integrated care pathways are embedded into services and designed so as to remove waste and un-necessary duplication
- staff training issues to ensure the right level of appropriate skills are embedded into services locally to deliver evidence based interventions.

We therefore strongly recommend that NHS Boards continue to build on the existing level of clinical systems improvement skills that have already been built up across mental health services. In particular, **NHS Boards should seek to ensure that relevant information systems, data analysis and service improvement resource is prioritised to support work around the delivery of the psychological therapies HEAT target.** The generic improvement allocation being made by QuEST
provides a potential source of funding for this work. However, NHS Boards may also need to look at redesign of existing resources. For instance, a number of NHS Boards have already recognised the importance of allocating appropriate information analysis time to mental health and hence have mainstreamed their collaborative posts. Others are looking at the redesign of practice development and clinical governance posts to support ongoing systems improvement work.

In addition, building on the work nationally to develop an integrated approach to improvement across the relevant national programmes, we recommend that **NHS Boards also put systems and processes in place to ensure appropriate linkages between different strands of improvement work** such as Releasing Time to Care, Mental Health Patient Safety Programme (once rolled out) and Psychological Therapies HEAT target.

Finally, at the programme closure event a number of representatives from NHS Boards raised the issue of making service improvement training mandatory for all NHS staff. It is worth noting that the Agenda for Change Knowledge and Skills Framework already includes service improvement as a core dimension. This means that all nursing, AHP, admin and some managerial staff are required to demonstrate service improvement knowledge and skills, though the extent of these will depend on the level identified as appropriate against this core dimension. **At a local NHS Board level it would be worthwhile ensuring that the systems improvement techniques promoted by the Mental Health Collaborative and other similar improvement programmes are clearly linked across to this dimension, and hence routinely built into individual KSF PDPs.**
Summary

It is sometimes easy to forget that, prior to the Mental Health Collaborative, many mental health services had never heard of PDSA cycles or systems improvement work and, other than the odd pocket of good practice, data was rarely being used to inform where to make improvements and evaluate the outcomes of any changes made.

Over what has effectively been two years (as most NHS Boards took about a year to get up and running), local Mental Health Collaborative teams working in partnership with local clinicians and managers, have delivered a wealth of improvements. This report only skims the surface of all that was achieved and there is so much more that could be included. However, as identified at the beginning of this report, we wanted to keep this as a brief summary that signposts to more detailed information in recognition that long reports rarely get read.

Even skimming the surface of the work done tells an impressive story. So this seems the appropriate time to say thank you to everyone who displayed such passion and energy towards delivering real and meaningful improvement. We are confident the work will continue – as we know that improving the services we deliver remains a key commitment for the vast majority of staff working in the delivery of mental health services.