Mental Health Quality Indicators: Background and Secondary Definitions

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Mental Health Quality Indicators

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Summary

- Action 38 of the Mental Health Strategy 2017-2027 commits to creating a Quality Indicator (QI) profile. This paper describes the process to create the QI profile, and lists the indicators in full.

- The QI profile is primarily a tool for monitoring and improving service quality. It will be complemented by a Mental Health Strategy Framework of data illustrating population mental health and wellbeing, strategic impact and parity of esteem between physical and mental health.

- The QIs set no new targets and build on data that are already available.

- Application will be to secondary mental health services. Primary care and third sector organisations can choose to use the indicators to evidence quality should they wish.

- Feasibility testing with Health Boards and national consultation with territorial and special Health Boards, Integration Authorities, Local Authorities, Third Sector Organisations, professional bodies and cross Government policy areas has been generally positive.

- Implementation will be phased, and ISD will work with Boards, Integration Authorities and other partners to optimise mental health data reporting by adapting or removing collection of data that is not clearly necessary or useful. Individual QIs may be modified over time.

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1. Background

Action 38 of the Mental Health Strategy 2017-2027[1] commits to developing a Quality Indicator (QI) profile in mental health which will include measures across six quality dimensions – person-centred, safe, effective, efficient, equitable and timely. It also commits to measuring progress towards parity by introducing a measurement framework similar to those used in physical health, which will draw on a range of information to understand the differences that are being made to, for example, premature mortality, what money is being spent, how long people wait to access services, rates of employment, and poverty levels.

To deliver these actions, two overlapping data reports are being created: i) a Quality Indicator profile, with balanced information predominantly measuring individual care and treatment as well as service response; and ii) a measurement framework with broader population-wide data on wellbeing and mental health.

This paper provides background information on the purpose and scope of the QI profile, a summary of its development, the actions needed to implement the QIs, and a full list of the indicators and their secondary definitions.

2. Purpose of the Quality Indicator profile

The final QI profile provides information about quality outcomes for services for people with mental health problems, located within the context of Integrated Authority provision. Together, the QIs form a quality profile for services. **They do not set new targets, and predominantly build on data that are already available.**

Their purpose is to provide information that supports:

- development of mental health outcome measures related to effectiveness of interventions and service user experience
- monitoring of the delivery of actions in the Mental Health Strategy
- national tracking of service quality for people with mental health problems
- Health and Social Care Partnership and Health Board reporting and benchmarking of performance in relation to local mental health provision
- Improvement work by organisations

In addition, organisations can use the data to look more closely at individual teams, services and specialties. Opportunities will exist for specialist mental health services to individually analyse the QIs for their populations, e.g. by gender, sexuality, deprivation; for child and adolescent, general adult, older people, learning disabilities and autism, forensic, substance misuse, perinatal; and for different service types e.g. psychological therapies.

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[1] Scottish Government (2017) Mental Health Strategy 2017-27 - a 10 year vision

This approach is in line with the direction set in Sir Harry Burns' Review of Targets and Indicators for Health and Social Care in Scotland[2], which emphasised the value of data for quality improvement.

3. Scope of the Quality Indicator profile

Mental health service provision, for all ages, is delivered on a tiered model. Generally, Health Boards are responsible for Tier 1, with integration authorities delivering Tiers 2, 3, and 4.

Tier 4 = highly specialist mental health services e.g. psychiatric inpatients
Tier 3 = specialist community mental health services
Tier 2 = community mental health at a primary care level
Tier 1 = population level mental health including third sector and eHealth

Initially the QIs will only apply to secondary services at Tiers 3 and 4. It will be up to primary and third sector organisations to decide if and how they use these indicators to evidence the quality of their work in relation to mental health.

4. Process to develop the Quality Indicator profile

The National Mental Health Performance and Indicators Advisory Group (MHPIAG) developed an initial suite of mental health quality indicators, with agreement that they should:

- be equally categorised across six quality outcomes (Timely, Safe, Person-centred, Effective, Efficient and Equitable)

- apply to all mental health specialties, regardless of age group or subspecialty where possible, with mental health being a broad term used to include conditions like dementia, learning disability, autism, and substance misuse

- encompass services and supports for people with mental health problems widely and not just in health services

- be as important as possible, in terms of the necessity of showing that what we do matters, and in terms of usability and confidence

- be mapped to the quality outcomes (listed above), as well as to national Health and Wellbeing indicators (listed in full in Annex A).

Following these principles, MHPIAG created a draft suite of five QIs for each of the six Quality Outcomes. These were taken to an open national workshop on 21 April 2016 for discussion. Further comments were requested by email from a range of stakeholders, and an expert reference group (Annex B) considered each of the QIs on 7 June 2016.

5. Feasibility testing of the Quality Indicator profile

A scoping exercise to feasibility test the draft QIs was carried out via the National Information Leads Group and the Healthcare Improvement Scotland Mental Health

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[2] Scottish Government and COSLA (2017) Targets and Indicators for Health and Social Care in Scotland: A Review

Access Improvement Support Team (MHAIST). Boards were asked to record whether data on each of the indicators were:

- currently reported on and readily available (coded Green/3)

- not currently routinely recorded, but a system to capture and report the required data already exists (coded Amber/2)

- not currently reported on, and the ability to capture and/or report is not currently available (coded Red/1)

12 of the 14 territorial Boards responded, with the results of the scoping exercise shown in Figure 1 below. Note that one of the indicators (Eq3) has since been replaced following consultation and there have also been some minor changes to language in three others.

Overall, there was variance across Boards, with individual QIs having different levels of availability in different places. However, only one QI was scored as red and orange across all the Boards that responded, indicating that most Boards will be able to report on even the most challenging QIs.

Indicator	A&A	Borders	D&G	Fife	Forth V	Grampian	GG&C	Highland	Lanark	Lothian	Orkney	Tayside	Shetland	WI
T1	3	3	0	3	3	3	3	3	3	3	0	3	3	3
T2	3	3	0	3	3	3	3	3	3	3	0	3	3	3
T3	3	3	0	3	3	3	3	3	3	3	0	3	3	3
T4	3	2	0	1	2	1	3	1	1	3	0	2	1	1
T5	3	1	0	1	1	1	2	1	1	1	0	2	1	1
S1	3	2	0	3	3	3	3	3	3	3	0	3	3	3
S2	2	3	0	1	1	2	3	1	2	3	0	2	1	2
S3	3	2	0	2	3	1	3	3	2	2	0	2	2	3
S4	3	2	0	2	3	2	3		2	3	0	3	3	3
S5	3	2	0	2	3	2	3	3	2	3	0	3		3
P1	1	1	0	3	0	2	0	1	1	3	0	1	2	1
P2	1	1	0	3	0	2	0	1	1	3	0	1	2	1
P3	1	1	0	3	0	2	0	1	1	3	0	3	1	1
P4	3	3	0	3	2	1	2		2	3	0	3	1	
P5	3	1	0	1	1	1	3	1	1	1	0	2	1	1
E1	2	2	0	3	3	3	3	3	3	2	0	3		2
E2	2	1	0	1	2	1	0		2	1	0	2	3	
E3	2	1	0	1	2	1	0		1	1	0	2	2	1
E4	2	2	0	1	1	1	3	1	1	1	0	2	1	1
E5	2	2	0	1	1	1	3	1	1	1	0	2	1	1
Ef1	3	2	0	2	3	3	3	3	2	2	0	2		3
Ef2	3	3	0	3	3	2	3	2	3	3	0	3		3
Ef3	3	2	0	3	3	3	3	3	3	3	0	3		3
Ef4	3	3	0	3	3	3	3	3	3	3	0	3	3	3
Ef5	2	3	0	1	2	3	3	1	3	3	0	3	1	3
Eq1	3	1	0	2	3	3	3		3	3	0	3	1	1
Eq2	3	2	0	1	2	3	0	3	2	3	0	3	1	
Eq3	3	2	0	3	2	3	3	3	3	3	0	2	3	3
Eq4	3	3	0	3	2	2	3	3	3	3	0	3		3
Eq5	1	1	0	1	1	1	1		1	1	0	2	1	1

Figure 1: Mental Health Quality indicators: results of scoping exercise by Health Board (2017)

Following further refinement by the National Mental Health Pharmacy group and other stakeholders an expert panel of Scottish Government policy, clinical and special board representatives reconvened on 15 March 2017 (Annex B) to agree refinements to the draft QIs. Following this, on 2 May 2017 a paper setting out the background and rationale for the QI profile was sent out widely for comment (Table 1). This sought views on the proposed process, the 30 draft indicators with their secondary definitions, and potential data collection sources. There was broad support and only minor refinements were necessary at this stage.

Table 1: Consultation responses by organisation

Organisation	Number consulted	Total Responses
Territorial Health Boards	14	7
Special Health Boards	7	2
Integration Authorities	32	8
Local Authorities	32	2
Third sector organisations	8	0
Professional bodies	6	2
Scottish Government policy outside mental health	9	0
Total	**108**	**21**

6. Implementation of the Quality Indicator profile

The delivery of the QI profile requires actions by:

- **Scottish Government** – national analysis of aggregated reports will allow consideration of improvement action. The Annual Report to Parliament on progress in relation to the Mental Health Strategy will use selected data to illustrate progress.

- **Information Services Division, NHS NSS** – collection, analysing and reporting data.

- **Healthcare Improvement Scotland** (HIS) – whilst working with boards through the Mental Health Access Improvement Support Team (MHAIST), HIS will encourage Boards to generate data required by ISD for collection, analysis and reporting of data.

- **Health Boards** – aligning data collection and systems to permit data gathering and reporting to ISD. Agreeing local clinical and personal outcome measures. Local analysis of reports with improvement actions.

- **Integration Authorities** - aligning data collection and systems to permit data gathering and reporting to ISD. Agreeing local clinical and personal outcome measures. Local analysis of reports with improvement actions.

A phased process is intended, as follows:

Data collection and reporting	Indicators	Start date
Existing LDP access mental health standards	T1,T2,T3,	From January 19
Data from health and wellbeing indicators	P1, P2, E1, Ef1, Ef2, Eq1	From January 19
Data from Adult Toolkit	S1, E1, Ef2, Ef3, Ef4, Eq1	From January 19
Other existing data	P3, P4, Eq2, Eq3, Eq4	From January 19
Currently uncollected data	T4, T5, S2, S3, S4, S5, P5, E2, E3, E4, E5, Ef5, Eq5	Incremental inclusion to full reporting from January 2021.

Creation of data recording and collection processes for the outstanding measures with incremental additional reporting will occur with the intention of full reporting of all 30 QIs by January 2021.

Management reports to Scottish Government, Health Boards and Integration Authorities will be made available on a monthly basis with quarterly publication on the ISD website.

In parallel with this phased collection and reporting, ISD will work with Boards, Integration Authorities and other partners to optimise mental health data reporting by adapting or removing collection of data that is not clearly necessary or useful. Criteria will be established to explicitly describe why it is necessary to collect the data, who uses it, how it is used and what the outcome of this is. This will require discussion from a variety of stakeholders, including individual clinicians, professions, organisations and academics.

The QI profile will, in due course, need to be reviewed and adapted to ensure it remains relevant.

7. Full list of Quality Indicators including secondary definitions

The detailed list of Quality Indicators below provides secondary definitions for each QI, and maps them against:

- the six Quality Outcomes (Timely, Safe, Person Centred, Effective, Efficient and Equitable)
- the nine Health And Wellbeing Outcomes
- relevant actions set out in the Mental Health Strategy

Timely

T1 Psych access	**% of people who commence psychological therapy based treatment within 18 weeks of referral**
Secondary definition	• LDP standard (http://www.sehd.scot.nhs.uk/dl/DL(2016)01.pdf)
Rationale	Psychological therapies are important evidence based treatments for a wide variety of mental health disorders.
Data source	ISD quarterly reports
Quality strategy	Timely, equitable
H&W indicators	**Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
MH strategy actions	**24.** Fund work to improve provision of psychological therapy services and help meet set treatment targets.

T2 CAMH access	**% of young people who commence treatment by specialist Child and Adolescent Mental Health services within 18 weeks of referral**
Secondary definition	• LDP standard (http://www.sehd.scot.nhs.uk/dl/DL(2016)01.pdf)
Rationale	Mental health treatment for children and adolescents is effective and will improve later life outcomes.
Data source	ISD quarterly reports
Quality strategy	Timely, equitable
H&W indicators	**Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
MH strategy actions	**17.** Fund improved provision of services to treat child and adolescent mental health problems. **18.** Commission an audit of CAMHS rejected referrals, and act upon its findings.

T3 Sub misuse access	**% of people who wait less than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery**
Secondary definition	• LDP standard http://www.sehd.scot.nhs.uk/dl/DL(2016)01.pdf

Rationale	Effective treatment exists for substance misuse that can minimise harm, promote and sustain abstinence and improve other outcomes. Drug and alcohol problems are common and their comorbidity worsens outcomes.
Data source	ISD publishes quarterly report
Quality strategy	Timely, equitable
H&W indicators	**Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
MH strategy actions	**27.** Test and learn from better assessment and referral arrangements in a range of settings for dual diagnosis for people with problem substance use and mental health diagnosis. **28.** Offer opportunities to pilot improved arrangements for dual diagnosis for people with problem substance use and mental health diagnosis.

T4 4 hour Emerg Assess.	**% of unscheduled presentations referred to specialist mental health services, who have had direct assessment by MH specialists within 4 hours**
Secondary definition	• Unscheduled presentations are emergency presentations from any source to all first line statutory emergency services, including emergency services provided by mental health and by acute services. • Direct assessment means one to verbal one assessment face to face, or using digital or telephonic technology. • MH specialists include any clinical member of a specialist mental health team of any discipline and grade.
Rationale	Mental health presentations make up a significant part of unscheduled presentations to front line emergency services. It is useful to know what proportion of these presentations are primarily mental health related and of those how many are referred on to MH specialists and how quickly this mental health response is.
Data source	It will be necessary to measure - time between referral of unscheduled presentations to mental health services until start of direct assessment. - work should start with data from emergency departments
Quality strategy	Timely, safe, equitable
H&W indicators	**Outcome 1.** People are able to look after and improve their own health and wellbeing and live in good health for longer. **Outcome 2.** People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably

	practicable, independently and at home or in a homely setting in their community. **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services **Outcome 5.** Health and social care services contribute to reducing health inequalities **Outcome 7.** People using health and social care services are safe from harm
MH strategy actions	**13.** Ensure unscheduled care takes full account of the needs of people with mental health problems and addresses the longer waits experienced by them. **14.** Work with NHS 24 to develop its unscheduled mental health services to complement locally-based services. **15.** Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings.

T5 First present. psychosis	% of first presentation psychosis patients that start SIGN or NICE guideline evidence based treatment within 14 calendar days of referral to specialist mental health services
Secondary definition	• First presentation psychosis means any psychosis regardless of diagnosis presenting to first line services, both inpatient and community. • Treatment means guideline evidence based therapeutic involvement beyond specialist mental health assessment • Applies to all ages. • SIGN = Scottish Intercollegiate guideline network 131 NICE = national institute for clinical excellence CG178.
Rationale	Delay in treating first presentation psychosis associated with poor outcomes. Mirrors treatment target that has been set by NHS England. Improvement in these services intended by mental health strategy and measurement will assist service development. Psychotic patients subject to multiple inequalities – in particular access to assessment and treatment.
Data source	Specialist mental health services will need to measure the time between referral of a patient who presents with a first presentation psychosis and the starting of physical, psychological and or social treatment as defined by SIGN or NICE.
Quality strategy	Timely, effective, equitable

H&W indicators	**Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected
	Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
	Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services
MH strategy actions	**26.** Ensure the propagation of best practice for early interventions for first episode psychosis, according to clinical guidelines.

Safe

S1 **Suicide rates**	**Suicide rates per 100,000 population**
Secondary definition	• Crude and age-sex-deprivation standardised suicide rates per 100,000 population over 5 year period
Rationale	Reducing suicides has been a national priority and is the topic of a dedicated mental health strategy. Population suicide rates are not entirely related to mental health service issues but these are a major component. Population suicide rates are associated with general mental wellbeing.
Data source	Adult toolkit source - SMR04, NRS
Quality strategy	Safe
H&W indicators	**Outcome 7.** People using health and social care services are safe from harm
MH strategy actions	

S2 **Discharge FU**	**% of all discharged psychiatric inpatients followed-up by community mental health services within 7 calendar days**
Secondary definition	• All hospital psychiatric inpatient wards included. • All community mental health services of all care groups and ages. • Follow up means one to verbal one assessment face to face, or using digital or telephonic technology by a mental health practitioner.
Rationale	Suicide prevention literature shows the first 7 days after discharge from inpatient psychiatry to be a high risk period.
Data source	SMR01 will report on patient discharges. Additional recording of community mental health service follow up will need to be made with measurement of time between discharge and review
Quality strategy	Safe, timely

H&W indicators	**Outcome 7.** People using health and social care services are safe from harm
MH strategy actions	

S3 Emerg. Self harm	**% of all unscheduled care presentations where self-harm is a presenting feature**
Secondary definition	• Unscheduled presentations are emergency presentations from any source to all first line statutory emergency services. • The presenting problems include a current act of self-harm as defined by NICE Quality Standard qs34 "*any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.*"
Rationale	Self-harm is a significant risk factor for completing suicide Self-harm poses a significant burden on people, acute and mental health services.
Data source	A&E ICD 10 coding SAS presentation coding
Quality strategy	Safe
H&W indicators	**Outcome 7.** People using health and social care services are safe from harm.
MH strategy actions	**13.** Ensure unscheduled care takes full account of the needs of people with mental health problems and addresses the longer waits experienced by them. **14.** Work with NHS 24 to develop its unscheduled mental health services to complement locally-based services. **15.** Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings.

S4 Medication safety	**% of people prescribed lithium who experienced lithium toxicity in the last 12 months**
Secondary definition	• Lithium toxicity is defined as any lithium level greater than 1.2 mmol/L for adults and 0.8 mmol/L for over 65 year olds.
Rationale	Routine monitoring to measure lithium levels should be well established. The primary function being to prevent, identify and

	manage lithium toxicity. The % of patients who develop lithium toxicity therefore is a proxy for the effectiveness of this monitoring.
Data source	Local prescribing registers and clinical systems
Quality strategy	Safe
H&W indicators	**Outcome 7.** People using health and social care services are safe from harm
MH strategy actions	

S5 IP violence	**Incidents of physical violence per 1000 occupied psychiatric bed days**
Secondary definition	• Physical violence means physical harm inflicted on a person from another. • Includes violence committed on or by any person including staff, patients and visitors.
Rationale	Reduction in physical violence in inpatient psychiatric settings is part of the Scottish patient safety programme for mental health
Data source	Hospital wards are submitting reports to SPSP MH Datix returns from inpatient psychiatric reports.
Quality strategy	Safe
H&W indicators	**Outcome 7.** People using health and social care services are safe from harm
MH strategy actions	

Person-Centred

P1 Caring support	**% of carers for people with mental health problems who feel supported to continue in their caring role (Integration indicator 8)**
Secondary definition	• Based on the agreement with the statement (Q45f) in the biennial health and care experience survey: "I feel supported to continue caring". The number of people who agree or strongly agree divided by the total number answering.
Rationale	This indicator reflects the fact that health and social care services need to be planned and delivered with a strong focus on the wellbeing of unpaid carers. In Scotland in 2013/14, 44% of carers agreed that they felt supported to continue caring. This varied between CHP areas from 34% to 54%. Integration Authorities would be looking to increase this over time.
Data source	Biennial national H&SCEsurvey

	Link to source: http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey Individual Local Authority/ CHP reports can be found here: http://www.healthcareexperienceresults.org/
Quality strategy	Person centred
H&W indicators	**Outcome 6.** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
MH strategy actions	

P2 Quality of life	**% of adults with mental health problems supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (Integration indicator 7)**
Secondary definition	• Based on agreement with the statement (Q36h) in the biennial health and care experience survey: "The help, care or support improved or maintained my quality of life". The number of people who agree or strongly agree divided by the total number answering.
Rationale	This indicator reflects the aggregate impact of local person centred work to improve personal outcomes, focussing on what is important for individuals' quality of life. It emphasises the increasing focus on personalisation of services, including the use of personal outcomes approaches. In Scotland overall, 86% of people agreed that the services maintained or improved their quality of life in 2013/14. This varied between CHP areas from 73% to 98%. It would be expected that local areas scoring low in this should investigate the underlying issues and seek to improve towards the best.
Data source	H&SCE survey **Link to source:** http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey Individual Local Authority/ CHP reports can be found here: http://www.healthcareexperienceresults.org/
Quality strategy	Person centred
H&W indicators	**Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

MH strategy actions	

P3 Matters to me	**% of replies for people with mental health problem that agree with statement "people took account of the things that mattered to me" in Health and Social Care Experience Survey**
Secondary definition	
Rationale	"what matters to me" is a fundamental consideration in all health and social care.
Data source	Biennial national H&SCEsurvey
Quality strategy	Person centred
H&W indicators	**Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected
MH strategy actions	**21.** Improve anticipatory care planning approaches for children and young people leaving the mental health system entirely, and for children and young people transitioning from CAMHS to adult mental health services.

P4 Advance statements	**Number of people with advanced statements registered per year with the Mental Welfare Commission for Scotland**
Secondary definition	• Includes any person of any age • Advanced statements as defined by Mental Health Act Scotland.
Rationale	Advanced statements are a type of patient generated anticipatory care plan that describes preferences for any future treatment under compulsion. Having an advanced statement is closely associated with individual collaborative care planning and health education.
Data source	MWCS register
Quality strategy	Person centred, equitable
H&W indicators	**Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected
MH strategy actions	**32.** Use a rights based approach in the statutory guidance on the use of mental health legislation

P5 Personal outcomes	**% of people in mental health services seen for at least 1 month that show improvement in any personal outcome measurement over the previous month**
Secondary definition	• Any personal outcome evidence based tool or measure can be used. • Applies to all ages, settings and care groups.
Rationale	Many personal outcome tools exist and there are different clinician and patient preferences. The measurement of this indicator will increase the use of these tools and track improvement.

Data source	Patients in follow up will need application of a personal outcome tool at least at assessment, at discharge and at 3 monthly intervals.
Quality strategy	Person centred
H&W indicators	**Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected
MH strategy actions	

Effective

E1 Delayed discharge	**Number of days people spend in hospital when they are ready to be discharged per 1,000 population (Integration indicator 19)**
Secondary definition	• Applies to all NHS psychiatric hospital inpatients, aged over 18. • Readiness for discharge decision made by consultant responsible for patient's inpatient care. • Includes both standard and code 9 delays (see Delayed Discharge data definitions manual for more detail)[3]
Rationale	Delayed discharge has significant resource implications for services and personal implications for patients. Delay can evidence problems in enacting discharge planning due to social support deficits and the availability of alternative community placement. People should not have to wait unnecessarily in hospital for more appropriate care to be provided after treatment in hospital. Unnecessary time spent in hospital can lead to a significant deterioration in a person's physical and mental health, with a potential loss of independence. This in turn will lead to a greater use of institutional care, at a higher cost to Integration Authorities. The risk of becoming a delayed discharge increases when a patient is admitted as an emergency, and the longer the delay the greater the chance of dependency and institutionalisation. The Delayed Discharge Expert report[4] group recommended that 'bed days lost' (the days between the 'ready for discharge' date and the actual date of discharge on an accumulated basis) was a more appropriate whole system measure for monitoring delays. This represents the opportunity cost of having an individual remain in hospital when another setting would be more appropriate. It provides a truer picture of the cost of delayed discharges in both financial and personal outcomes.

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[3] Delayed Discharge Expert Group (2012) Report on Delayed Discharge
[4] Delayed Discharge Expert Group (2012) Report on Delayed Discharge

Data source	The number of bed days lost to delayed discharge in all NHS psychiatric hospitals within the local authority area. http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Previous-Publications/
Quality strategy	Effective, person centred, efficient, timely
H&W indicators	**Outcome 2.** People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3. People who use health and social care services have positive experiences of those services and have their dignity respected.

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services. |
| MH strategy actions | |

E2 Antipsychotics	% people prescribed antipsychotics for reasons other than psychoses and bipolar disorder treatment
Secondary definition	• The denominator will be all patients prescribed an antipsychotic medication from section 4.3.6 of the BNF. • The numerator will be all patients with a diagnosis other than psychosis (including schizophrenia) and bipolar disorder.
Rationale	The use of antipsychotics is associated with a significant side effect burden and long term physical health problems. Identification of the level of use of these drugs for purposes other than their primary licensed indications is a potential marker for the effectiveness and quality of care.
Data source	Local clinical systems
Quality strategy	Effective, safe
H&W indicators	**Outcome 7.** People using health and social care services are safe from harm

Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services |
| MH strategy actions | **26.** Ensure the propagation of best practice for early interventions for first episode psychosis, according to clinical guidelines. |

E3 BMI	**% people with severe and enduring mental illness and / or learning disability who have had their BMI measured and recorded in the last 12 months**
Secondary definition	• Applies to people in secondary care with severe and enduring mental illness definition as standard. • Applies to people in secondary care with learning disability. • BMI = Body Mass Index calculated by measuring height and weight. • Recorded in paper or electronic case records.
Rationale	The physical health issues experienced by people with severe and enduring mental illness and people with learning disabilities are well documented. Mental Health services have been developing systems to monitor the physical health of people with severe and enduring mental illness and for people with learning disabilities. This indicator would provide a proxy measure for the effectiveness of this monitoring.
Data source	Local clinical systems
Quality strategy	Effective, safe
H&W indicators	**Outcome 7.** People using health and social care services are safe from harm **Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services
MH strategy actions	**30.** Ensure equitable provision of screening programmes, so that the take up of physical health screening amongst people with a mental illness diagnosis is as good as the take up by people without a mental illness diagnosis.

E4 functioning	**% of people seen for at least 1 month that show improvement in functioning using any clinical outcome measurement over the previous month**
Secondary definition	• Applies to all ages, settings and care groups • Any evidence based functioning outcome measurement tool is included. • Functioning means social functioning including employment, education and participation in social activities.
Rationale	Many clinical outcome tools that measure functioning exist and there are different clinician and patient preferences. The measurement of this indicator will increase the use of these tools and track improvement.
Data source	Patients in follow up will need application of a clinical outcome tool that measures functioning at least at assessment, at discharge and at monthly intervals.
Quality strategy	Effective, person centred

H&W indicators	**Outcome 3.** People who use health and social care services have positive experiences of those services, and have their dignity respected
	Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services
MH strategy actions	

E5 symptoms	**% of people seen for at least 1 month that show improvement in symptom severity using any clinical outcome measurement over the previous month**
Secondary definition	• Applies to all ages, settings and care groups • Any evidence based symptom severity outcome measurement tool is included. • Symptoms are symptoms or mental disorder.
Rationale	Many symptom severity outcome tools exist and there are different clinician and patient preferences. The measurement of this indicator will increase the use of these tools and track improvement
Data source	Patients in follow up will need application of a clinical outcome tool that measures mental health symptom severity at least at assessment, at discharge and at monthly intervals.
Quality strategy	Effective
H&W indicators	**Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services
MH strategy actions	

Efficient

Ef1 Emergency bed days	**Rate of emergency bed days for adults (Integration indicator 13)**
Secondary definition	• Number of days adults are in psychiatric hospital beds following emergency admission per 100,000 of the population.
Rationale	It is possible for the number of admissions to increase and bed days to reduce and vice versa, so this measure is included to ensure a balanced view. Once a hospital admission has been necessary in an emergency, it is important for people to get back home as soon as they are fit to be discharged to avoid the risk of them losing their confidence and ability to live independently. Integration Authorities have a central role in this by providing community-based treatment and support options, "step down" care and home care packages to enable people to leave hospital quickly

	once they are well enough. Additionally, care homes should where appropriate be able to support people with a wider range of physical and mental frailty and needs. Hospitals also have a role to play, by streamlining their processes and sharing best practice to ensure more people can leave hospital quickly once they are well enough. This will include improving rehabilitation and also reducing the possibility of infections, harm and injury all of which can result in longer stays.
Data source	Adult toolkit Rate of emergency bed days per 100,000 population for adults. This will be based on SMR04 data for psychiatric hospitals (note that some further work will be undertaken by ISD regarding this data source). Link to source: http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/ provides a link to data on emergency admission rates to acute hospitals. It is expected that the SMR04 component of the indicator will be available within the next 6-12 months**.
Quality strategy	Efficient
H&W indicators	**Outcome 2.** People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. **Outcome 7.** People using health and social care services are safe from harm
MH strategy actions	

Ef2 readmission	**% Readmissions to hospital within 28 days of discharge (Integration indicator 14)**
Secondary definition	- All hospital psychiatric inpatients included regardless of age and care group. - Number of readmissions for spells of inpatient treatment for mental health specialty within 28 days of patient's discharge from a previous spell of treatment (any length of stay) as a % of total admissions
Rationale	The readmission rate reflects several aspects of integrated health and care services – including discharge arrangements and co-ordination of follow up care underpinned by good communication

	between partners. The 28 day follow-up was selected as this is the time that the initial support on leaving hospital, including medicines safety, could have a negative impact and result in readmission. A longer period of follow up would be more likely to include admissions that are unrelated to the initial one, whereas a shorter period (e.g. 7 days) is more likely to only pick up immediate issues linked to the hospital care.
Data source	Adult toolkit – SMR04 Based on the SMR04 psychiatric hospital activity data, this rate is calculated from number of re-admissions to a psychiatric hospital within 28 days of discharge per 1,000 population.
Quality strategy	Efficient
H&W indicators	**Outcome 2.** People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. **Outcome 3.** People who use health and social care services have positive experiences of those services and have their dignity respected. **Outcome 7.** People using health and social care services are safe from harm **Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services
MH strategy actions	

Ef3 beds	**Total psychiatric inpatient beds per 100,000 population (NRAC adjusted)**
Secondary definition	• The number of beds for mental health specialities (adjusted for cross boundary flow) per 100,000 population (NRAC adjusted)
Rationale	Inpatient beds are an expensive resource, people prefer to be treated at home. Reducing need for beds is dependent on the creation of effective community resources. Number of beds in an area is an indicator of community alternative provision.
Data source	Adult toolkit – ISD (S)1
Quality strategy	Efficient
H&W indicators	**Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services
MH strategy actions	

Ef4 Mental health spend	Total mental health spend as a % of total spend.
Secondary definition	• For Health Boards and Local Authorities • All mental health specialities included
Rationale	The Mental Health Strategy 2017-2027 says: "*Improvements will be supported by increasing resources for mental health, including an increasing share of the NHS frontline revenue budget, and investing in innovation in services. We will also require transparent reporting of how Integration Authorities use their resources to support mental health in different settings and services, so we can demonstrate progress without stifling innovation and cross-service working.*" Parity of esteem requires health and social care providers to ensure that they commit equal importance to mental and physical health with clear relative allocation of monies.
Data source	Adult toolkit – ISD Cost Book
Quality strategy	Efficient, equitable
H&W indicators	**Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services.
MH strategy actions	**15.** Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings. **17.** Fund improved provision of services to treat child and adolescent mental health problems. **24.** Fund work to improve provision of psychological therapy services and help meet set treatment targets.

Ef5 DNAs	% of did not attend appointments for community based services of people with mental health problems
Secondary definition	• All ages and care groups included. • All community mental health outpatient appointments included. • All reasons for did not attend included but not reported in this indicator.
Rationale	Do not attends represent wasted resource, inefficient capacity use and difficulty in access for people to services.
Data source	All mental health services will require to measure the proportion of people who do not attend any mental health appointment for any reason.
Quality strategy	Efficient

H&W indicators	**Outcome 9.** Resources are used effectively and efficiently in the provision of health and social care services.
MH strategy actions	

Equitable

Eq1 Mortality rate	**Premature mortality rate (Integration indicator 11) = Standardised mortality rate for persons in contact with mental health services**
Secondary definition	- Age-sex standardised mortality rate of the mental health population compared to the general population - The mental health population is defined as any inpatient between ages 18 and 74 who has been discharged in the current financial year or in either of the 2 previous financial years who is alive at the beginning of the current financial year.
Rationale	Premature mortality is an important indicator of the overall health of the population. Scotland has the highest mortality rates in the UK. Between 1997 and 2013, the rate of mortality amongst those aged under 75 years decreased by 33%. Despite these decreases, more than 20,000 people aged under 75 still die each year.
	Deaths in this age group are more common in deprived areas, and so this indicator reflects health inequalities. In 2012, deaths in the most deprived areas were more than three times as common as deaths in the least deprived.
	People with severe and enduring mental illness die 15-20 years earlier than those without. Death is mainly due to cardiovascular disease. Deaths of people with learning disabilities are 20-25 years earlier than for the general population, and causes of deaths differ, with a higher proportion being preventable deaths, the commonest respiratory disease. This is therefore a powerful indicator if inequity.
	Delivering significant and sustainable improvements in health requires a focus on the underlying causes of poor health and inequalities. Poor health is not simply due to diet, smoking or other lifestyle choices, but also the result of other factors such as people's aspirations, sense of control, cultural factors and standards of care.
	Tackling poverty, reducing unemployment, promoting mental wellbeing, increasing educational attainment, improving access to health care and improving poor physical and social environments will, therefore, all contribute to reducing premature mortality. This needs to be complemented by specific action on the "big killer" diseases, such as cardiovascular disease and cancer where some of the risk factors, such as smoking, are strongly linked to deprivation, as well as addressing drug and alcohol problems and links to violence that affect younger men in particular.

Data source	Adult toolkit – SMR04, NRS European Age-Standardised mortality rate per 100,000 for people aged under 75 in Scotland. **Link to source:** Latest results published by National Records for Scotland (Refer to Table 4: Under 75s age-standardised death rates for all causes, administrative areas 2006 to 2012.) European Age-Standardised mortality rates are calculated by applying the age-specific rates for Scotland to the European Standard Population and expressed per 100,000 persons per year. The calculation follows a standard methodology which was updated in 2013, allowing for comparisons between countries and over time. Figures under the new 2013 European Standard Population are not comparable with those calculated under the 1976 European Standard Population, but trend data have been backdated to allow comparisons over time to be made using the new methodology. Further information on the ESP methodology is available on the National Records of Scotland website.
Quality strategy	Equitable, safe
H&W indicators	**Outcome 1.** People are able to look after and improve their own health and wellbeing and live in good health for longer. **Outcome 5.** Health and social care services contribute to reducing health inequalities
MH strategy actions	

Eq2 CTOs	**Number of emergency detention certificates (EDCs) per 100,000 population**
Secondary definition	• NRAC adjusted
Rationale	Use of compulsion measurement is a crude indicator of prevalence of severe and enduring mental illness and the success of services in their therapeutic relationship with an affected patient. The Mental Welfare Commission has highlighted geographical variance in use of emergency detention.
Data source	Mental Welfare Commission for Scotland
Quality strategy	Equitable
H&W indicators	**Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services **Outcome 5.** Health and social care services contribute to reducing health inequalities

MH strategy actions	**32.** Use a rights-based approach in the statutory guidance on the use of mental health legislation.

Eq3 LD health checks	**% of people with severe and enduring mental illness and/ or learning disability who have had an annual health check within previous 12 months**
Secondary definition	• All people with severe and enduring mental illness diagnosis including learning disability. • Annual health check means an assessment of health needs, guided physical examination and review of medication done by a health professional.
Rationale	Annual health checks can address the inequality of poorer physical health in people with mental health problems including learning disability. People with LD have poorer physical and mental health than other people.
Data source	Primary care SPIRE and secondary care records/ registers
Quality strategy	Equitable, effective
H&W indicators	**Outcome 1.** People are able to look after and improve their own health and wellbeing and live in good health for longer. **Outcome 5.** Health and social care services contribute to reducing health inequalities.
MH strategy actions	**30.** Ensure equitable provision of screening programmes, so that the take up of physical health screening amongst people with a mental illness diagnosis is as good as the take up by people without a mental illness diagnosis.

Eq4 CAMH admissions	**% of under 18 psychiatric admissions admitted outwith NHS specialist CAMH wards**
Secondary definition	• Specialist CAMH wards include all specialist NHS mental health hospital inpatient facilities
Rationale	If an under 18 year old requires psychiatric admission it is considered best practice for this to be to an NHS provided specialist facility. Currently 3 regional adolescent and 1 national child units exist. Admission out with these facilities may be due to rurality or to the absence of available beds. The use of non NHS facilities is expensive. Some children are admitted to general paediatric acute beds. This is a measure of age inequity.
Data source	SMR 01, SMR 04 The number of under 18 psychiatric admissions to all hospitals whether NHS or non NHS, acute or psychiatric will need measured to allow the % to specialist NHS facilities to be calculated.

Quality strategy	Equitable
H&W indicators	**Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services **Outcome 5.** Health and social care services contribute to reducing health inequalities
MH strategy actions	**19.** Commission Lead Clinicians in CAMHS to help develop a protocol for admissions to non-specialist wards for young people with mental health problems. **20.** Scope the required level of highly specialist mental health inpatient services for young people, and act on its findings.

Eq5 ACPs	**% of caseload with an active anticipatory care plan**
Secondary definition	• An ACP is any care plan, made and shared with a patient, that lists identified problems and approaches to help these. • ACPs would include any primary care generated ACP, any Distress Brief Intervention plan, any care programme approach plan, and adolescent or other transition care plan.
Rationale	Anticipatory care plans are created in primary care for people with complex comorbidity who are regular users of services. This is a measure of mental: physical health parity of esteem.
Data source	Services would need to identify how many people on their caseload had an ACP
Quality strategy	Equitable
H&W indicators	**Outcome 1.** People are able to look after and improve their own health and wellbeing and live in good health for longer **Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services **Outcome 5.** Health and social care services contribute to reducing health inequalities
MH strategy actions	**21.** Improve quality of anticipatory care planning approaches for children and young people leaving the mental health system entirely, and for children and young people transitioning from CAMHS to Adult Mental Health Services.

Annex A: Overview of Health and Wellbeing Outcomes and Indicators

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

Outcome 1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 5. Health and social care services contribute to reducing health inequalities.
Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
Outcome 7. People using health and social care services are safe from harm.
Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.

An associated Core Suite of Integration Indicators has been developed in partnership with NHS Scotland, COSLA as well as the third and independent sectors, drawing together measures that are appropriate for the whole system under integration.

A National Health and Wellbeing Outcomes Guidance Framework that applies to integrated health and social care has also been produced:

- Core Suite of Integration Indicators
- National Health and Wellbeing Outcomes Guidance Framework

The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using those services, carers and their families. More information about the outcomes is available here:

http://www.gov.scot/Publications/2015/02/9966/downloads

Integration Authorities are responsible for planning and delivering a wide range of health and social care services, and are accountable for delivering the National Health and Wellbeing Outcomes. Each Integration Authority is required to publish an annual performance report, which will set out how they are improving the National Health and Wellbeing Outcomes. These reports will all need to include information about the core suite of indicators, supported by local measures and contextualising data to provide a broader picture of local performance.

These indicators have been, or will be, developed from national data sources so that the measurement approach is consistent across all areas. They can be grouped into two types of complementary measures:

Outcome indicators based on survey feedback, to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality. While national user feedback will only be available every 2 years, it is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often.

1. Percentage of adults able to look after their health very well or quite well.
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5. Percentage of adults receiving any care or support who rate it as excellent or good
6. Percentage of people with positive experience of care at their GP practice.
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
8. Percentage of carers who feel supported to continue in their caring role.
9. Percentage of adults supported at home who agree they felt safe.
10. Percentage of staff who say they would recommend their workplace as a good place to work.*

Indicators derived from organisational/system data primarily collected for other reasons. These indicators will be available annually or more often.

11. Premature mortality rate.
12. Rate of emergency admissions for adults.*
13. Rate of emergency bed days for adults.*
14. Readmissions to hospital within 28 days of discharge.*
15. Proportion of last 6 months of life spent at home or in community setting.
16. Falls rate per 1,000 population in over 65s.*
17. Proportion of care and care at home services rated 'good' (4) or better in Care Inspectorate Inspections.
18. Percentage of adults with intensive needs receiving care at home.

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19. Number of days people spend in hospital when they are ready to be discharged.
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
22. Percentage of people who are discharged from hospital within 72 hours of being ready.*
23. Expenditure on end of life care.*

* Indicator under development

The indicators are designed to allow comparison between areas and to look at improvement over time – some relatively long term. It has been agreed that these indicators will not be subject to targets, although local areas may wish to set improvement aims where appropriate.

The core suite of indicators should, of course, be considered within the wider context of health and social care measurement. While they will provide an indication of progress towards the outcomes that can be compared across partnerships and described at a Scotland level, they will not provide the full picture. Local partnerships will need to collect and understand a wide range of data and feedback that helps understand the system at locality level, and manage and improve services.

It would be expected that Integration Authorities can demonstrate that they are using appropriate information in order to continuously improve services - working towards the National Health and Wellbeing Outcomes, as well as wider Community Planning Partnership outcomes and relevant National Outcomes.

Annex B: Expert reference group membership

John Mitchell, SG Psychiatric Adviser, Principal Medical Officer (Chair)
Lauren Murdoch, SG
Ally Winford, SG
Joan Blackwood, SG Nurse Adviser
Fiona McMahon, Acting Lead QuEST Mental Health Programme
Christine Breslin, SG AHP Adviser
Kirsty Licence, ISD Public Health Consultant
Beth Hamilton, SG Adviser
Gavin MacColl, MHAIST, ISD, NSS
Kirsteen Ellis, Improvement Adviser MHAIST, HIS
Johnathan MacLennan, Improvement Adviser, SPSP MH and HIS
Shirley Windsor, NHS HS
Pete Whitehouse, SG Health and Social Care Analysis