NHS
Quality
Improvement
Scotland

Standards for integrated care pathways for mental health

December 2007

In partnership with

The Scottish Government

social work inspection agency

Acknowledgements

NHS Quality Improvement Scotland (NHS QIS) would like to thank all those who have worked with us to produce the standards for integrated care pathways for mental health. We would like to acknowledge the commitment to partnership working made by all the voluntary and social care organisations, in particular the Association of Directors of Social Work (ADSW) and Social Work Inspection Agency (SWIA).

Contents

The integrated care pathways (ICPs) for mental health standards have four main elements.

- Process standards: describe the key tasks which affect how well ICPs are developed in a local area.
- Generic care standards: describe the interactions and interventions that must be offered to all people who access mental health services.
- Condition-specific care standards: build on the generic care standards and describe the interactions and interventions that must be offered by mental health services to people with a specific condition.
- Service improvement standards: measure how ICPs are implemented and how variations from planned care are recorded and acted on.

1.2 Condition-specific care standards

The standards for the five conditions build on and complement the key components identified in the generic care standards. Considered alongside the process and service improvement standards, the condition-specific care standards outline a set of expectations for the local management and organisation of care in mental health services. Equally, the standards represent an ongoing commitment to improving the quality of treatment and outcomes for service users and their informal carers.

As part of a wider system of continuous quality improvement, the generic and condition-specific care standards form the care elements of the ICP.

Mental health services provide support, assistance and treatment for those with a mental illness and their informal carers. The services may be provided by NHS primary care, secondary care, local authority social services, voluntary organisations and the independent sector. It is therefore essential that these individual services co-ordinate their work to meet the individual service user's needs and that this work can be shown to be fit-for-purpose.

In 2004, NHS Quality Improvement Scotland (NHS QIS) published a national overview of schizophrenia services in Scotland[1]. The key findings identified that mental health services sometimes lack co-ordination, do not deliver evidence-based interventions, do not record outcomes and often do not meet service user assessed needs. To address these findings, NHS QIS published its 3-year strategic work programme in 2005, Improving the Quality of Mental Health Services, 2005-2008[2]. To ensure that mental health services continue to improve, three key areas were identified: care, often provided by different organisations, should be co-ordinated by means of ICPs; the success of a service should be measured by the extent to which the needs of service users are actually met; and information systems should be developed to enable assessment of the first two key areas.

---

[1]   NHS Quality Improvement Scotland. National overview: schizophrenia. Edinburgh:NHS QIS; 2004 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/files/schizophrenia.pdf

[2]   NHS Quality Improvement Scotland. Improving the quality of mental health services in Scotland: a strategic work programme: 2005-2008. Edinburgh:NHS QIS; 2005 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/files/Final%20Strategy.pdf

1.3 Policy context

In 2006, the Scottish Executive Health Department (SEHD) published Delivering for Mental Health[3] (DfMH). DfMH addresses the need to set targets and commitments for the development of mental health services in Scotland. It takes forward the Millan Principles, which underpin Scotland's mental health legislation, Mental Health (Care and Treatment) (Scotland) Act 2003[4], and marks a national commitment to a new style of working for mental health services. NHS QIS is taking this work forward in conjunction with NHSScotland and partner organisations by developing standards for ICPs, as set out in Commitment 6 of DfMH:

'NHS QIS will develop the standards for ICPs for schizophrenia, bipolar disorder, depression, dementia and personality disorder by the end of 2007. NHS board areas will develop and implement ICPs and these will be accredited from 2008 onwards.'

Commitment 6 is linked to achieving the Health Improvement, Efficiency and Governance, Access and Treatment (HEAT) targets for mental health:

*   **Target 1:** Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10.
*   **Target 2:** Reduce suicides in Scotland by 20% by 2013.
*   **Target 3:** Reduce the number of re-admissions (within 1 year) for those that have had a hospital admission of over 7 days, by 10% by the end of December 2009.

---

[3]   Scottish Executive. Delivering for mental health. Edinburgh:SEHD; 2006 [cited 2007 Sept 06]; Available from: http://www.socialworkscotland.org.uk/resources/pub/ DeliveringForMentalHealth.pdf

[4]   Scotland. Mental Health (Care and Treatment) (Scotland) Act 2003. Edinburgh:Stationery Office [cited 2007 Sept 06]; Available from: http://www.opsi.gov.uk/legislation/scotland/ acts2003/20030013.htm

One of the main themes of the standards is the incorporation of a recovery approach. ICPs must capture the ethos and values of recovery and deliver recovery-orientated services.

The Scottish Recovery Network describes recovery as:

'…being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.'

Scottish and international evidence are providing a clearer picture on the factors which help and hinder recovery. A recovery approach, or recovery orientation, is best described as considering these elements and then assessing their implications for practice in mental health services.

In the implementation of ICP standards, local services are expected to consider the recovery experience and its implications for practice and to deliver recovery-orientated services. This may be done with support from the Scottish Recovery Network and tools such as the Scottish Recovery Indicator (www.scottishrecovery.net/content).

2 Standards for integrated care pathways for mental health

2.1 Process standards

The process standards are aimed at supporting NHS boards and partner agencies to lay essential foundations on which to develop their ICPs. The standards are also designed to ensure service user and informal carer involvement.

Standard 1: Named leads

> Standard statement 1:
> A named service lead in partnership with a named ICP co-ordinator is responsible for driving ICP development and implementation.

Rationale

A named service lead and ICP co-ordinator are both important for the process of developing and implementing a multi-agency and multidisciplinary ICP. The organisation needs to support these individuals to fulfil their roles.

- *Wakefield S, Peet M. Developing integrated care pathways in mental health: the critical success factors. Journal of Integrated Care Pathways. 2003;7(1);47-49.*
- *Furley S et al. Three years on: the experience of developing care pathways across a health and social care community. Journal of Integrated Care Pathways. 2006;10(2);69-73.*

Criteria

1a A named service lead is allocated responsibility for driving ICP development and implementation.

1b A named ICP co-ordinator is allocated responsibility for supporting ICP development and implementation.

Standard 2: Stakeholder involvement

> **Standard statement 2:**
> Systems are in place for educating and involving all stakeholders in ICP development.

Rationale

For the successful development and implementation of ICPs, it is crucial to include everyone who is involved in a service user's care. Successful implementation requires the full involvement of all stakeholders, including those who are not directly involved in front line care. Particular attention also needs to be paid to involving service users and informal carers.

— *Middleton S, Barnett J, Reeves D. What is an integrated care pathway? Hayward Medical Communications; 2001. What is...? Series 3(3) [cited 2007 Sept 06]; Available from: http://www.evidence-based-medicine.co.uk.*

— *Hughes V. Patient involvement: turning the rhetoric into reality. Journal of Integrated Care Pathways. 2002;6(1);3-8.*

— *National Leadership and Innovation Agency for Healthcare. Integrated care pathways: a guide to good practice. Llanharan, Wales: National Leadership and Innovation Agency for Healthcare; 2005 [cited 2007 Sept 06]; Available from: http://www.wales.nhs.uk/ sites3/Documents/484/Care%20Pathway%20GGP.pdf*

— *Challans E. How can users be involved in service improvements in health and social care, and why is this important? Journal of Integrated Care Pathways. 2006;10(2);49-58.*

— *Furley S et al. Three years on: the experience of developing care pathways across a health and social care community. Journal of Integrated Care Pathways. 2006;10(2);69-73.*

— *Hall J, Howard D. Integrated care pathways in mental health. Edinburgh:Churchill Livingstone; 2006.*

— *Integrated Care Pathway Users in Scotland (ICPUS). A workbook for people starting to develop integrated care pathways. ICPUS; 2007 [cited 2007 Sept 06]; Available from: http://www.icpus.org.uk/wp-content/uploads/2007/08/icpus_workbook_2007.pdf*

— *Voices of Experience (VOX) [online]. 2007 [cited 2007 Sept 06]; Available from: http://www.voxscotland.org.uk*

Standard 2: Stakeholder involvement (continued)

Criteria

2a Systems are in place to involve the following stakeholders in the ICP development process:

- multi-agency and multidisciplinary workforces (including advocacy services and voluntary organisations)
- service users, and
- informal carers.

2b Systems are in place to involve all stakeholders in awareness and education sessions about ICPs.

Standard 3: Process mapping

> **Standard statement 3:**
> A process mapping exercise is conducted in the early stages of ICP development.

Rationale

It is important to carry out a process mapping exercise early on in the ICP development process. Process mapping helps to identify and examine existing journeys of care from the perspective of staff, service users and informal carers. Teams can begin to see where changes or improvements can be made by identifying gaps, overlaps, strengths and weaknesses of current services and processes. This exercise alone can help to build good team working and develop shared goals and responsibilities.

- *Middleton S, Barnett J, Reeves D. What is an integrated care pathway? Hayward Medical Communications; 2001. What is...? Series 3(3) [cited 2007 Sept 06]; Available from: http://www.evidence-based-medicine.co.uk.*
- *Centre for Change and Innovation. A guide to service improvement: tools and techniques for the delivery of modern healthcare. Edinburgh: SEHD; 2005 [cited 2007 Sept 06]; Available from: http://www.nodelaysachiever.nhs.uk/NR/rdonlyres/EE2D0815-7042-49AE-81C6-7C6591BA8E7D/0/RG0035AGuidetoServiceImprovementNHSScotland.pdf*
- *National Leadership and Innovation Agency for Healthcare. Integrated care pathways: a guide to good practice. Llanharan, Wales: National Leadership and Innovation Agency for Healthcare; 2005 [cited 2007 Sept 06]; Available from: http://www.wales.nhs.uk/sites3/Documents/484/Care%20Pathway%20GGP.pdf*
- *Furley S et al. Three years on: the experience of developing care pathways across a health and social care community. Journal of Integrated Care Pathways. 2006;10(2);69-73.*
- *Hall J, Howard D. Integrated care pathways in mental health. Edinburgh:Churchill Livingstone; 2006.*
- *Integrated Care Pathway Users in Scotland (ICPUS). A workbook for people starting to develop integrated care pathways. ICPUS; 2007 [cited 2007 Sept 06]; Available from: http://www.icpus.org.uk/wp-content/uploads/2007/08/icpus_workbook_2007.pdf*

Standard 3: Process mapping (continued)

Criterion

3a   A process mapping exercise should:

- identify current patterns of service delivery and available resources
- examine the journey of care for service users and informal carers
- establish the strengths and weaknesses of current service provision
- quantify demands on the services
- identify the gaps in services
- identify gaps in staff skills and competencies, and
- identify how the journey of care can be improved.

Standard 4: Links to local care governance systems

> **Standard statement 4:**
> Each NHS board and partner agencies can demonstrate that local care governance systems support ICP development and implementation.

Rationale

To ensure safe and effective practice the involvement of care governance is essential to the development of ICPs.

— *Cook S, Scott M. Framework for the implementation of integrated care pathways. Journal of Integrated Care Pathways. 2004:8(3);129-132.*
— *NHS Lincolnshire Care Pathway Partnership. A care pathway toolkit: delivering service redesign through care pathway development. 2005.*
— *NHS Quality Improvement Scotland. National standards: clinical governance and risk management: achieving safe, effective, patient focused care and services. Edinburgh:NHS QIS; 2005 [cited 2007 Sept 06]; Available from: www.nhshealthquality.org/nhsqisfiles/ CGRM_CSF_Oct05.pdf*

Criteria

4a There are systems that demonstrate the relationship between local governance arrangements and the development, implementation and review of ICPs.

4b A local plan, which includes timescales, is developed and agreed, and details how:

- the organisation will deliver care using ICPs for new service users, and
- existing service users will have their care delivered through ICPs in the future.

Standard 5: Training needs assessment

> **Standard statement 5:**
> Training and supervision needs are identified and acted upon.

Rationale

There should be systems for reviewing service user and informal carer needs against available resources, staff skills, attitudes and capabilities. Knowing who needs which services, and monitoring whether their needs are met, offers a real opportunity to improve the quality of life and of care for service users and informal carers.

– *NHS Quality Improvement Scotland: National overview: schizophrenia. Edinburgh:NHS QIS; 2004 [cited 2007 Sept 06]; Available from: hhtp://www.nhshealthquality.org/nhsqis/ files/schizophrenia.pdf*
– *NHS Quality Improvement Scotland. National standards: clinical governance and risk management: achieving safe, effective, patient-focused care and services. Edinburgh:NHS QIS; 2005 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/ files/CGRM_CSF_Oct05.pdf (section 3b3)*
– *Sloan G. Clinical supervision in mental health nursing. Chichester:John Wiley & Sons; 2006.*
– *Scottish Recovery Network [online]. 2007 [cited 2007 Sept 06]; Available from: www.scottishrecovery.net*

Criteria

5a   There are systems to ensure that the training and supervision needs of staff are acted upon.

5b   Training and supervision needs are incorporated into the organisation's workforce development plans and/or local governance arrangements.

Standard 6: Recording and analysis of diagnostic information

> **Standard statement 6:**
> Systems are in place to record and analyse diagnostic information in each NHS board area.

Rationale

For planning purposes, it is important that NHS boards and partner agencies develop or adapt information systems to yield relevant and anonymous data about the diagnosis of people actively in contact with services. This information sits mainly in primary care. NHS boards should have a mechanism for bringing together anonymised data from primary care lists to identify the total number of people with a diagnosis and, where appropriate, drug misuse or alcohol problem. This information should also be available by local authority area.

Systems should be developed to ensure that information can be shared in a way which satisfies both the legal and professional obligations of the services involved in care delivery, and the legitimate expectations of service users and informal carers.

— *NHS Quality Improvement Scotland. Improving the quality of mental health services in Scotland: a strategic work programme: 2005-2008. Edinburgh:NHS QIS; 2005 [cited 2007 Oct 11]; Available from: http://www.nhshealthquality.org/nhsqis/files/ Final%20Strategy.pdf*

— *NHS Quality Improvement Scotland. National standards: clinical governance and risk management: achieving safe, effective, patient-focused care and services. Edinburgh:NHS QIS; 2005 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/ files/CGRM_CSF_Oct05.pdf (section 2b2)*

— *British Medical Association. Quality and outcomes framework guidance. 2006 [cited 2007 Oct 04]; Available from: http://www.bma.org.uk/ap.nsf/Content/qof06~clinincalind~ment alhealth*

Standard 6: Recording and analysis of diagnostic information (continued)

Criteria

6a   Systems are in place to record the numbers of service users with the diagnoses listed as follows:

- bipolar disorder
- borderline personality disorder
- dementia
- depression, and
- schizophrenia.

6b   Systems are in place to record the number of service users with a mental health diagnosis and drug misuse or alcohol problem.

6c   Systems are in place to record the number of service users receiving care through an ICP.

Standard 7: Recording and sharing of information

Standard statement 7:
Systems are in place to enable the recording and sharing of information.

Rationale

Information sharing between stakeholders is important for the provision of co-ordinated care delivery. The recording of information is also central to demonstrating what services have been delivered and what outcomes have been achieved. All transitions of care need to be accompanied by information in a standardised format, ideally electronically, to help support the new care team to provide a seamless service. There is a need to obtain service user consent to share information outwith the staff group who are providing the care. NHS boards and their partners should develop information sharing systems to enable this.

Issues of consent and confidentiality should not prevent the development of a positive partnership between practitioners and informal carers. There should be a clear understanding at the front line of what is expected of a practitioner if an informal carer asks for information. Organisations providing mental health services should ensure that their stakeholders receive training and support in working through these issues, which are embodied within the principles of the Adults with Incapacity and the Mental Health (Care & Treatment) Acts.

— *Scotland. Adults with Incapacity (Scotland) Act 2000. Edinburgh:Stationery Office; 2000 [cited 2007 Sept 06]; Available from: http://www.opsi.gov.uk/legislation/scotland/ acts2000/20000004.htm*
— *Scotland. Mental Health (Care & Treatment) (Scotland) Act 2003. Edinburgh:Stationery Office [cited 2007 Sept 06]; Available from: http://www.opsi.gov.uk/legislation/scotland/ acts2003/20030013.htm*
— *NHS Quality Improvement Scotland. National standards: clinical governance and risk management: achieving safe, effective, patient-focused care and services. Edinburgh:NHS QIS; 2005 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/ files/CGRM_CSF_Oct05.pdf (sections 2a9, 3e)*

Standard 7: Recording and sharing of information (continued)

— *Mental Welfare Commission for Scotland. Carers & Confidentiality. Mental Welfare Commission for Scotland; 2006.*
— *Scottish Executive Health Department. A good practice guide on consent for health professionals in NHSScotland. NHS HDL(2006)34 [cited 2007 Oct 04]; Available from: www.sehd.scot.nhs.uk/mels/HDL2006_34.pdf*
— *ISD Scotland. Mental health [online]. 2007 [cited 2007 Sept 06]; Available from: http://www.isdscotland.org/isd/1354.html*
— *Scottish Executive. Protocol for information sharing [cited 2007 Sept 07]; Available from: http://www.confidentiality.scot.nhs.uk/publications/GoldStandardFinalNov%202004.pdf*
— *Scottish Consumer Council. Confidentiality: it's your right: how the NHS protects your personal health information. Glasgow:SCC; 2007 [cited 2007 Sept 06]; Available from: http://www.hris.org.uk/mod_product/uploads/Confidentiality_version3_lowres.pdf*

Criteria

7a   A secure system is in place that allows for the recording of, and access to, information in the service user's care record.

7b   Information is recorded and transferred in accordance with the Health & Social Care Data Dictionary (http://www.datadictionary.scot.nhs.uk) and includes:

- the national data sets: Information Core for Integrated Care (ICIC) and the Psychiatric Inpatient Clinical Discharge Summary Information Set (PIC-DSIS), and
- current recommendations on consent, confidentiality and record-keeping standards.

Standard 8: Variances

> **Standard statement 8:**
> Systems are in place to record, analyse, share and act on ICP variances.

Rationale

Care delivered through an ICP enables the care team to reflect on individual and grouped variations from planned care.

— *Middleton S, Barnett J, Reeves D. What is an integrated care pathway? Hayward Medical Communications; 2001. What is...? Series 3(3) [cited 2007 Sept 06]; Available from: http://www.evidence-based-medicine.co.uk.*
— *Lincolnshire Care Pathway Partnership. Delivery service redesign through care pathway development: a care pathway toolkit. Lincolnshire Care Pathway Partnership; 2005.*
— *NHS Quality Improvement Scotland. National standards: clinical governance and risk management: achieving safe, effective, patient-focused care and services. Edinburgh:NHS QIS; 2005 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/ files/CGRM_CSF_Oct05.pdf (sections 3e1, 3e7)*
— *National Leadership and Innovation Agency for Healthcare. Integrated care pathways: a guide to good practice. Llanharan, Wales: National Leadership and Innovation Agency for Healthcare; 2005 [cited 2007 Sept 06]; Available from: http://www.wales.nhs.uk/sites3/ Documents/484/Care%20Pathway%20GGP.pdf*
— *Furley S et al. Three years on: the experience of developing care pathways across a health and social care community. Journal of Integrated Care Pathways. 2006;10(2);69-73.*
— *Hall J, Howard D. Integrated care pathways in mental health. Edinburgh:Churchill Livingstone; 2006.*
— *Integrated Care Pathway Users in Scotland (ICPUS). A workbook for people starting to develop integrated care pathways. ICPUS; 2007 [cited 2007 Sept 06]; Available from: http://www.icpus.org.uk/wp-content/uploads/2007/08/icpus_workbook_2007.pdf*

Standard 8: Variances (continued)

Criterion

8a   Systems are in place for:

- recording
- collating
- analysing, and
- reporting variances.

Standard 9: Referral and triage

> **Standard statement 9:**
> Systems are in place to manage referrals into mental health services.

Rationale

For a referrer, there are likely to be a number of options available locally to make a referral. If good quality referral information is provided by local services, service users can access the most appropriate services. Referral criteria are a way in which the quality of information for a potential service provider can be improved. Referral algorithms allow service users to be signposted to the most appropriate service and help reduce the waiting time.

A referral management system is important to enable prompt and accurate identification of service user needs, urgency and a preliminary assessment of risk.

- *SIGN. Report on a recommended referral document. Edinburgh:SIGN; 2000. SIGN Publication No. 31 [cited 2007 Oct 04]; Available from: http://www.sign.ac.uk/pdf/sign31.pdf*
- *Hall J, Howard D. Integrated care pathways in mental health. Edinburgh:Churchill Livingstone; 2006.*
- *Colgate R, Jones S. Controlling the confusion: management of referrals into mental health services for older adults. Advances in Psychiatric Treatments. 2007;13(I5); 317-324.*

Standard 9: Referral and triage (continued)

Criteria

9a   There is an agreed decision-making system to support referrals into mental health services.

9b   Service care providers have an agreed system on how referrals are managed within their mental health services, including:

- initial screening
- triage assessment, and
- signposting to required service according to complexity of need.

2.2 Generic care standards

When to deliver care through an ICP

People referred to mental health services often do not have a definitive diagnosis.
It is important that carefully considered assessment, care planning and early intervention take place even in the absence of a diagnosis. A generic ICP is therefore suggested as a main framework for mental health care. Condition-specific elements can be added for service users with a specific diagnosis.

- The service user's complexity of need may determine when care is delivered through an ICP. For new service users, care delivered through an ICP should commence when the need for a comprehensive assessment is identified (except for depression).
- NHS boards and partner agencies will need to develop a local plan to ensure that service users already receiving care from mental health services will have their care delivered through an ICP in the future.

Standard 10: Holistic assessment

> Standard statement 10:
> A holistic assessment is undertaken with the service user.

Rationale

A holistic assessment is necessary when a person has complex needs requiring multi-agency or multidisciplinary input. While the single shared assessment should form the basis of the holistic assessment, any assessment carried out should build on and not duplicate any previous assessments and should be reviewed as required.

Under the Community Care and Health (Scotland) Act 2002, an informal carer has the right to an assessment of needs and a plan to meet them.

— *Scotland. Community Care and Health (Scotland) Act 2002, Edinburgh:Stationery Office; 2002 [cited 2007 Oct 11]. Available from: http://www.opsi.gov.uk/legislation/scotland/ acts2002/20020005.htm*
— *NHS Quality Improvement Scotland. Admissions to adult mental health inpatient services. Edinburgh:NHS QIS; 2004 [cited 2007 Sept 06]; Available from: http://www. nhshealthquality.org/nhsqis/files/20307%20NHSQIS%20AdultMental%20BP.PDF*
— *Assessment Review Co-ordinating Group. National minimum information standards for single shared assessment for all adults: version 1.1. SEHD; 2006 [cited 2007 Sept 06]; Available from: http://www.scotland.gov.uk/Resource/Doc/76007/0038531.pdf*
— *Scottish Executive. Rights, relationships and recovery: the report of the national review of mental health nursing in Scotland. Edinburgh:Scottish Executive; 2006 [cited 2007 Sept 07]; Available from: www.scotland.gov.uk/Resource/Doc/112046/0027278.pdf*

2.2 Generic care standards

Criteria

10a A holistic assessment is carried out with the service user and identifies:

- current and past mental health problems (including the informal carer's perspective)
- current and past interventions for these problems (including outcomes, adverse reactions and side-effects)
- personal, family and social circumstances
- strengths and aspirations
- physical health problems
- functioning (eg life skills assessment)
- service user needs assessment (eg Avon Mental Health Measure) and, where appropriate, informal carer needs assessment
- capacity to consent to care and treatment, and
- drug and alcohol use and misuse.

10b A target time for completion of the holistic assessment is recorded.

Standard 11: Assessment and management of risk

> Standard statement 11:
> A risk assessment and management process is carried out.

Rationale

A safe and risk-controlled environment is essential for delivering high quality care and services free from harm, injury and adverse events. This includes risk of neglect and harm to self, to others and from others. Particular attention should be paid where children are involved.

Some service users will have particular immediate vulnerabilities due to their condition, such as dementia. For these groups, additional risks need to be assessed and managed as they present, and links to local vulnerable adult policies identified.

Care needs should be balanced against risk and emphasis should be placed on positive risk management involving all stakeholders. This includes recognising both the organisation's role and the individual practitioner's role in risk management.

Local governance structures should include a mechanism to review serious incidents or near misses.

- *Mental Health Reference Group. Risk management. SEHD; 2000 [cited 2007 Sept 06]; Available from: http://www.sehd.scot.nhs.uk/publications/mhrg/mhrg-00.htm*
- *Morgan S. Clinical risk management: a clinical tool and practitioner manual. London: The Sainsbury Centre for Mental Health; 2000 [cited 2007 Oct 04]; Available from: http://www.scmh.org.uk/80256FBD004F3555/vWeb/flKHAL6YDMAQ/$file/clinical_risk_management.pdf*
- *Clinical Resource and Audit Group (CRAG). Engaging people: observation of people with acute mental health problems: a good practice statement. Edinburgh: Scottish Executive; 2002 [cited 2007 Sept 06]; Available from: http://www.crag.scot.nhs.uk/topics/mhealth/opmh.pdf*

2.2 Generic care standards

- *The Royal College of Psychiatrists Special Working Party on Clinical Assessment and Management of Risk. Assessment and clinical management of risk of harm to other people. Council Report CR53; 1996 [cited 2007 Sept 06]; Available from: http://www.rcpsych. ac.uk/files/pdfversion/cr53.pdf*
- *NHS Quality Improvement Scotland. Admissions to adult mental health inpatient services. Edinburgh:NHS QIS; 2004 [cited 2007 Sept 06]; Available from: http://www. nhshealthquality.org/nhsqis/files/20307%20NHSQIS%20AdultMental%20BP.PDF*
- *NHS Quality Improvement Scotland. National standards: clinical governance and risk management: achieving safe, effective, patient-focused care and services. Edinburgh:NHS QIS; 2005 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/ files/CGRM_CSF_Oct05.pdf (sections 1a1, 1a3 to 1a7)*
- *Mental Welfare Commission for Scotland. Our annual report 2004-2005: our work and our views. Edinburgh:MWCS [cited 2007 Sept 06]; Available from: http://www.mwcscot.org. uk/web/FILES/A33825-MWC_AR_2005.pdf*
- *Department of Health. Best practice in managing risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services. London:DH; 2007 [cited 2007 Sept 06]; Available from: http://www.dh.gov.uk/en/ Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076511*

Criteria

11a There is a record of the service user's vulnerabilities and risks, including:

- self-harm
- suicide
- harm to others
- finance
- occupation
- social vulnerability
- sexual vulnerability
- abuse
- neglect, and
- informal carer risk assessment, where relevant.

Standard 11: Assessment and management of risk (continued)

11b The risk assessment leads to the generation of a risk management plan that is:

- developed with the service user
- communicated to all those involved and identifies roles and responsibilities
- reviewed at regular intervals, and
- amended as necessary.

11c Serious incidents or near misses are reported in accordance with local governance arrangements.

Standard 12: Specific risk assessment in women of childbearing age

Standard statement 12:
There is a record of the assessment of specific risks in women of childbearing age.

Rationale

There are particular risks for women who either become pregnant or are planning a pregnancy and who have or develop a mental illness.

- *The Royal College of Obstetricians and Gynaecologists. Confidential enquiry into maternal and child health: why mothers die 1997-1999. CEMACH Publication; 2001 [cited 2007 Sept 06]; Available from: http://www.cemach.org.uk/Publications/CEMACH-Publications/CEMD-Publications.aspx*
- *SIGN. Postnatal depression and puerperal psychosis. Edinburgh:SIGN; 2002. SIGN Publication No. 60 [cited 2007 Sept 06]; Available from: http://www.sign.ac.uk/pdf/sign60.pdf*
- *SIGN. Bipolar affective disorder. Edinburgh:SIGN; 2005. SIGN Publication No. 82 [cited 2007 Sept 06]; Available from: http://www.sign.ac.uk/pdf/sign82.pdf*
- *NICE. Antenatal and postnatal mental health: clinical management and service guidance. London:NICE; 2007. NICE clinical guideline 1 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/CG45*

Standard 12: Specific risk assessment in women of childbearing age (continued)

Criteria

12a There is a record of a risk assessment and management plan for women of childbearing age which includes:

- advice and explanation of risks of becoming pregnant during treatment
- access to contraceptive advice
- the considered involvement of a partner
- previous history of puerperal psychosis
- suitability of current medication while pregnant and in the postnatal period
- the effects of medication on the foetus and on the woman, and
- the risk of relapse if medication needs to be withdrawn or changed.

12b There is a record that practitioners follow a local treatment algorithm for the management of women who are pregnant and being cared for through the ICP process.

Standard 13: Physical health assessment and management

Standard statement 13:
A general physical health assessment and management of the findings are recorded.

Rationale

Service users with serious mental health problems are at considerably higher risk of physical ill health than the general population. Health promotion advice is particularly important for service users with serious mental illness, although evidence suggests that they are less likely than other members of the general population to be offered blood pressure checks and cholesterol screening if they have concurrent coronary heart disease, for example.

Services should be provided that address diet, nutrition, exercise, alcohol consumption, drug misuse and sexual health in ways that are responsive to the needs of service users. This also includes access to smoking cessation clinics, free dental and optical examinations and flu vaccinations.

- *American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care. 2004;27(2):596-601.*
- *Marder SR, Essock SM, Miller AL, Buchanan RW, Casey DE, Davis JM, et al. Physical health monitoring of service users with schizophrenia. Am J Psychiatry. 2004;161(8):1334-49.*
- *NICE. Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. London:NICE; 2002. NICE clinical guideline 1 [cited 2007 Sept 06]; Available from: http://www.nice.org.uk/page.aspx?o=cg001*
- *Scottish Executive. Delivering for mental health. Edinburgh:SEHD; 2006 [cited 2007 Sept 06]; Available from: http://www.socialworkscotland.org.uk/resources/pub/ DeliveringForMentalHealth.pdf*

Standard 13: Physical health assessment and management (continued)

— *British Medical Association. Quality and outcomes framework guidance. 2006 [cited 2007 Oct 04]; Available from: http://www.bma.org.uk/ap.nsf/Content/qof06~clinincalind~mentalhealth*
— *NICE. Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. London:NICE; 2006. NICE clinical guideline 38 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/cg38*

Criteria

13a The care record shows that physical health needs are assessed at least annually using the following features:

- the completion of a physical health assessment
- the provision of health promotion advice, and
- service users receiving medication should have side-effects and physical health assessed and managed according to the appropriate algorithm for that medication.

13b The care record shows information on the management of physical health needs, including:

- information on who is responsible for the physical health assessment (primary care or specialist services)
- evidence that results have been shared
- evidence that results have been acted upon, and
- evidence that information and/or advice on promoting a healthy lifestyle has been provided.

Standard 14: Diagnosis

> Standard statement 14:
> There is a record of a diagnosis or diagnoses.

Rationale

A particular diagnosis may suggest the use of certain treatments or the likely course and outlook for the service user with the condition. Information on how the diagnosis or diagnoses was reached should be included in the care record.

A diagnosis or diagnoses should be recorded and explained to the service user and informal carer. This includes access to information about the condition as well as the support and resources that may be available in the community.

— *American Psychiatric Association Work Group on Borderline Personality Disorder. Practice guideline for the treatment of patients with borderline personality disorder. American Psychiatric Association; 2001 [cited 2007 Sept 06]; Available from: http://www.psych. org/psych_pract/treatg/pg/BPD_05-15-06.pdf*
— *SIGN. Management of patients with dementia. Edinburgh:SIGN; 2006. SIGN Publication No. 86 [cited 2007 Oct 04]; Available from: www.sign.ac.uk/pdf/sign86.pdf*
— *World Health Organisation. International statistical classification of diseases and related health problems, Tenth Revision (ICD 10) Geneva:World Health Organisation.*

Criterion

14a The care record shows:

- the diagnosis or diagnoses
- information on how the diagnosis or diagnoses was reached following evidence-based guidelines or established diagnostic criteria, where available
- confirmation that the diagnosis or diagnoses has been explained to the service user and informal carer, and
- post-diagnosis support is offered.

Standard 15: Suitability for psychological and/ or psychosocial interventions

Standard statement 15:
The need for structured psychological and/or psychosocial intervention for the service user is assessed.

Rationale

Structured psychological and/or psychosocial interventions can benefit service users, either as the primary means of treatment or in addition to other treatments.

Evidence of the effectiveness of psychological therapies is based on the person delivering a therapy having been trained and accredited, and practising within a framework of supervision, support, audit and review.

— *SIGN. Psychosocial interventions in the management of schizophrenia. Edinburgh:SIGN; 1998. SIGN Publication No. 30 [cited 2007 Sept 06]; Available from: http://www.sign. ac.uk/pdf/sign30.pdf*
— *NICE. Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. London:NICE; 2002. NICE clinical guideline 1 [cited 2007 Sept 06]; Available from: http://www.nice.org.uk/page.aspx?o=cg001*
— *Krabbendam L, Aleman A. Cognitive rehabilitation in schizophrenia: a quantitative analysis of controlled studies. Psychopharmacology. 2003;169(3-4):376-82.*
— *Bateman AW, Tyrer P. Psychological treatment for personality disorders. Advances in Psychiatric Treatment. 2004;10:378–88.*
— *NICE. Depression: management of depression in primary and secondary care. London:NICE; 2004 NICE clinical guideline 23 [cited 2007 Sept 06]; Available from: http://guidance.nice. org.uk/CG23*
— *Tarrier N, Wykes T. Is there evidence that cognitive behaviour therapy is an effective treatment for schizophrenia? a cautious or cautionary tale? Behav Res Ther. 2004;42(12):1377-401.*

2.2 Generic care standards

— *SIGN. Bipolar affective disorder. Edinburgh:SIGN; 2005. SIGN Publication No. 82 [cited 2007 Sept 06]; Available from: http://www.sign.ac.uk/pdf/sign82.pdf*

— *NICE. Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. London:NICE; 2006. NICE clinical guideline 38 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/cg38*

Criteria

15a Psychological therapies are delivered by appropriately trained and accredited staff under practice supervision.

15b The assessed need for psychological and/or psychosocial interventions is recorded.

15c Where needs have been identified, there is a record that the service user has been offered a range of therapies, including educational, social and lifestyle advice as well as psychological and/or psychosocial therapies.

15d There are systems for the provision of psychological and/or psychosocial therapies, including:

- delivery within 3 months of referral
- review of individual service user progress, and
- recording of outcome.

Standard 16: Person-centred care

Standard statement 16:
There is a record that the service user has been actively involved in the planning of their care.

Rationale

Person-centred care should ensure that assessments, care planning and care delivery are based on the recovery outcomes identified by the service user rather than on the availability of services and treatments.

The care provided should be planned with the service user and their informal carer on the basis of assessed needs. Service users and informal carers should be provided with a range of information about the condition, treatment options, outcomes, risks, side-effects and rights on an ongoing basis.

Services should offer an appropriate choice of options that take into account the service user's values and beliefs, and meets the six strands of equality and diversity.

Most people using mental health services will not be subject to the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adults with Incapacity (Scotland) Act 2000, but the principles have a universal validity for service providers and those using them.

– *Scotland. Adults with Incapacity (Scotland) Act 2000. Edinburgh:Stationery Office; 2000 [cited 2007 Sept 06]; Available from: http://www.opsi.gov.uk/legislation/scotland/ acts2000/20000004.htm*
– *Scotland. Mental Health (Care and Treatment) (Scotland) Act 2003. Edinburgh:Stationery Office [cited2007 Sept 06]; Available from: http://www.opsi.gov.uk/legislation/scotland/ acts2003/20030013.htm*

2.2 Generic care standards

  — *NHS Quality Improvement Scotland. National standards: clinical governance and risk management: achieving safe, effective, patient-focused care and services. Edinburgh:NHS QIS; 2005 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/files/CGRM_CSF_Oct05.pdf (sections 2a1, 2a4 to 2a6)*
  — *Scottish Recovery Network [online]. 2007 [cited 2007 Sept 06]; Available from: http://www.scottishrecovery.net*

Criteria

16a The care record shows that care is planned and agreed with the service user and informal carer in a format that is accessible and takes into account personal values and beliefs.

16b The care record shows that advice has been provided to the service user and their informal carer on sources of further information and support, for example voluntary organisations and advocacy services.

Standard 17: Single care plan

> Standard statement 17:
> There is a single care plan that operates across all service care providers.

Rationale

The single care plan should be based on the multi-agency and multidisciplinary assessment of needs. To co-ordinate services and ensure continuity of care, roles and responsibilities should be agreed. For the service user, this should include discussion of service user role and responsibilities in promoting their own wellbeing. Information should also be provided to the informal carer to support them to care.

The service user should be involved in the nomination of a care plan co-ordinator, who has responsibility for planning, managing and reviewing the plan at an agreed frequency (at least annually). The service user should also be invited to give consent for a copy of the care plan to be held by their informal carer.

Crisis intervention plans should be developed with service users who are experiencing a crisis of such severity that without professional intervention the person would require a hospital stay (National Standards for Crisis Services, Scottish Executive 2006).

— *Scotland. Mental Health (Care and Treatment) (Scotland) Act 2003. Edinburgh:Stationery Office [cited2007 Sept 06]; Available from: http://www.opsi.gov.uk/legislation/scotland/ acts2003/20030013.htm*
— *NHS Quality Improvement Scotland. National standards: clinical governance and risk management: achieving safe, effective, patient-focused care and services. Edinburgh:NHS QIS; 2005 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/ files/CGRM_CSF_Oct05.pdf (sections 2a4, 2a6 to 2a8)*
— *Scotland. Delivering for health: delivering for mental health national standards for crisis services. Edinburgh:SEHD; 2006 [cited 2007 Sept 06]; Available from: http://www.scotland. gov.uk/Publications/2006/11/22094720/12*

2.2 Generic care standards

Criteria

17a The single care plan records a nominated co-ordinator who has been identified and agreed with the involvement of the service user.

17b The single care plan operates across all service care providers and:

- is based on the assessment of needs, strengths and past experience
- identifies goals and aspirations
- specifies tasks, treatment and interventions (including risk management)
- records roles and responsibilities of all individuals and agencies involved
- includes a record of service user desired outcome (self-directed outcome)
- includes a system to record disagreement
- records that service users are invited to hold a copy of the care plan, and
- records unmet needs since the last assessment.

17c The single care plan is reviewed regularly (at least annually and for dementia at least every 6 months).

17d The single care plan includes:

- a record of the service user's named person, where applicable
- the offer of an advance statement
- a crisis plan drawn up by the service user and care team, and
- a staying-well plan.

Standard 18: Recording medication decisions

Standard statement 18:
There is a record of individual medication decisions.

Rationale

There should be a firm evidence base for all medication. National licence conditions govern the indications, dosage and contra-indications for each available medication. Service care providers should have agreed and published algorithms which provide guidance on first, second and possibly third-line medication, dosage, length of treatment, review requirements, action to be taken over side-effects, and assessment of the effectiveness of medication.

Criterion

18a The care record shows the decision-making process, including when to initiate, change, maintain or end medication.

Standard 19: Treatment of substance misuse for service users with a mental illness

Standard statement 19:
Treatment is available for service users with a mental illness and substance misuse.

Rationale

Mental illness and co-existing substance misuse are associated with more severe problems, poorer outcomes from interventions and higher rates of dropout. The challenges of working together to help and support this group through early identification, intervention, integrated care and supported recovery are among the most pressing issues currently facing services in Scotland. Given that a wide range of disciplines and agencies may be involved, clarity of responsibilities and co-ordination of care is essential. Many individuals with co-existing problems may not meet the criteria set by specialist substance misuse services, and may also fall below the level at which a referral might be accepted by a secondary mental health service. Nonetheless, these service users may have many difficulties which may affect local services and their ability to implement HEAT targets.

- There are high rates of antidepressant prescribing in people with alcohol dependence.
- There is a strong relationship between substance misuse, mental illness and suicide.
- A substantial proportion of those re-admitted to a psychiatric hospital misuse substances or have alcohol problems in addition to a mental illness.

Standard 19: Treatment of substance misuse for service users with a mental illness (continued)

The needs of those who have co-existing problems and who require interventions should be met by a process of consultation and co-working between substance misuse and mental health services.

— *Scottish Executive. Delivering for mental health, mental health and substance abuse consultation draft:commitment 13. 2007 [cited 2007 Sept 06]; Available from: http://www.scotland.gov.uk/Resource/Doc/181007/0051353.pdf*

Criterion

19a When substance misuse is identified in a service user with a mental illness, there is a record that matched care appropriate to each person's level of need is offered.

Standard 20: Inpatient admission and discharge

> Standard statement 20:
> The reason for and the length of inpatient admission are recorded and discharge is planned.

Rationale

Careful consideration should be given to alternative services capable of meeting the service user's needs. However, there will be occasions where inpatient admission is the most appropriate course of action.

Where inpatient admission is required this should be as brief as necessary, and the aims stated and agreed.

The discharge or transfer of care of people from one setting to another is one area where the continuity of care can break down, especially if inadequate information is transferred.

Effective discharge planning should begin as early as possible from the time of admission and should involve the multi-agency and multidisciplinary team, the service user and their informal carer.

The discharge and/or transfer should be a seamless process, ensuring that appropriate services are in place to support the service user. Discharge and/or transfer plans need to be well co-ordinated, based on the service user's assessed needs, reviewed regularly, and include ongoing risk assessment and management. This can only be done through effective planning and communication.

- *Bateman AW, Tyrer P. Services for personality disorder: organisation for inclusion. Advances in Psychiatric Treatment. 2004;10:425-33.*
- *Fagin l. Management of personality disorders in acute inpatient settings. Part 1: Borderline personality disorders. Advances in Psychiatric Treatment. 2004;10:93-9.*

Standard 20: Inpatient admission and discharge (continued)

— *NHS Quality Improvement Scotland. Admissions to adult mental health in-patient services. Edinburgh:NHS QIS; 2004 [cited 2007 Sept 07]; Available from: http://www. nhshealthquality.org/nhsqis/files/20307%20NHSQIS%20AdultMental%20BP.PDF*
— *Scottish Executive. Delivering for mental health. Edinburgh:SEHD; 2006 [cited 2007 Sept 06]; Available from: http://www.socialworkscotland.org.uk/resources/pub/ DeliveringForMentalHealth.pdf*

Criterion

20a When a service user is admitted to hospital, the care record shows:

- the reasons for inpatient admission
- any alternative options considered
- the aims of admission, in accordance with the recommendations of Bateman & Tyrer (2004) and Fagin (2004) for the borderline personality disorder client group
- the expected and actual length of the inpatient stay, and
- the plan for discharge.

Standard 21: Measure of needs and outcome

> Standard statement 21:
> There is a service user and informal carer needs assessment, as well as a professionally rated validated measure of outcome.

Rationale

The use of a standardised measure of needs which is rated by service users and informal carers is an important tool for identifying how well services are able to meet these needs.

A professionally rated validated tool must be used to measure outcomes. The choice of tool or assessment scale should be based on the presentation, age and capacity of the service user.

— *Le Grande D, Kessler E, Reeve B. The Avon mental health measure. Mental Health Review. 1996;1(4):31-32.*
— *NHS Quality Improvement Scotland. Improving the quality of mental health services in Scotland – a strategic work programme: 2005-2008. Edinburgh:NHS QIS, 2005 [cited 2007 Oct 11]; Available from: http://www.nhshealthquality.org/nhsqis/files/ Final%20Strategy.pdf*
— *NHS Quality Improvement Scotland. Scottish schizophrenia outcomes study. 2006 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/nhsqis/files/ SSOSFinalReport_FINALprintver120606.pdf*

Criteria

21a The care record includes a needs assessment scale which is rated by service users and informal carers, eg Avon Mental Health Measure.

21b The care record includes a professionally rated assessment tool which is validated for the relevant client group to monitor outcome.

2.3 Condition-specific care standards

2.3 Condition-specific care standards

Bipolar disorder care standards

Given the nature of the illness and its sub-clinical forms, clinical experience indicates that a significant period of time may elapse between initial presentation and formal diagnosis of bipolar disorder (previously known as manic depression).

Bipolar disorder is a cyclical illness with three distinct treatment phases:

- acute mania
- depressive episodes, and
- maintenance therapy, including hypomania and mild depression.

Effective treatment of bipolar disorder includes the anticipation and detection of acute manic or depressive episodes, monitoring of the safety and efficacy of treatment regimes and screening for psychiatric and physical comorbidity.

Standard 22: Management of acute mania

Standard statement 22:
Treatment and outcomes are recorded for the acute mania phase.

Rationale

Treatment choices need to take account of National Institute for Health and Clinical Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines. Care delivered through an ICP should provide a mechanism to record any departures from these.

— *Young RC, Biggs JT, Ziegler VE, Meyer, DA. A rating scale for mania: reliability, validity and sensitivity. Br J Psychiatry. 1978;133:429-35.*
— *SIGN. Bipolar affective disorder. Edinburgh:SIGN; 2005. SIGN Publication No. 82 [cited 2007 Sept 06]; Available from: http://www.sign.ac.uk/pdf/sign82.pdf (p12)*
— *NICE. Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. London:NICE; 2006. NICE clinical guideline 38 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/cg38 (Quick reference guide (QRG) p11).*

Criteria

22a The care record shows that a treatment algorithm for acute mania, based on SIGN or NICE guidelines, is followed.

22b The care record shows a measurement of outcome in acute mania using a validated tool, eg Young Mania Rating Scale (YMRS).

Standard 23: Management of bipolar depression

> Standard statement 23:
> There is a record of screening for and management of bipolar depression.

Rationale

The evidence for treatment of bipolar depression has been summarised in NICE and SIGN guidelines. The use of selective serotonin reuptake inhibitors (SSRIs) is less likely to provoke manic episodes when compared with drugs from the tri-cyclic class.

— *Hamilton M. A rating scale for depression. Journal of Neurology, Neurosurgery and Psychiatry. 1960 Feb;23:52-62.*
— *Montgomery SA, Asberg M. A new depression scale designed to be sensitive to change. British Journal of Psychiatry. 1979 Apr;134:382-9.*
— *SIGN. Bipolar affective disorder. Edinburgh:SIGN; 2005. SIGN Publication No. 82 [cited 2007 Sept 06]; Available from: http://www.sign.ac.uk/pdf/sign82.pdf*
— *NICE. Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. London:NICE; 2006. NICE clinical guideline 38 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/cg38*

Criteria

23a The care record shows that a depression-screening algorithm is followed, eg Hamilton.

23b Where antidepressants are prescribed, the care record shows they are prescribed in combination with a mood stabiliser.

23c The care record shows the use of a professionally rated assessment tool to monitor outcome, eg Montgomery Asberg Depression Rating Scale (MADRS).

Standard 24: Keeping well and recovery

Standard statement 24:
There is a record of treatment and outcomes for the maintenance phase of bipolar disorder.

Rationale

The evidence for treatment of bipolar disorder in the maintenance phase has been summarised in NICE and SIGN guidelines.

- *Young RC, Biggs JT, Ziegler VE, Meyer DA. A rating scale for mania: reliability, validity and sensitivity. Br J Psychiatry. 1978;133:429-35.*
- *Montgomery SA, Asberg M. A new depression scale designed to be sensitive to change. British Journal of Psychiatry. 1979 Apr;134:382-9.*
- *SIGN. Bipolar affective disorder. Edinburgh:SIGN; 2005. SIGN Publication No. 82 [cited 2007 Sept 06]; Available from: http://www.sign.ac.uk/pdf/sign82.pdf (p14-15).*
- *NICE. Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. London:NICE; 2006. NICE clinical guideline 38 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/cg38 (QRG p16-18).*

Criteria

24a The care record shows that an algorithm based on treatment choices in NICE and SIGN guidelines is followed, including for the use of lithium, anticonvulsants, antipsychotics, and these in combination.

24b The care record shows the use of a professionally rated assessment tool to monitor outcome, eg using YMRS and/or MADRS.

Standard 25: Monitoring of medication

Standard statement 25:
There is monitoring of the safety and efficacy of medication for all phases of the illness.

Rationale

The NICE guideline on the management of bipolar disorder summarises the evidence for monitoring the safety and efficacy of medication for all phases of the illness. The guideline includes recommended checks and the frequency with which they should be carried out.

– *NICE. Bipolar disorder: the management of bipolar disorder in adults, children and adolescents, in primary and secondary care. London:NICE; 2006. NICE clinical guideline 38 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/cg38 (QRG p21-23).*

Criterion

25a The care record shows that an algorithm based on medication choices in the NICE guideline is followed.

Borderline personality disorder care standard

Working with service users with a diagnosis of borderline personality disorder (BPD) is inherently complex, but should never be a reason for excluding them from receiving the services they require.

The chaos and disorder that characterises the internal world of a service user with BPD can restrict effective multi-agency and multidisciplinary engagement. While not directly part of the ICP standards, the following principles of management are important to promote good care of people with BPD.

- Establish and maintain the therapeutic alliance while managing risk.
- Maintain flexibility.
- Establish conditions to make the patient safe.
- Tolerate intense anger, aggression and hate.
- Promote reflection.
- Set necessary limits.
- Understand the dynamics and monitor relationships between service users and staff.
- Monitor counter transference feelings, strong feeling that can be unconsciously evoked in staff, to understand the service user's communications and difficulties.
- Use a consistent approach.
- Set realistic and prioritised goals.
- Attempt to reach shared expectations.
- Treat comorbid Axis I disorders.
- Treat specific areas (eg anger, self-harm, social skills, offending behaviour).
- Give practical social support with housing, finance, child care etc.

– *Davison SE. Principles of managing patients with personality disorder. Advances in Psychiatric Treatment. 2002;8:1-9.*
– *National Institute for Mental Health in England. Personality disorder: No longer a diagnosis of exclusion. London:NIMHE; 2003 [cited 2007 Sept 06]; Available from: http://www. dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/ dh_4054230.pdf*

Standard 26: Medication

Standard statement 26:
There is a record of medication for BPD.

Rationale

Treatment choices for BPD should be based on current best practice and include the following.

- Consider the primary symptom complex (eg affect dysregulation, impulsivity, cognitive/perceptual disturbance).
- Educate the service user about reasons for medication, possible side-effects and expected positive effects.
- Make a clear recommendation, but allow the service user to make the decision. Do not try to persuade the service user to take the medication.
- Agree a length of time for trial of medication (unless intolerable side-effects) and do not prescribe another drug during this time, even if the service user stops taking the drug.
- Prescribe within safety limits, eg give prescriptions weekly.
- See the service user at agreed intervals to discuss medication and its effects: initially, this may be every few days to encourage compliance, to monitor effects and to titrate the dose.
- Do not be afraid to suggest stopping a drug if no benefit is observed and the service user experiences no improvement.

Standard 26: Medication (continued)

— *Tyrer P, Bateman AW. Drug treatment for personality disorders. Advances in Psychiatric Treatment. 2004;10:389–398.*
— *Livesley WJ. Principles and strategies for treating personality disorder. Can J Psychiatry. 2005;50(8):442-450.*
— *Binks CA, Fenton M, McCarthy L, Lee T, Adams CE, Duggan C. Pharmacological interventions for people with borderline personality disorder. Cochrane Database of Systematic Reviews. Issue 1; 2006.*

Criterion

26a The care record shows that a treatment algorithm for drug choices based on best practice is followed (for example as described in Tyrer & Bateman, 2004).

2.3 Condition-specific care standards

Dementia care standards

Dementia is a clinical diagnosis made when acquired deficits in more than one area of cognition are sufficient to interfere with social or occupational functioning, and represent a decline from a previous level. Dementia can result from a number of single or combined causes and is usually progressive.

Service users with dementia and their informal carers may have different needs at different stages of the illness. Care may occur in a variety of settings and be carried out by a number of practitioners. Under the quality and outcomes framework (QOF), GPs are required to offer service users, with a diagnosis of dementia, a face-to-face review of their care on a yearly basis. This review also includes a consideration of the needs of the service user's informal carer.

To deliver good quality care, close working arrangements should be developed with all stakeholders. In particular, at all stages of dementia care and delivery, services should:

• help the person with dementia understand and manage their illness and enhance their strengths
• help informal carers to continue caring for as long as is practical
• be consistent with the principles of the Adults with Incapacity (Scotland) Act 2000
• recognise the special needs of younger people with dementia, and
• anticipate the care and support people with dementia may need later in the illness to help service users and their informal carers plan ahead.

While not directly part of the dementia care standards, the following service features are important to promote good care of people with dementia.

• There should be a joint health and social care dementia plan for each local authority and NHS board area.
• Health and social care managers should co-ordinate and integrate services for people with dementia.
• Acute hospitals and other NHS services should plan and provide for people with dementia who have other illnesses in addition to dementia.
• Training in dementia should be available for all staff.
• People with dementia should not be excluded from other services they require because of their diagnosis or age.

Standard 27: Treatment for cognitive impairment

Standard statement 27:
Treatment for cognitive impairment is recorded.

Rationale

The evidence base for treatments for cognitive impairment is SIGN 86, NICE technology appraisal 111 and NICE clinical guideline 42.

- *NICE. Donepezil, galantamine, rivastigmine (review) and memantine for the treatment of Alzheimer's disease. London:NICE; 2006. NICE Technology Appraisal 111 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/TA111*
- *NICE, SCIE. Dementia: supporting people with dementia and their carers in health and social care. London:NICE; 2006. NICE clinical guideline 42. [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/cg42/niceguidance/pdf/English/download.dspx*
- *SIGN. Management of patients with dementia. Edinburgh:SIGN; 2006. SIGN Publication No.86 [cited 2007 Sept 06]; Available from: http://www.sign.ac.uk/pdf/sign86.pdf*

Criteria

27a The care record shows that a treatment algorithm for cognitive impairment based on current national recommendations is followed.

27b The care record shows that an appropriate assessment tool has been used to evaluate treatment outcome.

Standard 28: Matched intervention

Standard statement 28:
Service users who develop behavioural or psychological dementia symptoms receive an intervention matched to their needs.

Rationale

Behavioural and psychological dementia symptoms include aggression, agitation, depression and psychosis. These symptoms can be caused or worsened by a number of factors, including: physical illness, pain, drug side-effects and environmental changes. They can cause particular difficulties and need to be assessed and managed in a structured way to alleviate current symptoms and prevent future difficulties.

Antipsychotic medication should be reserved for severe aggression or psychotic symptoms where other approaches have failed or would be inappropriate.

— *Alzheimer Scotland. Planning signposts for dementia care services. Edinburgh:Alzheimer Scotland; 2000.*
— *NICE, SCIE. Dementia:supporting people with dementia and their carers in health and social care. London:NICE; 2006. NICE clinical guideline 42. [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/cg42/niceguidance/pdf/English/download.dspx*
— *SIGN. Management of patients with dementia. Edinburgh:SIGN; 2006. SIGN Publication No.86 [cited 2007 Sept 06]; Available from: http://www.sign.ac.uk/pdf/sign86.pdf*

2.3 Dementia care standards

Criteria

28a The care record shows that service users who develop behavioural or psychological dementia symptoms have a review of their care plan within 4 weeks.

28b There is a local system in place for a structured and systematic response to the development of behavioural or psychological dementia symptoms.

28c The care record shows that an appropriate assessment tool has been used to assess the efficacy of medication.

Standard 29: End of life care

> Standard statement 29:
> There is advance care planning in relation to end of life care.

Rationale

Advance care planning helps deliver care in a manner acceptable to service users with dementia and their informal carers (eg by promoting palliation of distressing symptoms rather than active treatment). Symptom control in service users with dementia who are dying is often poor and inappropriate hospitalisation can add to the distress. In the later stages of dementia, links with local palliative care services and use of care pathways for the dying may be useful.

– *Scottish Executive. Range and capacity review group: second report: the future of older people in Scotland. Edinburgh:Scottish Executive; 2006 [cited 2007 Oct 04]; Available from: http://www.scotland.gov.uk/publications/2006/04/25111735/0*

Criterion

29a The care record shows advance planning in relation to end of life care, which is:

- reviewed at least annually, and
- includes consideration of the preferred place of treatment if the condition worsens.

Schizophrenia care standards

Schizophrenia is a condition that can affect a person's perception, thinking, emotions and relationships. It usually begins in early adulthood and can impact upon a person's wellbeing for many years afterwards, sometimes for the rest of their life.

A diagnosis of schizophrenia is usually made when a person is complaining of hallucinations, delusions and other disturbances of perception and thinking (these are sometimes known as positive symptoms). The person may also be experiencing problems with their concentration, motivation, self-care and ability to communicate (these are sometimes known as negative symptoms).

It is believed that early intervention may prevent the development of some of the more debilitating problems associated with the condition (eg social withdrawal and occupational breakdown).

Standard 30: Early intervention

Standard statement 30:
In the early stages of schizophrenia an early intervention model of care is delivered.

Rationale

Early interventions can prevent initial problems and improve the prospect of recovery. Early intervention for first episode and relapses should provide a mix of specialist medication, psychological, social, occupational and educational interventions.

Following initial onset, therapeutic input in the first 2–3 years can prevent major impairments and vulnerabilities that can lead to a cycle of relapses and disability.

— *NICE. Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. London:NICE; 2002. NICE clinical guideline 1 [cited 2007 Sept 06]; Available from: http://www.nice.org.uk/page.aspx?o=cg001*

Criterion

30a The care record shows that an early intervention model is followed and covers first episode and relapses.

Standard 31: Delivery of psycho-educational, psychological and psychosocial therapies

Standard statement 31:
Psycho-educational, psychological and psychosocial therapies, which should include cognitive behavioural therapy (CBT) where indicated, are offered and delivered in a timely manner.

Rationale

People who have a diagnosis of schizophrenia have needs which cannot be met solely by medication. Providing psycho-educational, psychological and psychosocial therapies for service users and their informal carers can:

- improve the service user's symptoms
- help them develop and maintain vital relationships
- reduce their risk of relapse
- help informal carers to cope better, and
- enhance the service user's and informal carer's quality of life.

The strongest evidence base is for education programmes, family intervention and CBT.

- *SIGN. Psychosocial interventions in the management of schizophrenia. Edinburgh:SIGN; 1998. SIGN Publication No. 30 [cited 2007 Sept 06]; Available from: http://www.sign. ac.uk/pdf/sign30.pdf*
- *NICE. Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. London:NICE; 2002. NICE clinical guideline 1 [cited 2007 Sept 06]; Available from: http://www.nice.org.uk/page.aspx?o=cg001*

— *Krabbendam L, Aleman A. Cognitive rehabilitation in schizophrenia: a quantitative analysis of controlled studies. Psychopharmacology. 2003;169(3-4):376-82.*

— *Tarrier N, Wykes T. Is there evidence that cognitive behaviour therapy is an effective treatment for schizophrenia? a cautious or cautionary tale? Behav Res Ther. 2004;42(12):1377-401.*

Criterion

31a The care record shows that psycho-educational, psychological and psychosocial therapies are delivered according to locally agreed systems, and include information on:

- review of individual service user progress, and
- delivery within 3 months of referral.

Standard 32: Medication

Standard statement 32:
Medication, including for drug treatment-resistant schizophrenia, is recorded.

Rationale

It is important that a record of medication, including for drug treatment-resistant schizophrenia is recorded. As such, a local treatment algorithm based on the latest evidence base, and incorporating service user preference should be followed.

— *NICE. Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care. London:NICE; 2002. NICE clinical guideline 1 [cited 2007 Sept 06]; Available from: http://www.nice.org.uk/page.aspx?o=cg001 (full guideline pages 44-47 and Figures 4.1-4.6, pages 51- 56).*
— *Taylor D, Kerwin R, Paton C. The Maudsley 2005-2006 prescribing guidelines. 8th ed. London:Taylor & Francis. 2005.*

Criterion

32a The care record shows that an evidence-based medication algorithm for schizophrenia is followed. This algorithm includes drug treatment-resistant schizophrenia.

2.3 Condition-specific care standards

Depression care standards

Depressive illness is a common, recurrent and disabling condition, and may occur with anxiety disorder, drug misuse and alcohol problems. It has a significant impact on physical health and social and occupational functioning.

As its management will differ, a depressive condition must be distinguished from unhappiness. This will be determined on the basis of depth, degree and consistency of low mood over time, its pervasiveness and its impact on day-to-day functioning. Under the QOF, GPs are required to:

- screen patients with diabetes or coronary heart disease for depression, and
- use an assessment tool validated for use in primary care for patients with a new diagnosis of depression.

ICD–10 recognises mild, moderate and severe forms of depression, a recurrent nature, and the presence or absence of somatic (eg sleep disturbance, weight loss) and psychotic features. Mild depression is usually self-limiting and may respond to simple reassurance, direction to self-help materials and other community resources. Moderate to severe depression requires more formal, skilled intervention, in the form of drug treatment or evidence-based psychological therapy.

If there is little progress being made or new problems are identified, the ethos is one of stopping to re-assess, reviewing what has happened, beneficial or not, before planning further interventions. The journey ends when the service user feels they no longer require help. As depression can be a long-term condition, it is possible for service users to remain on the pathway indefinitely with an agreed care plan and regular review process in place.

Bipolar disorder

Previously known as manic depression, bipolar disorder is an illness that affects mood, causing a person to switch between feeling very low (depression) and very high (mania). Treatment of bipolar disorder is covered in the section on bipolar disorder standards in this document. History of hypomania should be checked in all adults presenting with depression.

Consideration needs to be given to depression as a possible side-effect of current medication or physical illness.

Overview of depression standards

For a condition such as depression, the service user's journey of care may occur predominantly in primary care, involving secondary mental health services to a much smaller extent. As such, the standards for depression are structured to reflect a journey of care based on both the service user's severity of symptoms and their complexity of need.

Standards 33–36 outline a discrete journey of care for service users with a diagnosis of depression whose complexity of need does not require specialist assessment and treatment.

Standard 37 addresses the needs of service users with a diagnosis of depression whose complexity of need require a comprehensive assessment. In such instances, the journey of care should follow both the generic and condition-specific care standards.

Standard 33: Use of an objective measure for people with depression

> Standard statement 33:
> A validated measure of depression is used at initial assessment and repeated at regular intervals to monitor progress and outcome.

Rationale

It is important to include a measure of the level of depression using an objective tool at various points throughout the service user's journey of care. This will aid monitoring of the impact of any interventions. The PHQ9 is an example of a tool that can be relevant across the depression pathway.

The frequency of repeating the measure will vary depending on individual circumstances and should occur when changes to treatment are made.

— *Hamilton M. A rating scale for depression. Journal of Neurology and Neurosurgical Psychiatry. 1960;23:56-62.*
— *Spitzer RL, Williams JBW, Kroenke K, et al. Patient health questionnaire PHQ9 [online] [cited 2007 Sept 06]; Available from: http://www.depression-primarycare.org/clinicians/toolkits/ materials/forms/phq9/questionnaire*
— *NICE. Depression: management of depression in primary and secondary care. London:NICE; 2004 NICE clinical guideline 23 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/CG23*
— *British Medical Association (BMA). Quality and outcomes framework guidance [online]. 2006 [cited 2007 Oct 04]; Available from: http://www.bma.org.uk/ap.nsf/Content/qof06~ clinincalind~mentalhealth*

— *Scottish Executive. National evaluation of the doing well by people with depression programme. Edinburgh:Scottish Executive; 2006 [cited 2007 Sept 06]; Available from: http://www.scotland.gov.uk/Resource/Doc/135895/0033676.pdf*

— *Gilbody S, Richards D, Barkham M. Diagnosing depression in primary care using self-completed instruments: UK validation of PHQ–9 and CORE–OM. Br J Gen Pract. 2007;57(541):650-2.*

Criterion

33a The care record shows that a validated measure of depression is used at initial assessment and repeated at regular intervals to monitor progress and outcome.

Standard 34: Assessment of need leading to self-help and signposting

Standard statement 34:
There is a record of the offer and uptake of assessment of need, leading to appropriate self-help and signposting within 4 weeks of initial presentation.

Rationale

For people presenting with low mood or an unclear diagnosis, an assessment of need is required, leading to evidence-based self-help materials and signposting. Interventions will depend on identified need and will often involve giving information and signposting to appropriate agencies. Advice should include lifestyle changes, such as planned exercise, healthy eating and sensible drinking.

For moderate to severe depression, the assessment of need will also allow wider issues to be addressed. The emphasis on a self-help/signposting approach encourages the service user to take an active role in their treatment and recovery.

In the watchful waiting period, it is possible that service care providers will wish to refer service users for a self-help assessment.

At higher levels of need/severity, the generic care standards (comprehensive assessment, risk assessment, single care plan) apply. This assessment would normally be undertaken by a member of a specialist team.

- *NICE. Depression: management of depression in primary and secondary care. London:NICE; 2004 NICE clinical guideline 23 [cited 2007 Sept 06]; Available from: http://guidance.nice. org.uk/CG23*
- *Scottish Executive. Delivering for health. Edinburgh:Scottish Executive; 2005 [cited 2007 Sept 07]; Available from: http://www.scotland.gov.uk/Resource/Doc/76169/0018996.pdf*
- *Scottish Executive. National evaluation of the doing well by people with depression programme. Edinburgh:Scottish Executive; 2006 [cited 2007 Sept 06]; Available from: http://www.scotland.gov.uk/Resource/Doc/135895/0033676.pdf*

2.3 Depression care standards

Criteria

34a The care record shows that service users receive an assessment of need which leads to interventions appropriate to identified need, with an emphasis on evidence-based self-help, lifestyle advice, physical activity and signposting. This should occur within 4 weeks of initial presentation.

34b The uptake of these interventions, in up to 3–4 sessions, are recorded:

- lifestyle advice (including physical activity, debt and relationships)
- evidence-based self-help material/guided self-help, and
- targeted information/signposting about local or national statutory or voluntary organisations.

Standard 35: Depression-focused brief psychological therapies

Standard statement 35:
There is a record of the offer and uptake of depression-focused brief psychological therapies within 6 weeks.

Rationale

Depression-focused brief psychological therapies, approximately 6–8 sessions over 10–12 weeks, benefit people with clinically significant symptoms of depression:

- if there is no significant improvement after 8 weeks of appropriate antidepressant treatment
- for those who do not take or refuse antidepressant treatment
- for those who prefer to avoid the side-effects of medication, and
- for those who express a personal preference for psychological therapies.

– *NICE. Depression: management of depression in primary and secondary care. London:NICE; 2004 NICE clinical guideline 23 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/CG23*

Criterion

35a The care record shows that:

- an algorithm for depression-focused brief psychological therapies is followed, and
- service users are offered an appointment date that is within 6 weeks of referral.

Standard 36: Treatment is commenced after an objective measure of severity

Standard statement 36:
The decision to commence antidepressants/psychological therapy is informed by an objective measure of severity.

Rationale

Antidepressants and/or psychological therapy are interventions that are generally not warranted in service users presenting solely with low mood or unhappiness. Assessment options include a cut-off score on an evidence-based questionnaire and/or a clinical diagnosis based on ICD–10 or DSMIV criteria. It is not recommended that decisions be solely based on a questionnaire score without additional information gained from a clinical interview.

Most local areas will already have an antidepressant algorithm that gives a clear indication of the clinical threshold for the commencement of prescriptions. A decision to start a treatment should match the need and preference of the service user. Single, uncomplicated severe depressive episodes may be safely and successfully treated in primary care. Equally, a mild disorder complicated by substance misuse, adverse social factors, suicidality and so on may require multidisciplinary assessment and treatment in secondary care.

— *NICE. Depression: management of depression in primary and secondary care. London:NICE; 2004 NICE clinical guideline 23 [cited 2007 Sept 06]; Available from: http://guidance.nice.org.uk/CG23*

Criteria

36a The care record shows that a local algorithm is followed, detailing the threshold for:

- antidepressant prescribing
- psychological therapies, and
- other evidence-based interventions.

36b There are systems agreed by stakeholders to ensure that service users with complex needs are referred for multidisciplinary assessment and management.

Standard 37: Chronic/treatment-resistant depression

Standard statement 37:
Specialist assessment and treatment is available for service users with treatment-resistant, recurrent and chronic depression.

Rationale

Service users whose depression appears to be resistant to treatment, or who have complex needs, require specialist assessment. Suicide may be a high risk, so it is important to ensure that informal carers and families are supported. There are specific evidence-based interventions, eg electroconvulsive therapy (ECT), mood stabilisers, antipsychotics and longer term psychological therapy, which may be of considerable benefit when prescribed for the right individuals. These may have to be continued in the long term in a stable, supportive therapeutic relationship.

— *NICE. Depression: management of depression in primary and secondary care. London:NICE; 2004 NICE clinical guideline 23 [cited 2007 Sept 06]; Available from: http://guidance.nice. org.uk/CG23*
— *NHS Connecting for Health. Do once and share: depression care pathway: mapping a solution. 2006 [cited 2007 Sept 06]; Available from: http://www.southstaffshealthcare.nhs. uk/goodPractice/DCP/DCPMappingSolution_FINAL.pdf (p14-19).*
— *Sequenced Treatment Alternatives to Relieve Depression [online]. 2007 [cited 2007 Oct 04]; Available from: http://www.edc.pitt.edu/stard.*

Criteria

37a The care record shows that those who appear to be resistant to treatment when the local algorithm has been followed to its conclusion are referred for specialist assessment and treatment.

37b Where such specialist assessment and treatment cannot be provided locally, there are regional arrangements allowing service users to access appropriate services, eg tertiary referral.

2.4 Service improvement standards

ICPs can have a significant impact on continuous quality improvement. There need to be mechanisms to collect and aggregate information on variations from the ICP. In doing so, such variances help to drive service review, identify stakeholder training needs, and inform local governance arrangements.

The service improvement standards are designed to help ensure that ICPs are being implemented and actively used for variance analysis, service redesign, training analysis and, ultimately, demonstrating a positive impact on care.

Standard 38: Systems for reviewing and analysing variances

Standard statement 38:
The information gathered through regular review of ICPs and from analysis of variance is leading to practice and service change.

Rationale

There needs to be a multi-agency and multidisciplinary process for reporting, acting on, monitoring and reviewing variances.

Grouped variations may indicate where service re-design and improvement is required, and systems should be in place to allocate resources appropriately.

All variances from planned care need to be reported, acted on, monitored and reviewed at:

- service user and informal carer level
- local service management level, including senior members of the care team, and
- NHS board and local authority directorate level.

Criteria

38a The multi-agency and multidisciplinary care team reviews individual and grouped variances.

38b The local management team reviews grouped variances to identify areas where service re-design can improve service delivery.

38c The NHS board and local authority care governance structures receive collated ICP variance reports.

38d All stakeholders are given feedback on the actions taken in response to variances.

Standard 39: Collecting stakeholder views on ICP care

Standard statement 39:
Stakeholder views about ICP care are collected and acted on.

Rationale

All staff should be able to contribute to the development and updating of the ICP. Involving staff in the early stages of ICP development should be supplemented by the regular gathering of feedback from staff once ICP care is introduced. This allows for updating and improvement of the ICP in line with daily practicalities and will improve participation from frontline staff.

Just as important is the gathering of feedback from service users and informal carers about their experience of having their care delivered through an ICP.

As a minimum, an annual survey of staff, service users and informal carers needs to be conducted and the results fed into the process of updating the ICPs.

— *Hall J, Grant R, Pritlove R. Is everything in the garden rosy? An integrated care pathway for acute inpatient mental health care, from development to evaluation: Part 1. Journal of Integrated Care Pathways. 2005;9: 67-73.*
— *Grant R, Hall J, Pritlove R. Is everything in the garden rosy? An integrated care pathway for acute inpatient mental health care, from development to evaluation: Part 2. Journal of Integrated Care Pathways. 2005;9: 101-105.*
— *Hall J, Howard D. Integrated care pathways in mental health. Edinburgh:Churchill Livingstone; 2006.*

Standard 39: Collecting stakeholder views on ICP care
(continued)

Criteria

39a A survey (or similar) of staff, about the ICP process is conducted at least annually and the survey results acted on.

39b A survey (or similar) of service users and informal carers about the care they have received is conducted at least annually, and the survey results acted on.

3 Appendices

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland.

We achieve our objectives through five key functions that link together:

- providing clear advice and guidance on effective clinical practice
- setting clinical and non-clinical standards of care
- reviewing and monitoring the performance of NHS services
- supporting NHS staff in improving services, and
- promoting patient safety and implementation of clinical governance.

We deliver our commitments to the public and to NHSScotland by following an approach that is:

- **independent** – we reach our own conclusions and report on what we find
- **open and transparent** – we explain what we do, how and why we do it, and what we find, using language and formats that are easy to understand and to access, and
- **sensitive and professional** – we recognise needs, beliefs and opinions and respect and encourage diversity.

Our work is:

- **partnership-focused** – we work with service users and the public, NHSScotland and many organisations to improve the quality of care and avoid duplication
- **evidence-based** – we base our conclusions and recommendations on the best evidence available, and
- **quality-driven** – we make sure our own work is monitored and evaluated, internally and externally.

Appendix 2:
Background on integrated care pathways

What is an integrated care pathway?

An ICP is a tool that allows the comparison of planned care with care actually given. The implementation of ICPs will improve the quality of mental health services in Scotland by focusing the attention of local care providers on key steps along the journey of care. The most important aspect of ICPs is the recording, analysing and acting on variances.

However, an ICP is much more than a document of care. It encompasses how care is organised, co-ordinated and governed, and embodies a system of continuous quality improvement. The development of ICPs offers new opportunities for quality improvement in mental health services, whether from NHSScotland, local authorities or voluntary organisations.

NHS QIS' task is to provide a synopsis of evidence and good practice, emphasise the links between key components of care, and set standards for the local development of ICPs. What is not being developed is a national ICP.

How the standards were developed

The standards for ICPs have been developed using a collaborative approach. All stakeholders have been involved, including service users and their informal carers, people from healthcare, local authorities and voluntary organisations. This has given access to the expertise of those who have experienced a mental illness, care providers, managers of services as well as experts in ICP development and implementation.

Guidelines published by SIGN and NICE have provided the main evidence base for the ICP standards. These guidelines have been supplemented by journal articles and reviews. Evidence tables were produced summarising the guidelines and other published literature relating to each topic and are available from the NHS QIS website. Good practice, as defined by members of our development group and widely consulted on, was also used to set standards where no strong evidence base exists.

Clinical governance and risk management standards

Every patient using healthcare services should expect these to be safe and effective. The NHS QIS standards for clinical governance and risk management[5] will ensure NHS boards can provide assurance that clinical governance and risk management arrangements are in place, and are supporting the delivery of safe, effective, service user focused care and services.

The clinical governance and risk management standards underpin all care and services delivered by NHSScotland and provide the context within which ICP standards should be developed and implemented.

The clinical governance and risk management standards are available on request from NHS QIS or can be downloaded from the website.

Collaborative approach to implementation and accreditation

NHS QIS is working in collaboration with all stakeholders in the development and implementation of the ICP standards. National ICP co-ordinators and public involvement support workers have been appointed to network with service care providers to provide advice, support and training on local ICP development. This process is also linked to a supportive and facilitative approach to the accreditation of local ICPs.

The accreditation of local ICPs will follow a number of key principles.

- Accreditation will be based on the ICP standards.
- A facilitative and supportive approach will be adopted with service care providers.
- Emphasis will be placed on a recovery approach, outcome measurement and variance analysis.
- As ICPs are much more than a document of care given, service care providers need to demonstrate how their ICPs embody a system of care planning, organisation, co-ordination and governance.
- As with all NHS QIS assessments, results will be placed in the public domain.

---

[5] *NHS Quality Improvement Scotland. National standards: clinical governance and risk management: achieving safe, effective, patient focused care and services. Edinburgh: NHS QIS; 2005 [cited 2007 Sept 06]; Available from: http://www.nhshealthquality.org/ nhsqisfiles/CGRM_CSF_Oct05.pdf*

Appendix 2:
Background on integrated care pathways

Equality and diversity

Service users and their informal carers must be treated with respect, taking into consideration their differing understandings of mental health. Personal and community values, which may be influenced by cultural, religious or family systems, as well as experiences of racism, discrimination or social disadvantage, must also be taken into consideration.

Service users must not be excluded from services because of their diagnosis, age or any disability. Each NHS board and local authority will have developed an equalities scheme under the Disability Discrimination Act 2005[6] which will apply equally to service provision for those with a mental illness.

If there is a language barrier, the following support and services should be offered:

• written information in the preferred language and/or an accessible format
• independent interpreters
• psychological or talking interventions in the preferred language, and
• identify, record and address specific needs in the care plan.

Groups that require special consideration

Clinical, service user and informal carer expertise remains paramount in delivering the best care possible that matches the level of need. A service user having their care delivered through an ICP may not have a definitive diagnosis or may have multiple diagnoses. They may have one or more comorbidities or may have a learning disability. In personalising care plans, all relevant factors need to be taken into consideration; care may need to be delivered according to an existing ICP other than those referred to here.

Age group
The standards in this document apply to adults 18 years of age or older. They do not address the assessment or treatment of children/young people under the age of 18. Specific differences in assessment and treatment for older adults may need to be taken into account.

---

6   *UK. Disability Discrimination Act 2005. London:Stationery Office [cited 2007 Sept 06]; Available from: http://www.opsi.gov.uk/ACTS/acts2005/20050013.htm*

Learning disabilities

The Scottish Executive published The Same as You? A Review of Services for People with Learning Disabilities in 2000[7], which acts as the policy framework for the care and support of this population. The review sets out the needs of people with learning disabilities and the action necessary to ensure they are addressed.

As a population, people with learning disabilities are living longer and into older age. Overall, the population is increasing. This means all services will experience an increasing number of people with learning disabilities with a mental illness. As a population, people with learning disabilities have high health needs and experience significant health inequalities, greater than the general population. People with Learning Disabilities in Scotland: The Health Needs Assessment Report[8] was published in 2004 by NHS Health Scotland and details the health needs and differing health profile of the population.

The mental health profile of people with learning disabilities does not mirror that of the general population. For example, there is a higher incidence of mental illness in this population, with schizophrenia being more common than when compared to the general population. The prevalence of dementia is high with an earlier onset, and is common in specific groups, such as those with Down's Syndrome. Depression and anxiety states are also common and significant. Current evidence suggests lower levels of drug misuse and alcohol problems in this population, however practitioners report increasing numbers of people with learning disabilities presenting with these problems.

---

7   *Scottish Executive. The same as you? a review of services for people with learning disabilities. Edinburgh; 2000 [cited 2007 Sept 06]; Available from: http://www.scotland. gov.uk/ldsr/docs/tsay-00.asp*

8   *NHS Health Scotland. People with learning disabilities in Scotland: the health needs assessment report. Glasgow:Health Scotland; 2004 [cited 2007 Sept 06]; Available from: http://www.gla.ac.uk/departments/psychologicalmedicine/UAP%20in%20 Learning%20Disabilities/LDFullReport.pdf*

Appendix 2:
Background on integrated care pathways

A specific recommendation in The Same as You? states that the care programme approach (CPA) should be used to support the care of people with learning disabilities with complex care needs. This recommendation concurs with the principles of ICPs. There has been a growth in the number of specific assessment and treatment services across NHSScotland for adults with learning disabilities, and a range of community-based services are in place, including multidisciplinary community learning disability teams. It is therefore anticipated that service users with a learning disability and a mental illness will usually have their care co-ordinated by community learning disability teams, with assistance from adult general mental health services when this is appropriate or necessary.

Perinatal mental health and women of childbearing age
Special considerations apply for women planning a pregnancy, women who are pregnant or in the postnatal period. For example, in addition to the existing predicted risk for women during the immediate postnatal period, there is a predictable difficult time for women who have previously experienced bipolar disorder (with a 1 in 2 chance of relapse). Also during the postnatal period, there is a risk of postpartum depression developing, even where there has been no previous history of depression.

Medication issues are extremely important in women of childbearing age, with a number of widely-used medications posing significant foetal risks. Risk benefit considerations in all women of childbearing age need to be discussed when medications are prescribed. This should also include discussing and balancing risks of treatment and relapse, the restricted use of medication and the alternative approach through the use of psychological treatments. An assessment of a woman's suitability for a psychological treatment should be fast-tracked so that the optimum intensity of psychological treatment can be delivered as soon as possible.

A multi-agency and multidisciplinary steering group was formed in April 2006 to oversee the ICP project. The steering group directed the work of seven subgroups, which were tasked with development work: general standards group, public involvement group, bipolar disorder group, borderline personality disorder group, dementia group, schizophrenia group and depression group.

Over 60 health and social care staff together with over 40 service users, informal carers and representatives of voluntary organisations, have been brought together in these subgroups. This includes primary and secondary care clinicians (consultants, psychologists, GPs, other doctors, nurses, AHPs, pharmacists), service managers, ICP experts, information professionals, Scottish Government representatives, social care and local authority representatives as well as an NHS QIS project management team that includes three national ICP co-ordinators.

STEERING GROUP

Dr Alastair Cook (Chair)	Associate Medical Director, NHS Lanarkshire
Mr Simon Bradstreet	Director, Scottish Recovery Network
Dr Keith Brown	Consultant Psychiatrist, NHS Forth Valley
Dr Denise Coia	Consultant Psychiatrist, The Scottish Government Healthcare Policy and Strategy Directorate
Ms Pat Elsmie	Counsellor/Manager, Saheliya
Mr Keir Hardie	Project Worker, Highland Users Group (HUG)
Mr Michael Henderson	Consultant Clinical Psychologist, NHS Borders
Dr Guro Huby	Reader, University of Edinburgh
Mr Stuart Lennox	Operational Manager Mental Health, Glasgow City Council Social Work Services
Mr Alex McMahon	Head Mental Health Delivery and Services Unit/Mental Health Nursing & Learning Disability Advisor, Scottish Executive Health Department
Mrs Angela Moran	Community Mental Health Team Manager, NHS Greater Glasgow and Clyde

Appendix 3: Group membership

Dr Gary Morrison	Consultant Psychiatrist, NHS Dumfries & Galloway
Mr Mike Muirhead	Head of Consultancy, NHS National Services Scotland
Mrs Pat Murray	Director of Pharmacy Service, NHS Lothian
Dr Alastair Philp	Programme Principal, NHS National Services Scotland
Professor Ian Reid	Professor of Psychiatry, University of Aberdeen
Mr Rod Richard	Assistant Area Community Care Manager, Highland Council
Dr Ann Smyth	Director of Training for Psychology Training, NHS Education Scotland
Mrs Cecilia Thompson	Head Occupational Therapist, NHS Grampian
Dr Linda Treliving	Consultant Psychiatrist in Psychotherapy, NHS Grampian
Mr Andrew Wills	Psychiatric Acute Rehabilitation Services Manager, NHS Lothian

GENERAL STANDARDS GROUP

Dr Alastair Cook (Chair)	Associate Medical Director, NHS Lanarkshire
Ms Shaben Begum	Director, Scottish Independent Advocacy Alliance
Dr Alasdair Gray	GP/Mental Health Lead, NHS Fife
Mr Keir Hardie	Project Worker, Highland Users Group (HUG)
Dr Guro Huby	Reader, University of Edinburgh
Dr Karen Jenkins	Clinical Effectiveness ICP Co-ordinator, NHS Greater Glasgow and Clyde
Miss Patricia Kent	Integrated Care Pathway Manager, NHS Lanarkshire
Mr Alex McMahon	Associate Director, The Scottish Government

GENERAL STANDARDS GROUP (continued)

Ms Ann-Marie Newman	Manager, Lanarkshire Links
Mrs Cecilia Thompson	Head Occupational Therapist, NHS Grampian
Mr Andrew Wills	Psychiatric Acute Rehabilitation Services Manager, NHS Lothian

PUBLIC INVOLVEMENT GROUP

Ms Joyce Mouriki (Chair)	Senior Public Partnership Officer, NHS Quality Improvement Scotland
Ms Hilary Allen	Representative, Falkirk & District Association for Mental Health
Ms Shaben Begum	Representative, Scottish Independent Advocacy Alliance
Mr Philip Bryers	Representative, Alzheimers Scotland
Ms Trish Burnett	Representative, Scottish Association for Mental Health (SAMH)
Mr Ted Clelland	Public Partner, Lothian
Mr Alan Douglas	Representative, Bipolar Fellowship Scotland
Ms Pat Elsmie	Public Partner, Tayside
Ms Kate Fearnley	Representative, Alzheimers Scotland
Mr George Frame	Public Partner, Glasgow
Ms Moira Gillespie	Chair, Mental Health Network
Ms Edie Gledhill	Public Partner, Fife
Ms Carol Gortmans	Public Partner, Lothian
Dr Sandra Grant	Public Partner, Glasgow
Ms Alison Guest	Public Partner, Lothian
Mr Keir Hardie	Representative, Highland Users Group (HUG)
Ms Lindsay Johnson	Research Fellow, Glasgow Caledonian University

Appendix 3:
Group membership

Mr Eddie Kelly	Representative, Falkirk & District Association for Mental Health
Ms Ruth Lang	Representative, Depression Alliance Scotland
Ms Aileen Lawson	Public Partner, Lothian
Mr Paul Lindsay	Public Partner, Tayside
Ms Carolyn Little	Representative, User and Carer Involvement
Mr Chris Lock	Public Partner, Forth Valley
Ms Sandra McDougall	Representative, Scottish Association for Mental Health (SAMH)
Ms Liz McEwan	Representative, Mental Health Foundation
Mr James McKillop	Public Partner, Glasgow
Ms Christina McMellon	Representative, Penumbra
Mr Shaun McNeill	Secretary, Voices of Experience (VOX)
Ms Charlotte Mitchell	Public Partner, Lothian
Dr Martin Moar	Public Partner, Lothian
Mr Graham Morgan	Representative, Highland Users Group (HUG)
Ms Lami Mulvey	Representative, Edinburgh Carers Council
Ms Margo Neilly	Representative, Lochaber Community Mental Health Service
Ms Ann-Marie Newman	Representative, Lanarkshire Links
Mr Dave Robb	Public Partner, Grampian
Mr Stuart Shaw	Public Partner
Ms Lissa Smith	Representative, Voice of Carers across Lothian (VOCAL)
Mr Lez Stalling	Representative, Falkirk Users Reference Group
Ms Maureen Summers	Public Partner, Tayside

PUBLIC INVOLVEMENT GROUP (continued)

Ms Mary Weir	Chief Executive, National Schizophrenia Fellowship (NSF) (Scotland)
Ms Melanie West	Public Partner, Grampian
Mr Laurence Wilson	Chairperson, Bipolar Fellowship Scotland

BIPOLAR DISORDER GROUP

Professor Ian Reid (Chair)	Professor of Psychiatry, University of Aberdeen
Dr Jacqueline Anderson	Consultant Psychiatrist, NHS Greater Glasgow and Clyde
Ms Lyn Docherty	Practice Development Manager, Scottish Association for Mental Health (SAMH)
Mr Alan Douglas	Development Officer, Bipolar Fellowship Scotland
Mr Bobby Duffy	Assistant Director, Scottish Association for Mental Health (SAMH)
Ms Sharon Fegan	Occupational Therapist, NHS Lothian
Mrs Edie Gledhill	Public Partner, Fife
Dr Kenneth Lawton	General Practitioner, Royal College of General Practitioners
Mrs Fiona Mitchell	Community Psychiatric Nurse, NHS Forth Valley
Matthias Schwannauer	Consultant Clinical Psychologist/Senior Lecturer, University of Edinburgh
Mrs Marion Shawcross	Social Work Officer, Mental Welfare Commission
Mr Laurence Wilson	Chairperson, Bipolar Fellowship Scotland

BORDERLINE PERSONALITY DISORDER GROUP

Dr Linda Treliving (Chair)	Consultant Psychiatrist in Psychotherapy, NHS Grampian
Mr James Dalrymple	Crisis Services Project Manager, Scottish Association for Mental Health (SAMH)

Appendix 3:
Group membership

Professor Kate Davidson	Consultant Clinical Psychologist, NHS Greater Glasgow and Clyde
Mr Mike Diamond	Principal Officer, North Ayrshire Council
Ms Ann Forsyth	Joint Lead Occupational Therapist, NHS Greater Glasgow and Clyde
Ms Carol Gortmans	Vice Chair, National Schizophrenia Fellowship (NSF) (Scotland)
Dr Morag Henderson	Consultant Psychiatrist, NHS Ayrshire & Arran
Ms Lindsay Johnson	Research Fellow, Glasgow Caledonian University
Mrs Susan McConachie	Mental Health Nurse Practitioner, NHS Forth Valley
Ms Jo Mullen	Co-ordinator, Moray BPD Support
Dr Tom Murphy	Consultant Psychiatrist in Psychotherapy, NHS Lothian
Ms Sheelagh Rodgers	Head of Psychological Services, NHS Highland
Ms Kate Sloan	Nurse Practitioner in Psychotherapy, NHS Greater Glasgow and Clyde
Mrs Kathleen Yates	Adult Psychotherapist, NHS Tayside

DEMENTIA GROUP

Dr Gary Morrison (Chair)	Consultant Psychiatrist, NHS Dumfries & Galloway
Mr Philip Bryers	Scottish Dementia Working Group (SDWG) Co-ordinator, Alzheimer Scotland
Mr Ted Cleland	Public Partner, Lothian
Dr Peter Connolly	Consultant Old Age Psychiatrist, NHS Tayside
Mr Colm Cunningham	Associate Director, Health and Social Care, Dementia Services Development Centre
Dr Lorna Dunlop	General Practitioner, NHS Greater Glasgow and Clyde

DEMENTIA GROUP (continued)

Dr David Findlay	Consultant Psychiatrist, NHS Tayside
Mr Jim Jackson	Chief Executive, Alzheimer Scotland
Miss Gail Kilbane	Dementia Nurse Specialist, NHS Greater Glasgow and Clyde
Ms Catherine Mason	Senior Social Worker, NHS Grampian
Miss Margo Mason	Senior Occupational Therapist, NHS Lothian
Mr Sandy McAfee	Consultant Clinical Psychologist, NHS Lothian
Mr James McKillop	Public Partner, Glasgow
Dr Peter Murdoch	Consultant Geriatrician, NHS Forth Valley
Mr Stewart Thompson	Public Partner, Glasgow

SCHIZOPHRENIA GROUP

Dr Keith Brown (Chair)	Consultant Psychiatrist, NHS Forth Valley
Mr Colin Beck	Service Manager, City of Edinburgh Council
Dr Stewart Grant	Consultant Clinical Psychologist, NHS Dumfries & Galloway
Dr Alasdair Gray	General Practitioner/Mental Health Lead, NHS Fife
Mrs Alison Guest	Public Partner, National Schizophrenia Fellowship (NSF) (Scotland)
Ms Eilidh MacDonald	Practice Development Manager, Scottish Association for Mental Health (SAMH)
Mrs Fiona Mackay	Community Mental Health Nurse, NHS Highland
Dr Martin Moar	Public Partner, Lothian
Ms Gill Urquhart	Head of Occupational Therapy, The State Hospitals Board for Scotland

Appendix 3:
Group membership

Ms Mary Weir	Chief Executive, National Schizophrenia Fellowship (NSF) (Scotland)
Dr Tom White	Consultant Forensic Psychiatrist, NHS Tayside

DEPRESSION GROUP

Mr Michael Henderson (Chair)	Consultant Clinical Psychologist, NHS Borders
Mrs Roslyn Anderson	Planning Officer (Mental Health), Midlothian Council Social Work
Dr Lorna Champion	Consultant Clinical Psychologist, NHS Lothian
Dr Chris Freeman	Consultant Psychiatrist, NHS Lothian
Ms Sharon Hackney	Project Manager, NHS Ayrshire & Arran
Ms Ruth Lang	Information Officer, Depression Alliance Scotland
Mr Christopher Lock	Public Partner, Forth Valley
Dr Fiona Murray	Specialist Registrar, NHS Fife
Mrs Elizabeth Rafferty	Start Project Manager, NHS Greater Glasgow and Clyde
Dr Michael Smith	Consultant Psychiatrist, NHS Greater Glasgow and Clyde
Dr Mark Storey	General Practitioner, NHS Greater Glasgow and Clyde
Dr Christopher Williams	Senior Lecturer in Psychiatry, University of Glasgow

Support from NHS QIS is provided by the Patient Safety and Performance Assessment Directorate: Mr Sam Atkinson (Project Officer), Ms Rosie Cameron (National ICP Co-ordinator), Mrs Selina Clinch (Senior Project Officer), Mr Sean Doherty (Team Manager), Dr Ali El-Ghorr (Programme Manager), Mr Mark Fleming (National ICP Co-ordinator), Ms Jill Gillies (Project Officer), Ms Brin Jardine (Project Officer, until April 2007), Mr Trevor Johnston (Project Assistant), Dr John Loudon (Mental Health Adviser), Mrs Elaine Mackay (Project Administrator), Ms Linda McKechnie (National ICP Co-ordinator), Ms Joyce Mouriki (Senior Public Partnership Officer) and Ms Jan Warner (Director of Patient Safety and Performance Assessment).

accreditation

A process, based on a system of external peer review using written standards, designed to assess the quality of an activity, service or organisation.

acute sector

Hospital-based health services which are provided on an inpatient or outpatient basis. See secondary care.

advocacy services

The new Mental Health (Care and Treatment) (Scotland) Act 2003 states that any person with a mental health 'disorder' has a right to access independent advocacy services. The Act places a duty on NHS boards and local authorities to secure the availability (to persons in its area with a mental disorder) of independent advocacy services, and to take appropriate steps to ensure that those persons have the opportunity of making use of those services. Section 259 (4) describes independent advocacy services as: '...services of support and representation made available for the purpose of enabling the person to whom they are available to have as much control of, or capacity to influence, that person's care and welfare as is, in the circumstances, appropriate.' Simply put, an advocate can assist someone, at a time when they may be particularly vulnerable, to say what they need and want. The phrase 'as appropriate' does not mean that the independent advocate will make a judgement about the level of control an individual can exercise over their own life. Rather, it indicates that persons to whom the individual's views are put by an independent advocate are still able to exercise their professional judgement about how much of the patient's views should be taken on board. For example, where an advocate tells a medical worker a patient's views, the medical worker will make a professional judgement based on his/her codes of conduct.

AHPs

See allied health professions.

algorithm

A set of agreed or binding routines by which a process can be carried out.

allied health professions (AHPs)

Healthcare professionals directly involved in the provision of primary and secondary healthcare. Includes several groups such as physiotherapists, occupational therapists, dietitians, etc. Formerly known as professions allied to medicine (PAMs).

AMPS

Assessment of motor and process skills

antipsychotic drug
A drug used to alleviate the symptoms of a psychotic illness, such as schizophrenia. Antipsychotic drugs are sometimes called neuroleptics. Atypical antipsychotic drugs are a newer type of antipsychotic drug which have a different way of acting in the brain from older drugs.

assessment
The process of measuring the quality of an activity, service or organisation.

Avon Mental Health Measure
This is a descriptive instrument designed to enable self-assessment of need and help service users prepare for care programming and care management, and to provide information to help plan better service responses.

bipolar disorder
A mental health problem involving extreme swings of mood (highs and lows). Both men and women of any age from adolescence onwards and from any social or ethnic background can develop bipolar disorder.

BMA
British Medical Association

borderline personality disorder (BPD)
A severe and complex mental disorder characterised by pervasive instability in moods, interpersonal relationships, self-image and behaviour. One of the core signs and symptoms in BPD is the proneness to impulsive behaviour, a disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption.

BPD
See borderline personality disorder.

care co-ordinator
A named member of staff who co-ordinates care and arranges to review the care plan regularly with the service user and other care providers. The care co-ordinator may change according to different needs along the care journey and it could be any member of the multi-agency care team who is given this role, or the service user themselves. Local guidance should be in place specifying who may be appointed to this role. This person should be able to make links to local mechanisms for commissioned and purchased services.

care plan

See plan of care.

---

care programme approach (CPA)

A process which aims to ensure that people with severe and enduring mental illness (such as schizophrenia), who also have complex social care needs, are provided with co-ordinated care and supervision.

---

care record

Information about the physical or mental health of a service user, which has been made by, or on behalf of the care team.

---

carer

See informal carer.

CBT

See cognitive behavioural therapy.

CEMACH

Confidential enquiry into maternal and child health

---

clinical governance

Ensures that patients receive the highest quality of care possible, putting each patient at the centre of his or her care. This is achieved by making certain that those providing services work in an environment that supports them and places the safety and quality of care at the top of the organisation's agenda. Management of clinical risk at an organisational level is an important aspect of clinical governance. Clinical risk management recognises that risk can arise at many points in a patient's journey, and that aspects of how organisations are managed can systematically influence the degree of risk.

In jointly managed services, the above governance structures are called 'care governance' and operate across health and social work.

---

clinical psychologist

Clinical psychologists aim to reduce psychological distress and to enhance and promote psychological wellbeing. They deal with a wide range of psychological difficulties, including anxiety, depression, relationship problems, learning disabilities, child and family problems and serious mental illness. To assess a client, a clinical psychologist may undertake a clinical assessment using a variety of methods including psychometric tests, interviews and direct observation of behaviour. Assessment may lead to therapy, counselling or advice. Clinical psychologists work largely in health and social care settings including hospitals, health centres, community mental health teams, child and adolescent mental health services and social services.

---

cognitive behavioural therapy (CBT)

A collection of therapeutic approaches carried out with the aim of changing behaviour and altering thought patterns. The therapist helps the person to identify their own untrue or destructive beliefs in order to reduce distress and develop coping strategies.

Community Care and Health (Scotland) Act 2002

The Act makes further provision for social care provision in relation to arrangements and payments between NHS bodies and local authorities.Website: http://www.opsi.gov.uk/legislation/scotland/acts2002/asp_20020005_en_2#pt1

---

community mental health team

A group of professionals from a variety of different disciplines (eg medical, nursing, social work) who work together to provide a range of mental health services outwith the hospital setting.

---

consultant psychiatrist

A qualified doctor who has completed special advanced training in diagnosing and treating mental illnesses.

CORE

Clinical outcomes for routine evaluation

CPA

See care programme approach.

---

crisis

A broad range of situations where a person is not able to see the way forward. For example, a crisis could be a situation where a person receives bad news, has financial problems, feels anxious, frightened or depressed. A crisis could last from a few hours to a few days.

criterion (singular)/criteria (plural)

A rule giving the detailed and practical information on how to achieve a standard.

DfMH

Delivering for Mental Health

dementia

A progressive illness which affects the brain. It can affect memory, thinking and actions. People of any age can develop dementia, although it is more common in older people.

depression

A common, recurrent and disabling condition, and may occur with anxiety disorder, drug misuse and alcohol problems. It has a significant impact on physical health, and social and occupational functioning.

diagnosis

Identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and possible causes for the symptoms.

Disability Discrimination Act 2005

The Act has been significantly extended since the 1995 Act and now gives disabled people rights in the areas of:

- employment
- education
- access to goods, facilities and services, and
- buying or renting land or property, including making it easier for disabled people to rent property and for tenants to make disability-related adaptations.

Website: http://www.opsi.gov.uk/ACTS/acts2005/20050013.htm

discharge

A discharge marks the end of an episode of care. Types of discharge include inpatient discharge, day-case discharge, day patient discharge, outpatient discharge and discharge from the care of allied health professionals (see AHPs).

DSM

Diagnostic and statistical manual of mental health disorders.

ECT

Electroconvulsive therapy

evaluation

The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.

evidence-based practice

Evidence-based clinical practice is an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best.

family therapy

Supportive interventions which are intended to help a person and their family cope better with their illness. Family therapy programmes can have several different elements, eg an education programme, analysis of family relationships, family sessions to address problems identified in this analysis, and support groups for relatives.

GP

General practitioner

guidelines

Systematically developed statements which help in deciding how to treat particular conditions.

HDL

See Health Department Letter.

health board
See NHS board.

Health Department Letter (HDL)
A formal communication from the former Scottish Executive Health Department to NHSScotland (previously known as a Management Executive Letter – MEL).

---

healthcare professional
A person qualified in a health discipline.

HEAT
Health Improvement, Efficiency and Governance, Access and Treatment

---

history
When a healthcare professional obtains an account from a person, and usually a carer/relative, of how an illness or disorder has developed, together with details of the person's social and personal background. A diagnosis is usually made on the basis of the history that has been obtained, a physical examination and other necessary investigations, eg blood tests.

HONOS
Health of the Nation Outcome Scale or HONOS65+.

ICD
See International Classification of Diseases.

ICIC
Information core for integrated care

ICP
See integrated care pathway.

ICPUS
Integrated Care Pathway Users in Scotland

---

implementation
Putting into practical effect; carrying out a task or project.

Appendix 4:
Glossary

informal carer

Informal carers, who may be family or close friends, have a major role in supporting people with mental health difficulties to recover or cope as best they can with the condition. Informal carers are not paid carers. Supporting informal carers to care, while retaining their own life and wellbeing, allows service users to live in their preferred environment for as long as possible and to access support services when needed. This helps to avoid crisis or the need for higher level interventions.

integrated care pathway (ICP)

An explicit agreement by a local group of staff and workers, both multidisciplinary and multi-agency, to provide a comprehensive service to a clinical or care group on the basis of current views of good practice and any available evidence or guideline. It is important that the group agree on communication, record keeping and audit. There should be a mechanism to pick up when a patient has not received any care input specified by the pathway so that the omission can be remedied. The local group should be committed to continuous improvement of the integrated care pathway on the basis of new evidence of service developments or of problems in implementation.

International Classification of Diseases (ICD)

A medical reference book which provides information about clinical descriptions and diagnostic guidelines, to assist clinicians in classifying and diagnosing illnesses and disorders. Website: www. who.int/classifications/icd/en

intervention

Healthcare action intended to benefit the patient.
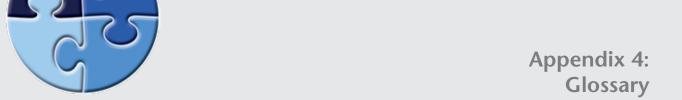
Information Services Division (ISD)

Part of NHS National Services Scotland. Health service activity, manpower and finance data are collected, validated, interpreted and distributed by ISD. These data are received from NHS boards and general practices. Website: www.isdscotland.org

legislation

Laws passed by a parliament.

MADRS

Montgomery Asberg Depression Rating Scale

Mental Health (Care and Treatment) (Scotland) Act 2003

This law came into effect in October 2005 and deals with how people with a mental illness, learning disability or other mental disorder can be given care and treatment. It says:

- when a person can be taken to hospital against his/her will
- when a person can be given treatment against his/her will
- what rights a person has when they are receiving care and treatment, and
- what safeguards are in place to protect a person's rights.

The law is based on a set of principles, and these principles should be taken into account by anyone involved in a person's care and treatment. Web location: www.opsi.gov.uk/legislation/Scotland/acts2003/20030013.htm

mental illness

A general term for a wide range of disorders where mental functioning such as perception, memory, emotion or thought is affected.

Mental Welfare Commission for Scotland

An independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. The commission's duties are set out in mental health law. Website: www.mwcscot.org.uk/home/home.asp

monitoring

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

multidisciplinary mental health team

A group of professionals from a variety of different disciplines such as medicine, nursing, and social work, who work together to provide a range of mental health services. The composition of such teams varies from area to area. A multidisciplinary mental health team can work in a number of settings, such as in the community, when it is termed a community mental health team.

National Institute for Health and Clinical Excellence (NICE)

The independent NHS organisation responsible for providing national guidance on treatments and care for those using the NHS in England and Wales. Its guidance is for healthcare professionals and patients and their carers, to help them make decisions about treatment and healthcare. NICE guidance and recommendations are prepared by independent groups that include healthcare professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Website: www.nice.org.uk

NHS

National Health Service

NHS board

There are 22 NHS boards of two types: 14 territorial boards responsible for healthcare in their areas and eight special health boards which offer supporting services nationally. See NHS board (territorial) and special health board.

NHS board (territorial)

There are 14 territorial boards, the mainland being covered by 11 and the island groups (Orkney, Shetland and the Western Isles) by three. They are responsible and accountable for strategic planning, service delivery, performance management and governance within their local areas. Each NHS board uses the organisational building blocks of NHS direct care, such as community health partnerships or operating divisions, in a way which suits its geography and population. NHS boards work together in regional planning arrangements for those services which require that wider perspective.

NHS QIS

See NHS Quality Improvement Scotland.

NHS Quality Improvement Scotland (NHS QIS)

A special health board established (January 2003) to lead in improving the quality of care and treatment delivered by NHSScotland. To do this it sets national standards and monitors performance, and provides NHSScotland with advice, guidance and support on effective clinical practice and service improvements. Website: www.nhshealthquality.org

NHSScotland

The National Health Service in Scotland.

NICE
See National Institute for Health and Clinical Excellence.

---

nurse
A person who is specially trained to provide services that are essential to or helpful in the promotion, treatment, maintenance, and restoration of health and wellbeing.

---

occupational therapy
The treatment of mental and physical health problems by encouraging people to participate in specific activities that will help them to reach their maximum level of function and independence in all aspects of their daily life. An occupational therapist is a person specially trained to provide such assessment and treatment.

---

outcome
The end result of care and treatment and/or rehabilitation. In other words, the change in health, functional ability, symptoms or situation of a person, which can be used to measure the effectiveness of care and treatment, and/or rehabilitation.

---

patient journey
The pathway through the health services taken by the person who is receiving treatment, and as viewed by that person.

---

pharmacist
A qualified professional who understands the nature and effect of medicines and how they are produced and used to prevent and treat illness, relieve symptoms or assist in the diagnosis of disease. Pharmacists use their expertise for the wellbeing and safety of users and the public.

PHQ9
One of the screening tools recommended in the quality and outcomes framework of the General Medical Services contract. It may be used to give a relative measure of the extent of the patient's depression. It is a simple to use self-report, diagnostic tool for depression consisting of 9 questions. The answers to these questions are used to calculate an overall 'score' for depression. This score, together with the GP knowledge of the patient's circumstances, helps to facilitate a decision regarding the best course of action for this particular patient.

PIC-DSIS
See the Psychiatric Inpatient Clinical Discharge Summary Information Set.

Appendix 4:
Glossary

plan of care
A written document which is developed with the user, and which details the roles and responsibilities of all individuals involved in the person's care and when their care arrangements are to be reviewed. The plan of care developed when a person is diagnosed is termed the initial plan of care. The plan of care developed when a person is admitted to hospital is termed the inpatient plan of care. The plan of care developed when a person is discharged from hospital is termed the discharge plan of care.

policy
The highest level statement of intent and objectives within an organisation. A policy can also be a required process or procedure within an organisation.

prescription
A set of written instructions from a doctor to a pharmacist regarding the preparation and dispensing of a drug, etc for a particular patient. The term can also be used to describe the drug, etc prescribed in this way, or a set of written instructions for an optician stating the type of lenses required to correct a patient's vision.

primary care
The conventional first point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively, delivered through general practices. Primary care services are the most frequently used of all services provided by the NHS. See acute sector and secondary care.

procedure
The steps taken to fulfil a policy.

protocol
Operational instructions to regulate activity. Protocols may be national, or agreed locally to take into account local requirements.

Psychiatric Inpatient Clinical Discharge Summary Information Set (PIC-DSIS)
A data standard developed to provide a summary of care received during an inpatient psychiatric stay.

psychiatry
A branch of medicine concerned with the diagnosis, care and prevention of mental illnesses

psychological
Relating to human behaviour.

---

psychological interventions
A range of interventions based on identified psychological concepts and theory, which have been acquired through training and maintained through supervision. This type of service is provided by a wide range of professionals, for example: clinical/counselling psychologists; counsellors; psychiatrists; specialist and mental health nurses; psychotherapists; members of primary care teams; social workers; voluntary organisation workers with special skills, and a wide range of other mental health and non-mental health professionals working in a variety of services and settings.

---

psychologist
See clinical psychologist.

---

psychology
The scientific study of human behaviour and the corresponding mental processes.

---

psychosis
A type of major mental illness associated with loss of insight. The signs and symptoms of psychosis may include hallucinations, delusions and agitated behaviour. Episodes of psychosis may be short-lived or recurring. Schizophrenia is one type of psychosis.

---

psychosocial
Relating social conditions to mental health.

---

quality and outcomes framework (QOF)
A system to remunerate general practices for providing good quality care to their patients and to encourage further improvement of the quality of healthcare delivered. It is a fundamental part of the General Medical Services contract, introduced on 1 April 2004, and measures achievement against a range of evidence-based indicators, with points and payments awarded according to the level of achievement.

QOF
See quality and outcomes framework.

QRG
Quick reference guide

---

rationale
Scientific/objective reason for taking specific action.

RCGP
See Royal College of General Practitioners.

RCPsych
See Royal College of Psychiatrists.

---

referral
The process by which a patient is transferred from one professional to another, usually for specialist advice and/or treatment.

---

relapse
The worsening of symptoms which a person is experiencing, or the return of symptoms associated with an illness.

---

risk management
A systematic approach to the management of risk, staff and patient/client/user safety, to reducing loss of life, financial loss, loss of staff availability, loss of availability of buildings or equipment, or loss of reputation. Risk management involves identifying, assessing, controlling, monitoring, reviewing and auditing risk.

Royal College of General Practitioners (RCGP)
Professional and advisory body overseeing education and qualifications of general practitioners.
Website: www.rcgp.org.uk

Royal College of Psychiatrists (RCPsych)
Professional and advisory body overseeing education and qualifications of psychiatrists.
Website: www.rcpsych.ac.uk

---

schizophrenia
A psychotic illness. It is a complex mental illness which affects different people in different ways. The first symptoms of schizophrenia usually develop in early adulthood.

SCIE
Social Care Institute for Excellence

Scottish Executive
Formerly the name of the Scottish Government. See Scottish Government.

Scottish Government
The devolved government for Scotland, with responsibilities including health policy and the administration of NHSScotland. Until September 2007, the devolved government was named the Scottish Executive. Website address: www.show.scot.nhs.uk/sehd

---

Scottish Intercollegiate Guidelines Network (SIGN)
To help improve the quality of healthcare SIGN develops national clinical guidelines aimed at reducing variations in clinical practice and in outcomes for patients. Founded in 1993 by the Academy of Royal Colleges and Faculties in Scotland, SIGN became part of the national clinical effectiveness body, NHS QIS, on 1 January 2005. The evidence base for many of the clinical standards developed by NHS QIS has been drawn from SIGN guidelines. For further information relating to SIGN guidelines or the methodology by which SIGN guidelines are developed, contact: SIGN Secretariat, 28 Thistle Street, Edinburgh, EH2 1EN. Website: www.sign.ac.uk

---

secondary care
Care provided in an acute sector setting. See acute sector and primary care.

---

self-assessment
Assessment of performance against standards by the individual/clinical team/NHS operating division/ NHS board providing the service to which the standards are related. See assessment.

---

service user
A person receiving the services of a health authority or voluntary or independent organisation is called a service user. Some people do not identify with the term 'user' and may instead prefer 'patient' or 'client'.

---

side-effect
An effect of treatment in addition to its desired therapeutic effect. A side-effect is usually unpleasant and unwanted.

SIGN
See Scottish Intercollegiate Guidelines Network.

Appendix 4: Glossary

SIGN guideline
Scottish Intercollegiate Guidelines Network guideline. See guidelines and Scottish Intercollegiate Guidelines Network.

signposting
Directing people to other sources of information and support. These may be other services provided by the NHS, local authorities, voluntary sector, private sector or others. Signposting may include supporting service users to make initial contact with these other service providers.

single shared assessment (SSA)
A person-centred, streamlined assessment overseen by a single professional with other specialist involvement as appropriate. The SSA takes a more holistic approach to assessment, with benefits for people who use services. The results should be acceptable to all professionals in social work, health and housing.

social inclusion
Helping people to feel and be part of the society in which they live.

social work services
Provide advice and practical help for problems resulting from social circumstances. A social worker is a person who has obtained a professional qualification in social work. A social worker supports vulnerable people and their informal carers with the aim of enhancing the quality of all aspects of their daily lives.

special health board
The name given to health boards with a national remit. These boards are focused on specific areas, for example NHS Education for Scotland, or NHS Quality Improvement Scotland. Special health boards match regional NHS boards in terms of administrative grading. Website: www.show.scot.nhs.uk/organisations/specialhbs.htm

SSRI
Selective serotonin reuptake inhibitor

standard
Agreed level of performance.

statutory
Required or created by law.

strategy
A high-level document indicating a framework for achieving objectives and perhaps incorporating a plan.

symptom
A reported feeling or observable physical sign of a person's condition that indicates a physical or psychological abnormality.

systematic
Methodical, according to plan and not casually or at random.

treatment
To organise and manage healthcare and related services for a person. This can be carried out by one or more healthcare providers. This can include meetings or discussions between healthcare providers about a patient, and the referral of a patient for healthcare from one provider to another. The aim of treatment is to aid recovery where possible, and to ease symptoms.

treatment plan
Protocol of care which specifies what should be done, by whom, when and with what aim.

watchful waiting
Active observation and regular monitoring of a patient without actual treatment.

YRMS
Young Mania Rating Scale

You can read and download this document from our website.

We can also provide this information:

- by email
- in large print
- on audio tape or CD
- in Braille, and
- in community languages.

NHS Quality Improvement Scotland

Edinburgh Office	Glasgow Office
Elliott House	Delta House
8-10 Hillside Crescent	50 West Nile Street
Edinburgh EH7 5EA	Glasgow G1 2NP
Phone: 0131 623 4300	Phone: 0141 225 6999
Textphone: 0131 623 4383	Textphone: 0141 241 6316

Email: comments@nhshealthquality.org
Website: www.nhshealthquality.org