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29 January 2016

Dear Community Health Activity Data Project Team,

Consultation on Community Mental Health Team Activity Data Dataset

The Royal College of Nursing (RCN) is the UK's largest professional association and union for nurses with around 430,000 members, of which around 40,000 are in Scotland. Nurses and health care support workers make up the majority of those working in health services and their contribution is vital to delivery of the Scottish Government's health policy objectives.

We welcome the opportunity to respond to the Community Mental Health Team Activity Data Dataset consultation. RCN Scotland is broadly supportive of the need to improve the availability and quality of community health activity data since there is a recognised lack of community data with much remaining underdeveloped. Good data will be essential to support future planning of community services, shifting the balance of care and the effective integration of health and social care, all of which depend on robust data.

There are lessons that can be learnt from the first phase of the Community Health Activity Data project which is focusing on District Nursing. We have concerns, based on conversations that we have been engaged in, that this data is already being caricatured by senior officials in blunt and inappropriate ways which fail to appreciate the holistic nature of nursing's contribution to improving health and which will support crude cost reduction targets that undermine delivery of the new, statutory Health and Wellbeing Outcomes. Whilst we appreciate the limits that have been placed on ISD in terms of developing brand new data sets appropriate to a changed landscape, we retain our concern that the consequence of measuring task alone will result in an ill-informed, reductionist approach to the future development and funding of nursing teams.

RCN Scotland would like to contribute the following general comments to this consultation on the proposed community mental health team activity dataset:

- The project approach centres on existing information systems with the intent not to start collecting new data but to look at what data is already being collected locally and extracting data to 'reuse' at national level. Systems should enable 'record once, use many times for many purposes'. Data to support commissioning, workforce planning, performance monitoring, quality improvement and research should be derived wherever possible from record content defined for primary use with appropriate safeguards. However the consultation does not adequately comment on the accuracy and quality of the available data, including any requirements to data cleanse to ensure validity.

- The project needs to identify gaps in current data collection within existing systems and between NHS Boards. We are concerned that there will be many areas where this data for community mental health is not collected in existing systems, and ask how much of the clinical aspects will be collected in the future without adding to the data collection burden for clinical staff. We have concerns about future funding decisions being made on incomplete data and the potential for misinterpretation.

- We recommend that the Project Team ensures there are clear evaluation criteria and funding to measure whether objectives such as routine collection with no additional burden are achieved, with strategies in place to assess if there is adverse impact on clinical time/quality.

- We support that the proposed dataset covers multidisciplinary community mental health teams. However we are aware that systems, where they exist, are often for singular professions, and would ask how the project will address this.

- From the pilot exercises with selected boards, we would ask for further information about how the information was collected and what was able to be collected from each NHS Board that participated in the pilot. There are also a number of questions that require clarification:
    - What existing local sources were available, what data has been provided for which medical specialities, nursing and allied health professional staff groups, and importantly where do gaps exist?
    - What has been learned about existing data quality and validity from the pilot areas?
    - The consultation recognises that there are differences in how NHS Boards are recording community data. How will the minimum core dataset be rolled out to NHS Boards and enforced?

- The dataset does not address 'integrated' teams. We would like to see additional information on the fit with social work information, and which identifiers will be used to link health and social care datasets, given the focus on using the datasets for resource allocation and the development of a cost dataset. It is important that data is linked in order to provide a full picture to inform the work at every layer of health and social care integration delivery. Further clarity is required regarding how this data will link with the Health and Social Care Data Integration and Intelligence Project (HSCDIIP) and ensure that the full set of data is used effectively by partnerships.

- In October 2015, it was agreed at the Health and Social Care Data Integration and Intelligence Project (HSCDIIP) Project Board meeting that the HCSDIIP

and Community Health Activity Data (CHAD) project boards would merge into one this year, and further meetings of the stakeholder project boards ceased. With the work streams continuing without opportunity for discussion and review with stakeholders, we ask for further clarification about the next steps for this overarching project board and which stakeholders will be asked to participate.

- A clear risk assessment needs to be presented which refers to data accuracy and quality, processes in place for data collection and coding procedures. We would emphasise the need for risk management so that potential hazards are identified and addressed as this project is progressed.

- A focus on outcomes and quality are essential to include in intervention and resource focused data sets. We would suggest further exploration of how the dataset as currently drafted will support decision making for quality safe effective community care. Unless data about whether clinical and service standards are being met are also available, making informed decisions about resource allocation will be problematic.

- Although we are aware that the Project Team has been working with a number of NHS Boards to develop the draft dataset, it is not explicitly clear to what degree the proposed content was based on rigorous 'sense checking' of terminology and values with clinical staff and other stakeholders. Although there are commitments given to not adding to the data burden, if the data is poor and the coding remote from practice, then collation of an accurate and valid dataset will be problematic.

- We therefore suggest a further step is included such as further discussion with the Mental Health Nursing Forum Scotland to sense check the data items, definitions and values.

- The requirement for further rigorous testing with senior nurses, clinical staff and stakeholders with the specific remit of sense checking the terminology and values, can be illustrated by the following points about values and definitions within the draft dataset.

    - Although it is important that information about patient/client needs and nursing care is structured using standardised terminology, this requirement does not outweigh the need for the information to be understood. The complexity of modern day care delivery and decision-making must be reflected and distinguish the different roles and settings community nursing staff now work in and reflect the effect of different skill levels. The value of ensuring that nursing concepts can be captured within electronic clinical records is essential in order to make nursing visible and valued. This must be addressed so that the values communicate the complexity of activity.

    - Section 1 *Demographics* - Page 13, the addition of sexuality could be a relevant question, in the light of increased morbidity amongst LGBT groups, and to improve services offered by mental health services by enabling identification of under representation.

    - Section 2 *Referrals* - We would seek clarity as to whether one initial point of referral is being counted or whether individual referrals throughout the patient's journey are being collected, as for example

there will be referrals within teams and organisations at different points in care.

- 2.9 *Location of contact* – We recommend expanding value 1 *Acute General Hospital including Day Hospital* into a set of codes for a wider range of hospital settings including acute, rehabilitation, intensive psychiatric care, forensic, and accident and emergency. For example the inclusion of accident and emergency departments would then capture liaison psychiatry activity.

- 2.16 *Patient/Client Related Activity Type* - The roll up of activities into one category of 'Admin' to include a wide range of activity, including referrals to other services and correspondence to other professionals, is not useful. We recommend a more stratified approach to activity measurement which can accommodate dealing with other agencies and making links for patients in other services. This is particularly important given dealing with other agencies regarding patient's circumstances, and that many patients will have multimorbidities, including physical health issues.

- 2.19 *Staff Pay Band* – Does the term consultant apply to doctors only? Other professional groups now have this term i.e. Consultant Nurse.

- 2.21 *Speciality/Discipline* - Two terms 'mental health nursing' and 'community psychiatric nursing' are used separately. We suggest adopting 'community mental health nursing' as one term.

- Section 3 *Interventions* - There is no explicit mention of interventions that are being used to promote recovery. This is a conspicuous omission considering the focus that recovery has had in Scotland, and vital given ongoing care required for many patients to enable them to remain well and achieve the best quality of life they can.

- Whilst there are no specific nursing interventions mentioned in this section, we consider that the terms are broad enough to capture the activities of a community mental health nurse, with the exception of the example of recovery, which also applies to disciplines other than nursing.

- The suggested dataset mainly expresses activity and inputs. Such data is effective at judging current demand, but its ability to demonstrate whether redesign would have a better outcome for care users is limited. If the process is to support joint commissioning, strategic planning and service redesign at a local level, data also needs to demonstrate outcomes and the effectiveness of services. A number of publications by Audit Scotland also highlight the need for data to better monitor performance and the importance of demonstrating the impact of service change on people's lives. Explaining exactly how this data is going to inform decisions would therefore be welcome.

- RCN Scotland supports the suggestion to ensure that data is reported quarterly.

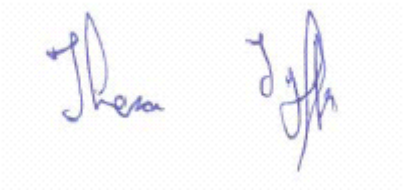
- We would wish to see clear timescales and actions setting out the next steps regarding providing national support and advice on the roll out and the implementation of minimum core dataset to NHS Boards.

- Given the project direction from the Technical Advisory Group for Resource Allocation (TAGRA) and the intention for the creation to the community health activity dataset to allow the review and adjustment of the formula used to remunerate NHS Boards for community activity; further information on the existing formula and the proposed way forward for review and adjustment is required. Detail about the how a cost dataset will be created, and the intention to cost at patient/client level, is also a necessity.

While the proposed dataset provides a wide-ranging set of data, RCN Scotland believes that the approach raises a number of issues that should be addressed as part of this process before the roll out the dataset to all NHS Boards from April 2016.

To discuss any of the issues in this submission further, please contact Sian Kiely, Knowledge and Research Manager at sian.kiely@rcn.org.uk or 0131 662 6169.

Yours sincerely,



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