ORIGINAL ARTICLE

Quality indicators for primary care mental health services

T Shield, S Campbell, A Rogers, A Worrall, C Chew-Graham, L Gask

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See end of article for authors' affiliations

Correspondence to: Dr S Campbell, National Primary Care Research and Development Centre, University of Manchester, Williamson Building, Oxford Road, Manchester M13 9PL, UK; stephen.campbell@man.ac.uk

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Objectives: To identify a generic set of face valid quality indicators for primary care mental health services which reflect a multi-stakeholder perspective and can be used for facilitating quality improvement.
Design: Modified two-round postal Delphi questionnaire.
Setting: Geographical spread across Great Britain.
Participants: One hundred and fifteen panellists representing 11 different stakeholder groups within primary care mental health services (clinical psychologist, health and social care commissioner, community psychiatric nurse, counsellor, general practitioner, practice nurse/district nurse/health visitor, psychiatrist, social worker, carer, patient and voluntary organisations).
Main outcome measures: Face validity (median rating of 8 or 9 on a nine point scale with agreement by all panels) for assessing quality of care.
Results: A maximum of 334 indicators were rated by panels in the second round; 26% were rated valid by all panels. These indicators were categorised into 21 aspects of care, 11 relating to general practices and 10 relating to health authorities or primary care groups/trusts. There was variation in the total number of indicators rated valid across the different panels. Overall, GPs rated the lowest number of indicators as valid (41%, n=138) and carers rated the highest number valid (91%, n=304).
Conclusions: The quality indicators represent consensus among key stakeholder groups in defining quality of care within primary care mental health services. These indicators could provide a guide for primary care organisations embarking on quality improvement initiatives in mental health care when addressing national targets and standards relating to primary care set out in the National Service Framework for Mental Health for England. Although many of the indicators relate to parochial issues in UK service delivery, the methodology used in the development of the indicators could be applied in other settings to produce locally relevant indicators.

The central role played by primary care in the recognition and delivery of care for people with mental health problems is now widely acknowledged.[1] However, ensuring the quality of primary mental health care remains a challenge in both developed and developing nations and, even in countries such as the UK with well established primary care and mental health services, there is considerable geographical variation in the quality of care delivered.

In England it is only recently that a National Service Framework and strategy for mental health care has been developed. In the past, whether and how mental health care should be subjected to quality assessment was interpreted and implemented by those working in different localities. Moves towards establishing a standardised and generic system of quality measurement in mental health care in England began in the 1990s when the Clinical Standards Advisory Group focused on both the management of schizophrenia[2] and depression[3] and, with the latter, moved towards examining the quality of provision in primary as well as secondary care. This was subsequently followed by the National Service Framework for Mental Health[4] which included the role of primary care in the delivery of mental health care (box 1). The implied development of protocols within primary care as part of Standard 2 of the National Service Framework indicates the very low baseline from which issues of quality within primary care mental health services start.

The English National Service Framework identifies primary care groups and primary care trusts as the lead organisations for developing roles and responsibility for primary care and access to services.[5] They are required to address methods of quality improvement in primary mental health care. However, there are few validated measures of mental health care available for use. Valid indicators of mental health care are important in assessing and improving quality of care as they can

Box 1 National Service Framework for Mental Health for England

The National Service Framework for Mental Health forms part of the Government's agenda to drive up quality and reduce unacceptable variations in health and social services. Developed by health and social care professionals, service users and carers, health and social service managers and partner agencies, the National Service Framework for Mental Health focuses on the mental health needs of working age adults up to 65. The document sets out national standards, national service models, local action and national underpinning programmes for implementation over a 10 year period. In addition, the National Service Framework for Mental Health provides a series of national milestones and performance indicators to assure progress and to support effective performance management. An organisation framework for providing integrated services and commissioning services across the spectrum of mental health service provision is also included.
Standard 1: Mental health promotion
Standards 2 & 3: Primary care and access to services
Standards 4 & 5: Effective services for people with severe mental illness
Standard 6: Caring about carers
Standard 7: Preventing suicide

Box 2 Eleven single specialty panels involved in the Delphi process

- Eight professional panels
  - clinical psychologist
  - health and social care commissioner
  - community psychiatric nurse
  - counsellor
  - general practitioner
  - nurse (practice, district, health visitor)
  - psychiatrist
  - social work
- Carer panel
- Patient panel
- Voluntary organisation panel

Box 3 Definition of terms

Validity

Extent to which the indicator related to an aspect of care which is important for providing high quality care for mental health problems in primary care.

Clarity

Extent to which the indicator was expressed in clear, precise, and unambiguous language.

Agreement

Round 1: 60% or more of ratings within a panel fell within the region 7–9.

Round 2: 75% or more of ratings within a panel fell within the region 7–9.

show variations in care, including suboptimal care.[6] They can also be used as a catalyst for facilitating quality improvement initiatives, which is particularly relevant given the difficulties and challenges faced by primary care groups and primary care trusts in implementing the mental health National Service Framework.[7] Although there are a number of guidelines relating to mental health problems, these tend to focus on specific conditions and care provided within secondary care. There is little relevant internationally published research in this area, but in the US a National Inventory of Mental Health Quality Measures identified a number of gaps between existing measures for mental health care and quality related needs of primary stakeholders.[8]

Thus, there are few indicators available for quality assessment of primary mental health care, and few that can be applied at the system level—for example, practice or primary care organisation—rather than at the level of the diagnostic group (such as depression or anxiety) or that reflect the views of key stakeholders in the primary mental health setting, particularly patients and carers.

We present the results of a Delphi survey[9–11] which aimed to develop a generic set of face valid service quality indicators for primary care mental health services that reflect the perspectives of key stakeholder groups. Although the Delphi approach has been used previously within mental health care, this has largely been to set research priorities,[12] establish models of good practice,[13 14] and identify essential components of various aspects of mental health care.[15 16] Previous work has not been concerned with developing measures for quality improvement within mental health care and has generally included only a limited number of perspectives. Indeed, the patient's perspective has been conspicuously absent from consensus methods in the past .[17] Given that the acceptability of indicators depends on their perceived relevance and value to potential users,[18] the inclusion of different perspectives—including those of patients and carers—is an important part of the process.

METHODS

Process

A two-round postal Delphi survey was carried out between March and July 2000. The study was conducted entirely by post for cost purposes and to include more respondents over a greater geographical area.

Panellists

Eleven single specialty panels were convened. These consisted of eight separate professional panels, one carer panel, one patient panel, and one made up of people from voluntary organisations (box 2). Panellists from professional groups reflected a combination of practitioners and those selected on the basis of their national reputation—that is, publication record, involvement in specialist societies, or as nominees of professional organisations. Similarly, the patient and carer panels contained patients and carers as well as known patient/carer advocates and those involved in key patient/carer organisations. The composition of panels reflected a geographical spread across Great Britain. Each panel was composed of 9–12 representatives. Panellists were sent a letter of invitation to participate. Those who were unable to take part were asked to nominate a possible replacement.

Indicators

A preliminary set of indicators was constructed from a number of sources. Firstly, previously published guideline statements and quality indicators and standards relating to primary mental health care were reviewed, as well as sources of published/grey literature produced by key organisations. Secondly, patient focus groups were convened to identify aspects of care (and thus indicators) considered important from the patient/user perspective. Finally, 22 of the standards set out in the National Service Framework for Mental Health for England were included. A total of 367 indicators were identified which covered a range of aspects of care at practice, primary care group, and health authority levels.

Questionnaire

The list of potential indicators was developed into a Delphi questionnaire which is reproduced in full on the journal website (www.qshc.com). The indicators were categorised into three levels of service which related to those provided by individual practices, primary care groups, and health authorities. Campbell and colleagues[19] have proposed that quality of care is a combination of access (whether users get the care they need) and effectiveness of clinical and interpersonal care (whether the care is effective when they get it). Practice level indicators were categorised according to these two elements. Some of the indicators could have been placed in one or more categories but, to avoid duplication, these indicators were put into only one category.

Subsequent amendments were made following consultation with a six member reference group composed of a health care commissioner, general practitioner, patient, community psychiatric nurse, counsellor, and psychiatrist.

Delphi round 1

During the first round the Delphi panellists were asked to rate the indicators on two continuous integer 9-point scales for validity and clarity (box 3) with 1=lowest and 9=highest rating.

Indicators were clarified and modified after feedback from the first round according to written comments made by panellists. Fifteen indicators receiving an overall median clarity score across panels of ≤6 were rewritten but retained; 38 indicators were discarded on this basis because of perceived duplication and lack of relevance to primary care, while an additional five indicators were included. A maximum number of 334 indicators could therefore potentially have been

Box 4 Practice level indicators

Practice: ACCESS

Access
- Patients are able to make a routine appointment to see a GP within 2 days
- There is equity of access to talking treatments regardless of ethnic origin, age, place of residence, socioeconomic status, and sex
- There is good access to integrated and community based mental health services out of hours (deputising/cooperative/GP and community mental health services)
- A member of the primary health care team is available as a point of contact for all patients to talk to in an emergency

Practice policies and procedures
- There is a written protocol/strategy to ensure that specific difficult to place groups are not excluded from registration with the practice (e.g. homeless, drug misusers, residential care residents)
- There is an agreed definition of severe and enduring mental illness which is explicit and standard within the practice
- There is a written complaints procedure which is prominently displayed
- Practices have a written policy for dealing with violent or abusive patients
- Clear written practice protocols are in place for obtaining specialist help in an emergency/crisis situation

Information for patients and carers
- Patients are given information about their condition, treatments, medication (including side effects) and coping strategies
- Information (i.e. practice information leaflets, health promotion leaflets) is easy to understand and available in appropriate languages for patients and carers whose first language is not English

Medical records
- Medical records, including computerised records, are up to date and summarised
- The confidentiality of medical records is protected and ensured at all times
- Details of currently prescribed maintenance drugs are prominently recorded in the medical record

Practice: EFFECTIVENESS

Patient-staff relations
- Staff treat all people registered with the practice with respect, courtesy and consideration irrespective of age, sex, religious/cultural beliefs, or diagnosis
- Staff are aware that mental health problems affect people of both sexes, all ages, backgrounds, and socioeconomic status
- Staff are aware that patients with a mental illness may be concerned about feelings of stigmatisation and are treated in a way to minimise these feelings
- Staff are aware that a diagnosis of mental illness does not make an individual legally unable (incompetent) to decide about treatment
- Patients are not made to feel that they are wasting health professionals' time
- Patients are listened to and taken seriously
- Physical symptoms in people with mental health problems are taken seriously and not automatically considered as psychosomatic
- Staff are responsive to patients' fears and concerns about the unwanted side effects of medication, including addiction
- Staff are aware of the potential impact of a mental health problem on patient behaviour (i.e. non-attenders with mental health problems should be accorded greater latitude)
- Patients with a mental health condition are treated as individuals with individual needs and not as a "diagnosis" (i.e. not labelled as depressed but treated as a person with depression)
- Health professionals communicate simply in language that is easy to understand

Confidentiality and consent
- Confidential discussions take place in private
- There is an appropriate (i.e. private, quiet, relatively non-clinical) room for counselling/visiting mental health staff
- Where practicable, patient consent is sought before giving information to carers

Comprehensive assessments
- Assessment of physical, psychological, and social health needs in patients with mental health problems includes an assessment of risk
- Assessment takes into account language barriers; the needs of people with disabilities (including sensory impairment), ethnic, cultural and religious preferences

Patient involvement in treatment plans
- Patients are as fully involved as practicable in the formulation and delivery of their care (e.g. through the use of self-care plans)
- Where appropriate, patients are offered treatments other than medication
- Treatment plans are individually tailored for each patient
- Patients are involved, unless impracticable, in any decisions about referral
- Where practicable, patients are informed of the reasons for referral to specialists or other professionals

Psychotropic prescribing
- Prescribing for mental health conditions is based on up to date evidence and, where available, local management protocols
- Choice of medication is based on individual patient factors including the desirability of sedation, previous response to a drug treatment including adverse reactions, co-morbid psychiatric or medical conditions, concurrent drug treatment, and relative risk of medication in overdose
- Clear and accessible information is provided with every prescribed psychiatric drug including information about the potential benefits and unwanted side effects
- Prescribed medication is at the minimum necessary dosage
- No drug is prescribed unless the health professional understands the potential efficacy and side effects
- Patients not responding to first line drug treatment at the therapeutic dosage are asked about adherence
- Patients are offered referral to a mental health worker if they are experiencing difficulties undertaking withdrawal from medication

Psychological treatment
- Counsellors, psychotherapists, and other practitioners of talking treatments working within practices:
  - are appropriately trained and hold appropriate qualifications
  - have regular supervision
  - make the boundaries of the patient-professional relationship clear and transparent

Box 4 continued

Follow up
- Patients with a diagnosis of mental illness are offered regular appointments to monitor and follow up treatment, symptoms, side effects and adherence
- Patients on repeat maintenance drugs are offered regular reviews of their medication including monitoring for possible side effects and interactions with other drugs
- During withdrawal from any medication patients are seen regularly for monitoring and support

included within each panel's round 2 questionnaire. However, not all panels received all 334 indicators because individual median panel scores were created for each indicator. Indicators which did not receive a median validity score of 7–9 with agreement within a panel were not included in that panel's second round questionnaire. Agreement was defined as 60% or more scores in the top (7–9) tertile (box 3).[20] Each panel therefore had a unique second round questionnaire.

Delphi round 2

Each panellist was sent a second round questionnaire which included three types of feedback based on first round validity

Box 5 Higher level (primary care group/trust and health authority) indicators

Registration with a general practice
- There is a written protocol/strategy to ensure that specific difficult to place groups are not excluded from registration with general practices (e.g. homeless, drug misusers, residential care residents)

Equity of access
- Services (including talking treatments) are available to all practices
- There are written policies on equity of access to services
- Patients are able to make a routine appointment to see a GP within 2 days
- There is evidence of a clear local programme to address and combat discrimination and to promote social inclusion of individuals and groups with mental health problems (e.g. through collaborative initiatives and partnerships with other agencies)
- The frequency of use of translator services by practices is monitored and is linked to practice population profiles

Referrals
- Written guidelines are in place to ensure that, where services are not provided locally, GPs can refer patients outside their locality
- There is a single point of rapid access for urgent referrals to specialist mental health services (duty professional or fast tracking service)

Psychotropic prescribing
- There are agreed written protocols and guidelines, based on best available evidence, for prescribing psychotropic medication
- There are locally agreed written protocols for prescribing across the primary-secondary care interface including hospital initiated prescribing

Comprehensive range of good quality mental health services
- There is a designated individual who acts as the mental health lead
- Specialist services are based on locally agreed written service plans and agreements which include the range, quality, and volume of mental health services
- A range of services is available, including talking treatments

Mental health promotion
- Procedures exist which demonstrate a commitment to promoting the mental health of all individuals and communities
- Health authorities or primary care trusts, in collaboration with social services and primary care groups, work with individuals and communities to promote mental health

Out of hours care
- There is good access to integrated and community based mental health services out of hours (deputising/cooperative/GP and community mental health services)
- There are locally agreed written standards and protocols for the delivery of out of hours care for mental health problems
- There are locally agreed standards and protocols for responding to mental health crises out of hours

Training and development
- There is a demonstrable commitment to promote continuous professional and practice development in primary care
- Practices are offered protected time for GPs and nurses to attend appropriate training courses
- There is evidence that training is organised to address specific training needs, for example:
  - mental health key workers and the Care Programme Approach
  - GPs and the Mental Health Act (1983)
  - health visitors and the management of postnatal depression
  - initiatives to make all health professionals aware of the impact of a mental health problem on patients' perspectives and actions
- There are adequate numbers of approved Section 12, Mental Health Act (1983) doctors
- There is evidence of initiatives to recruit doctors trained under Section 12 of the Mental Health Act (1983)

Effective partnerships between health authorities, local authorities and primary care groups/trusts
- There is a range of collaborative initiatives in place with other key agencies demonstrating effective partnerships (local authorities, voluntary agencies, other primary care groups/trusts)

Monitoring
- There are written protocols and mechanisms in place for monitoring prescribing of psychotropic drugs
- There is a written protocol/strategy to monitor whether specific difficult to place groups are excluded from registration with general practices (homeless, drug misusers, residential care residents)
- There is evidence of monitoring to ensure that out of hours standards are met

Table 1 Percentage of indicators rated valid by each panel after the Delphi process

Panel	Percentage of indicators rated valid after Delphi process	
	Delphi round 1 (n=367)	Delphi round 2 (n=334)*
Carer	83% (n=305)	91% (n=304)
Patient	78% (n=286)	86% (n=287)
Voluntary organisations	79% (n=290)	86% (n=286)
Community psychiatric nurse	78% (n=288)	86% (n=286)
Clinical psychologist	76% (n=278)	79% (n=263)
Health and social care commissioner	61% (n=225)	66% (n=220)
Nurse	66% (n=243)	66% (n=219)
Social worker	64% (n=236)	62% (n=206)
Counsellor	59% (n=216)	56% (n=187)
Psychiatrist	53% (n=195)	49% (n=162)
General practitioner	50% (n=183)	41% (n=138)

*n is given as 334 rather than 367 as only a maximum number of 334 indicators could potentially have been included in each panel's unique round 2 questionnaire.

scores for each indicator (panellist's own previous score, panellist's median panel score, and the frequency distribution of scores within the panellist's own panel). Panellists were then asked to re-rate the indicators specific to their panel for validity.

Proposed analysis

Previous research has shown that use of a higher cut off point (≥8) is associated with greater reproducibility and reliability.[21] Validity after second round ratings was therefore defined as an overall median for each panel of ≥8. A more stringent level of agreement of 75% or more in the top (7–9) tertile was applied (box 3). Indicators rated with an overall validity score of 8 or 9 with agreement by all panels were considered face valid indicators. Those rated valid by all panels were operationalised into aspects of care by the research team to produce indicators which could be used pragmatically to facilitate quality improvement. χ^2 tests were used to determine whether there were significant differences between the types of indicators rated valid by different panels—for example, between the different levels of service.

RESULTS

Response rate

A response rate of 90% was achieved in round 1 and 89% in round 2. The number of returned questionnaires on which analysis was based ranged from a minimum of eight (counsellor, community psychiatric nurse, nurse, psychiatrist) to a maximum of 11 (clinical psychologist, voluntary organisations) per panel. All final analyses reported in this paper are based on second round results.

Consensus among panel ratings

Most of the indicators (97%, n=324) were rated valid by at least one panel in round 2; 26% of the indicators were rated valid by all panels. The latter set of indicators represents a consensus among key stakeholder groups in defining quality of mental health care in primary care and, as such, formed the focus of the study. These indicators have been categorised into 21 aspects of care, 11 relating to general practice and 10 relating to health authorities or primary care groups/trusts (boxes 4 and 5).

Differences in panel ratings

The extent of intra-panel disagreement was extremely low with less than 1% disagreement within any one panel. Disagreement was defined as 30% or more scores in both the bottom (1–3) and top (6–9) tertiles.[20] However, there were major differences between panel ratings. Table 1 shows the variation in the total number of indicators rated valid across different panels after the first and second rounds of the Delphi process. Overall, GPs rated the lowest number of indicators as valid (41%) and carers rated the highest number valid (91%).

Panels rated different aspects of care as valid—for example, the GP panel did not rate protocols or guidelines for the management of separate mental health problems (including depression and anxiety) as central to providing good quality care, whereas the carer, clinical psychologist, community psychiatric nurse, patient, and voluntary organisation panels did. Moreover, χ^2 tests showed that GPs were the only stakeholder group who significantly rated more indicators as valid at the practice level than at the level of the primary care group and health authority ($p<0.01$). For all other groups there was either no significant difference in their ratings between different levels (commissioners, counsellors, patients, psychiatrists and social workers) or they rated significantly more indicators as important at the higher level ($p<0.05$) (carers, clinical psychologists, community psychiatric nurses, nurses, voluntary organisations). Given that the focus of this paper is the indicators which were rated valid by all panels, a more detailed account of the major differences between panel ratings will be reported separately as part of a follow up study exploring the factors which influence the ratings of stakeholders in a Delphi survey.

DISCUSSION

Our results show that it is possible to identify agreement between groups of stakeholders in identifying a generic set of valid quality indicators for primary care mental health services. All panels agreed that 26% of the indicators were valid measures of quality of care. However, the results of the Delphi survey also show that different stakeholders value different aspects of quality of care. The final set of indicators listed in boxes 4 and 5 provide a starting point for the development of quality improvement tools.

Limitations of the study

Although the Delphi process is a well validated method for assessing opinion,[9–11] this study has some important limitations. Firstly, the indicators rated were based on best available evidence in 2000 and, as such, must be reviewed in the light of major new research findings. The final set of indicators cannot be considered a comprehensive assessment of service level mental health services. Rather, they represent a consensus among key stakeholder groups in defining quality of care within primary care mental health services.

Secondly, appropriate composition of panels in consensus methodologies is a key factor in determining the legitimacy of the findings.[21 22] Considerable care was taken to select panels in order to reflect a range of expertise. This involved combining practitioners and those with a national reputation (based on publication record and membership of national committees/organisations) for the professional groups, and also including known patient and carer advocates/members of key organisations within the patient and carer panels. However, panels could not be said to be representative of their stakeholder perspective, but merely suggestive of their profession/group.

Thirdly, the aim of the study was to identify indicators rated valid by all stakeholders/panels but, because we attempted to identify all relevant stakeholder groups, there was a built-in bias in having a larger number of professional panels than a single patient and carer panel. Even though the rating process was democratic with each panel's ratings carrying equal weight, because the carer and patient panels rated more of the indicators valid than, for example, the GP or psychiatrist panels, this meant that the final set of indicators included fewer of the aspects of care of value to patients or carers than of value

to GPs or psychiatrists. Those panels rating the least number of indicators valid (GPs, psychiatrists, counsellors) therefore had greater influence on the final set of indicators than those rating the highest numbers of indicators valid (carers, patients, voluntary organisations, and community psychiatric nurses). However, this did not detract from the aim of the study to identify a common set of indicators.

Finally, the set of indicators developed required additional editing by the research team in order to operationalise them for use within quality improvement strategies. However, the meaning of the indicators remained intact.

Implications for quality improvement

The fact that only 26% of the quality indicators were agreed by all panels has implications for quality improvement and assurance purposes, given that the relative proportion of statements agreed amongst panels—particularly between professionals and users—differed. Such differences in the ratings of the various panels reflect the natural diversity of opinion within mental health care. The indicators rated valid by each panel also provide opportunities for quality improvement strategies which address the aspects of care rated valid by each different perspective (these are available from the authors). Policy makers in all countries intending to use consensus methods to provide a multidisciplinary approach to quality assessment and improvement within health and social care need to give thought to this issue in order to create a more equal partnership between what consumers value and what providers value in terms of quality care.

Quality indicators are defined as a measurable element of performance for which there is evidence or consensus that they can be used to assess the quality, and hence change in the quality of care provided.[23] While the indicators listed in boxes 4 and 5 represent consensus among the 11 panels, many are professional aspirations and standards rather than measurable indicators. This is perhaps a reflection of the underdeveloped and nascent evidence base from which to develop outcome based indicators for primary mental health care, and the difficulty in collecting such data in the setting of primary care even in a system as complex and well developed as that in the UK. Measurement depends on reliable data systems which, although readily available in the US health maintenance organisations, are only now in development in healthcare settings in other western countries. It is necessary to set up these systems and infrastructure before quality assurance/control can be both feasible and reliable. We have therefore not attempted to distinguish between the conventional (measurable) quality indicators and the more aspirational indicators. While a number of the indicators will be easily measurable, others—such as those included within patient-staff relations—will require more innovative and eclectic approaches to measurement. Although this will provide considerable challenges to primary care organisations in facilitating quality improvement, the state of the literature relating quality of care to outcome in mental health care compared with conditions such as coronary heart disease[7] necessitates such an approach to quality improvement.

The final set of indicators can be used for both quality improvement (which does not need measurement) and quality assessment (which does). Importantly, these indicators are not intended to provide a comprehensive tool set for measuring quality of care. Rather, they can be used as a starting point for discussion by primary care organisations and practices and as a means of assisting primary care organisations to address the national targets and standards relating to primary care set out in the National Service Framework for Mental Health for England. They also represent a potential for identifying the current baseline of care provision. In this way the indicators raise awareness around important issues of primary mental health care. This is particularly relevant in localities where progress in developing primary care mental health services is limited and a cultural shift to increase the profile of mental health care is required.

Key messages

- Valid quality indicators can show variations in the quality of care and can act as catalysts for facilitating quality improvement initiatives.
- Few indicators are available for use in primary mental health care, especially at the level of the system (practice or primary care organisation) rather than the diagnostic group, or reflecting the views of key stakeholders (patients and carers).
- A maximum of 334 indicators were rated by 11 stakeholder panels in the second round of a Delphi study, 26% of which were rated valid by all panels.
- This generic set of service quality indicators represents a consensus among key stakeholder groups in defining quality of care within primary care mental health services which can be used in quality improvement strategies.

When applying quality indicators it is important to ensure that they are done realistically and that they reflect local circumstances.[24] Some areas of the UK have a better infrastructure for primary care mental health services than others.[7] We have not therefore attempted to establish standards for these indicators. Rather, primary care organisations or practices may adopt a standard which is relevant to their local circumstances and needs and initiates debate at a local level.

Other potential uses of the indicators are to act as sign posts in defining quality of care and to indicate areas where additional resources may be required. The indicators could then be used to aid primary care organisations and/or practices to set locally achievable goals and to develop local standards of care. Given that the indicators themselves are not a comprehensive set of quality measurement tools, it may be necessary—depending on the aims of the quality improvement strategy—to supplement these indicators with other key local and national documents within this field.

Conclusion

The quality indicators developed in this study, although not comprehensive, represent a consensus among key stakeholder groups in defining quality of care within primary care mental health services. They can be used as a starting point in quality improvement strategies and as a means for assisting primary care organisations to address the national targets and standards relating to primary care set out in the National Service Framework for Mental Health for England. Although many of the indicators relate to parochial issues in UK service delivery, the methodology used in their development—with its multi-stakeholder input and involvement of patients, carers, and professionals—could be applied in other settings to produce locally relevant indicators.

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The Delphi questionnaire and accompanying glossary are available on the journal website (http://qhc.bmjjournals.com/supplemental)

Authors' affiliations

T Shield, S Campbell, A Rogers, L Gask, National Primary Care Research and Development Centre, University of Manchester, Manchester M13 9PL, UK
A Worrall, College Research Unit, Royal College of Psychiatrists, London SW1H 0HW, UK
C Chew-Graham, Department of General Practice, University of Manchester, Manchester M14 5NP, UK

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NATIONAL PRIMARY CARE RESEARCH & DEVELOPMENT CENTRE

UNIVERSITY OF MANCHESTER

STEPHEN CAMPBELL, LINDA GASK, ANNE ROGERS, TRACEY SHIELD. 0161 275 7601

DEVELOPING QUALITY INDICATORS FOR MENTAL HEALTH IN PRIMARY CARE

ROUND 1 DELPHI QUESTIONNAIRE: MARCH 2000

Instruction sheet

This questionnaire represents round one of a two round postal Delphi survey. During this round we are asking you to rate the importance of a wide range of indicators contained in the questionnaire on two scales: validity and clarity.

In order to maximise reliability and consistency of rating please try and complete the questionnaire in one sitting.

Definition of validity

Ratings refer to the extent to which you believe that each indicator is important for measuring the quality of mental health care in primary care. Valid indicators are likely to require a variety of different methods in order to collect data. It would be our intention to use the most valid means possible to operationalise indicators; not rely on one method. At this stage please ignore whether you think that data can be collected for an indicator and just rate its importance to quality of care. Feasibility of data collection will be rated in the second round questionnaire.

Definition of clarity

The indicator is expressed in clear, precise and unambiguous language.

Rating scale:

Each indicator has a 9-point scale. 1 represents the lowest and 9 the highest rating. Please consider using the full range of the scales from 1 to 9 and not simply 1 and 9. For example, on the validity scale a rating of between 1 and 3 would mean that, in your opinion, the indicator is not a valid measure of quality. A rating of between 4 and 6 would mean that the indicator was an uncertain or equivocal measure of quality and a rating of between 7 and 9 would mean that you considered the indicator to be a valid measure of quality. Please remember to provide a 1-9 rating for each indicator. **Please do not leave any scales blank**.

For each indicator we need you to rate the indicator as in the following example:

	Indicator	**Validity ***	**Clarity ***
	Somebody on the primary care team should take the lead on mental health care	1 2 3 4 (6) 7 8 9	1 2 3 4 (6) 7 8 9

If you feel that you are unable to comment on an indicator please strike it out thus:

	Indicator	**Validity ***	**Clarity ***
	~~Somebody on the primary care team should take the lead on mental health care~~	~~1 2 3 4 5 6 7 8 9~~	~~1 2 3 4 5 6 7 8 9~~

A glossary is provided at the end of the list of indicators, which defines some of the terms used in this questionnaire. Words or phrases contained in the glossary are in **bold type**.

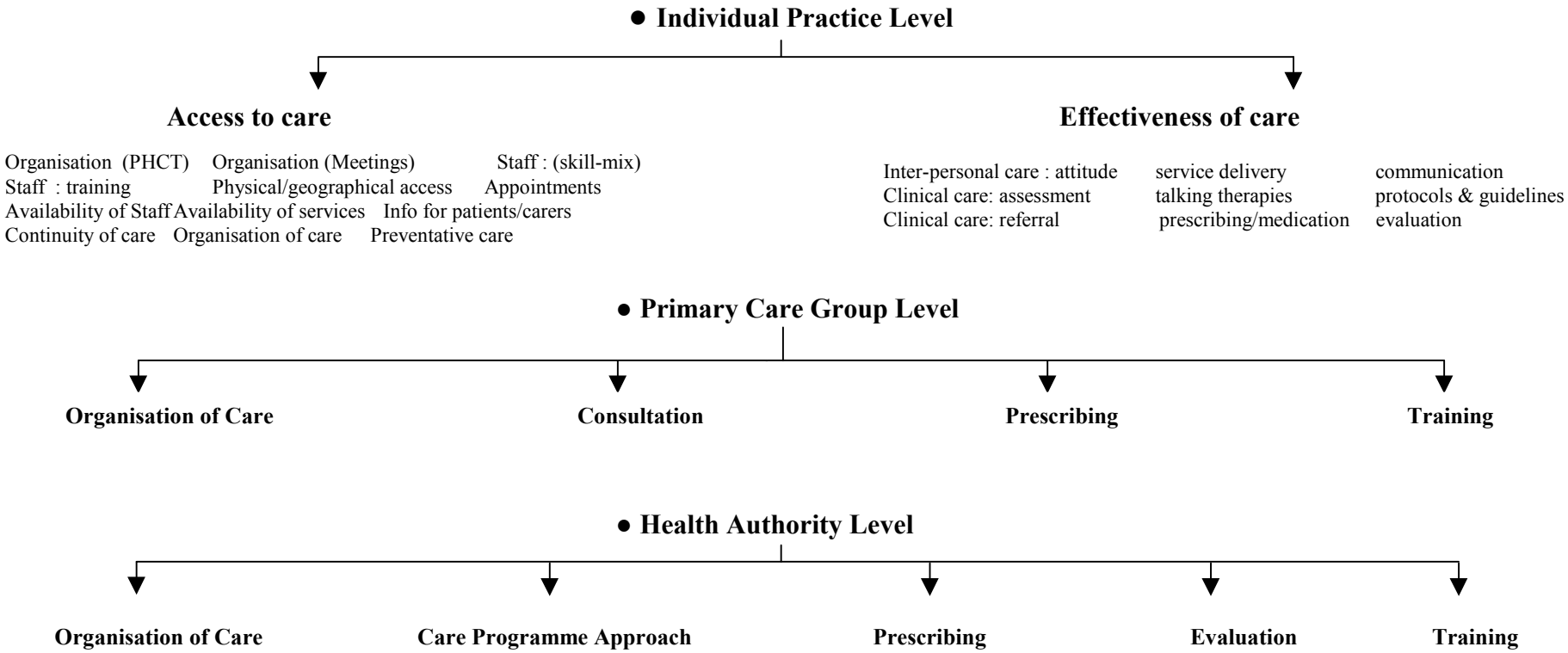
Note: If you feel that any of these criteria should be reformulated or reworded please give us your suggestions when you return the document. Please feel free to comment on any or all of the indicators.

The list of indicators has been divided into three levels of service:

- indicators relating to services provided by **Individual General Practices** (divided into *acces*s and *effectiveness* of care)
- indicators relating to services provided by **Primary Care Groups**
- indicators relating to services provided by **Health Authorities**

The indicators have been organised under separate headings within these three areas to reflect key aspects of quality of care.
Some of the indicators could have been placed in one or more categories, but to avoid duplication these indicators have been put into only one category.

The indicators are subsequently organised as follows:



Thank you

PRACTICE LEVEL INDICATORS

PART 1 : ACCESS

	Indicator	Validity *	Clarity #
	ORGANISATIONAL STRUCTURE (PRIMARY HEALTH CARE TEAM)		
1	In each general practice, one named member of the **primary care team** should take the lead on mental health care, i.e. organise and co-ordinate care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
2	This person should be a :		
	a. General Practitioner	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b. Practice Nurse	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c. Community / district nurse	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d. Community Psychiatric Nurse	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e. **Link-worker**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	f. Counsellor	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

Clarity. 1=The meaning of the indicator is unclear and ambiguous. 5= The meaning of the indicator is neither clear nor unclear. 9=The meaning of the indicator is clear and unambiguous.

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	ORGANISATIONAL STRUCTURE (MEETINGS)	Validity *	Clarity #
3	There should be planned meetings about mental health care, held on a least a quarterly basis, between :		
	a). GPs and other members of the Primary Health Care Team (e.g. practice nurses, counsellors)	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b). Members of the PHCT and secondary care staff (e.g. community psychiatric nurses, psychiatrists psychologists)	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c). Members of PHCT and **carer** groups	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	STAFF CHARACTERISTICS : SKILL-MIX	**Validity ***	**Clarity #**
4	Practice nurse(s) should be routinely involved in the care of mental health problems	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
5	The practice nurse(s) should receive specific training and support for depot injections	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
6	Health visitors should have specific training in post natal depression	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
7	At least one general practitioner in a practice should have **specific training in mental health**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
7a	50% of the general practitioners in a practice should have **specific training in mental health**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
8	The practice should have a counsellor as part of the **core team**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
9	The practice counsellor should have been trained in **evidence based therapies**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
10	A member of the **primary health care team** in every practice should be trained in arranging and running self-help groups such as art-therapy or gardening	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	STAFF CHARACTERISTICS : TRAINING	Validity *	Clarity #
11.	The following members of staff should have attended at least one training event relating to mental health within *the last two years:*		
	a. General Practitioners	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b. Practice nurses	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c. Receptionists	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d. Health visitors	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e. District nurses	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
12	Practices should offer **protected time** for GPs and nurses to attend appropriate training courses	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
13.	Practices should perform an **annual skills audit** or annual training needs analysis for mental health	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
14	Staff training should involve the promotion of the health and well-being of **patients** as well as the treatment of illness	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
15	Mental health keyworkers should have been trained in the core areas of the **Care Programme Approach**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
16	All staff should be aware of the roles and responsibilities of :		
	a. all members of the primary health care team with regards to mental health	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b. the roles and responsibilities of advocacy and user groups	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
17	All general practitioner should have an understanding of their role under the **1983 Mental Health Act**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	PHYSICAL / GEOGRAPHIC ACCESS	Validity *	Clarity #
18	**Patients** should be registered with a GP for at least 6 months	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
19	There should be adequate facilities for disabled patients	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
20	Patients with : a. **agoraphobia** should be offered services in their homes b. panic attacks should be offered services in their homes	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9

	APPOINTMENTS	Validity *	Clarity #
21a	Patients with **a mental illness** should be able to make an urgent appointment to see a general practitioner on the same day	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
21b	Patients with **mental illness** should be able to make a routine appointment to see a general practitioner within three days	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
22	Patients with **mental illness** should have access to counselling on an emergency basis	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
23	Patients with **mental illness** should be given flexible lengths of appointment rather than fixed time appointments to provide more time for talking	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
24	Patients on a mental health register for **severe and enduring mental illness** should be seen at least every six months by a nominated member of staff	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
25	Patients on a **mental health register** for severe and enduring mental illness should be invited by their GP to an annual, comprehensive assessment together with the practice nurse or community psychiatric nurse where appropriate	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	AVAILABILITY: STAFF AVAILABLE ON SITE OR BY REFERRAL OFF SITE	**Validity ***	**Clarity #**
26	General practices should have access to a:		
	a). community psychiatric nurse **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b). community psychiatric nurse **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c). psychologist **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d). psychologist **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e). counsellor **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	f). counsellor **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	g). psychiatrist **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	h). psychiatrist **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	i). social worker **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	j). social worker **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	k). welfare rights officer **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	l). welfare rights officer **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	m). occupational therapist **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	n). occupational therapist **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	AVAILABILITY: STAFF AVAILABLE ON SITE OR BY REFERRAL OFF SITE (continued)	**Validity ***	**Clarity #**
27	General practices should have immediate access to **community mental health teams** through referral to a **duty professional**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
28	General practices should have immediate access to crisis support through a **fast tracking service** for urgent referrals	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
29	Patients should be able to see a general practitioner of their own gender	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
30	It can be arranged for a patient to consult with either a male or female mental health professional as preferred, where practical.	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
31	Patients should have access to the primary care health professional of their choice	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
32	Patients should be able to ask to see a general practitioner of a particular cultural background	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
33	General practitioners and other members of the **primary health care team** should make home visits for patients experiencing a mental health crisis This should be irrespective of: a). the time of day b). the area a patient lives in	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
33	**Secondary psychiatric services** should make home visits for patients experiencing a mental health crisis This should be irrespective of: a). the time of day b). the area a patient lives in	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
34	Clear practice protocols should be in place for obtaining specialist help in an emergency/crisis situation	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	AVAILABILITY: SERVICES AVAILABLE ON SITE OR BY REFERRAL	Validity *	Clarity #
35	Access to all forms of talking treatment should be equal regardless of:		
	a) mental health diagnosis	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) ethnic origin	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c) age	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d) place of residence	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e) socio-economic status	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	f) gender	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
36	The following clinics/services should be available :		
	i). Routine practice counselling **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	ii). Routine practice counselling **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	iii). Bereavement clinic **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	iv). Bereavement clinic **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	v). Marriage guidance counselling **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	vi). Marriage guidance counselling **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	vii). Substance/misuse clinic **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	viii). Substance/misuse clinic **by referral of site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	ix). Home detox services in conjunction with primary care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	x). Stress clinic **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	xi). Stress clinic by referral **off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	xii). Ante and postnatal depression counselling **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	xiii). Ante and postnatal depression counselling **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	xiv). Terminal care counselling **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	xv). Terminal care counselling **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	xvi). Complementary medicine **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	xvii). Complementary medicine **by referral off site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	xviii).Self-help groups **on site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	xix). Self-help groups **by referral off-site**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	AVAILABILITY: SERVICES AVAILABLE ON SITE OR BY REFERRAL (continued)	Validity *	Clarity #
37	Patients should be given the option of alternative/complimentary therapies or other activities such as local leisure activities	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
38	Translator services should be provided for patients whose first language is not English	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
39	Practices should have access to an **advocacy service**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
40	Advocates should be allowed in a consultation: a. if the patient wants an advocate b. if the patient would benefit from the presence of an advocate	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
41	General practices should provide specific mental health services for ethnic minority groups	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
42	**Genetic counselling** should be made available for families at risk from mental illnesses with a genetic component such as schizophrenia, dementia and Alzheimer's disease	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
43	Practices should have access to a day care /drop-in/crisis centre for patients	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
44	Out of hours **community mental health** services should be available "as patients don't stop being ill at 5.00 p.m."	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
45	Emergency cover should be available at all hours when general practice surgeries are closed	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	INFORMATION FOR PATIENTS /CARERS	Validity *	Clarity #
46	Patients should have access to benefits advice	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
47	Regular reviews of possible benefit entitlements should be undertaken by a member of the Primary Health Care Team	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
48	Information on **self-help groups** and community networks should be available and prominently displayed in practices	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
49	Information should be available in appropriate languages for all patients	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
50	Information on treatments, medication (including side-effects) and coping strategies should be available	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
51	Practices should have a written complaints procedure which is prominently available to patients	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
52	Information on patient access to medical records should be publicly displayed	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
53	Practices should have : a. A **local resource directory** available to professionals, in order to offer advice and information to patients, such as local art groups, creative writing and studying opportunities. b. Access to a **link-worker** who has a full understanding of services available locally	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
54	Practices should have a resource of information about mental health which patients can borrow, including self-help manuals, books, videos and tapes.	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
55	Family and friends involved in the care of a patient with mental illness should have access to information / education about the impact of the illness on the patient as a whole	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	CONTINUITY OF CARE	Validity *	Clarity #
56	Patients should be booked to see the same GP for subsequent consultations to ensure continuity of care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
57	Patients on psychotropic medication should be reviewed regularly with appointments **initiated by the general practitioner**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
58	All patients with **severe and enduring mental illness** should have a **keyworker**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
59	All patients with mental illness should have a **keyworker**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	ORGANISATION OF CARE	Validity *	Clarity #
60	The primary responsibility for the provision of mental health care in general practice should lie with general practitioners	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
61	Practices should use **prompted templates** on computer to record and manage mental health problems	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
62	All patients with severe and enduring mental illness should have an **integrated care plan**, with a care co-ordinator responsible for implementing, reviewing and explaining the care plan	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
63	Patients who are long term users of benzodiazepine medication should be recorded on a benzodiazepines register	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
64	Patients with a diagnosis of **severe and enduring mental illness** recorded should be included on a register	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
65	Patient medical records should be up to date and summarised	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
66	General practices should have an **annual written business plan**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
67	The annual plan should be written in consultation with those members of the primary health care team who provide services for those with mental health problems	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
68	Patients should be given the option of referral to talking therapies on a one-to-one basis or within a group	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
69	When a patient registers with a new practice, the patient's previous medical records should be obtained promptly	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
70	The confidentiality and privacy of patient medical records must be protected and ensured at all times	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	PREVENTATIVE CARE	Validity *	Clarity #
71	Practice should : a. have a register of patients who have a family history of mental health problems b. mark patients' records to show that the patient has a diagnosed mental illness and to alert health professionals to this diagnosis	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
72	Practices should regularly screen high-risk groups for mental illness such as older people, unemployed, new mothers	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
73	a. Patients at higher risk of mental illness should be provided with information about the prevention of illness and reduction in stress b. All patients should be provided with information about the prevention of illness and reduction in stress	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9

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PRACTICE LEVEL INDICATORS

PART TWO : EFFECTIVENESS

	INTER-PERSONAL CARE: ATTITUDE TO PATIENTS	Validity *	Clarity #
74	Staff should be friendly and treat patients with respect, courtesy and consideration irrespective of :		
	a. age	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b. sex	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c. diagnosis	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
75	Patients should be treated as individuals with individual needs and not as a diagnosis	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
76	Religious and cultural beliefs should be respected	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
77	Patients should be as fully involved as practicable in the formulation and delivery of their care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
78	All staff should be explicitly aware that being diagnosed as mentally ill does not make someone legally unable (incompetent) to decide about treatment	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
79	All patients have the right :		
	a) to have someone to talk to	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) to be listened to	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c) to be taken seriously	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
80	Health professionals should be aware that mental health problems affect people of both sexes, all ages, backgrounds and socio-economic status	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
81	All staff should take a holistic approach to mental health and recognise the mental, emotional, physical, social and spiritual aspects of mental health and mental health problems	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
82	All staff should listen to, and take seriously, peoples fears and concerns about the unwanted side-effects of medication and where possible offer alternative treatment	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
83	Patients' decisions to refuse treatment should be respected	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	INTER-PERSONAL CARE: ATTITUDE TO PATIENTS (continued)	Validity *	Clarity #
84	Health professionals should be aware of the impact of a mental health condition on the patient's perspectives and actions	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
85	Health professionals should be aware that some patients are concerned about feelings of being stigmatised when diagnosed with a mental health problem	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
86	Confidential discussions should take place in private	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
87	Areas should be provided for reception staff to obtain and give confidential information	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
88	Patients should be allowed to play an active part in their own treatment i.e. self-care plans	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
89	Patients should be encouraged to play an active part in their own treatment e.g. **self-care plans**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
90	Suicide attempts must never be described as attention-seeking	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
91	Health professionals should realise that the needs of patients with mental health problems are not static and that health care should respond flexibly to changes in mood and symptoms and positive or negative social and personal life events	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
92	Patients consulting with a mental health condition must never be made to feel that they are a nuisance or are wasting health professionals' time	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
93	Primary care professionals should have a caring and positive attitude towards patients	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	INTER-PERSONAL CARE: SERVICE DELIVERY	Validity *	Clarity #
94	There should be an appropriate (i.e. private, quiet, relatively non-clinical in feeling) room for counselling / visiting mental health staff	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
95	The language used by the patient (if non-English speaking) should be prominently recorded on the patient's medical record	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
96	Treatments other than medication should be offered and discussed	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
97	Practices should have a written policy for dealing with violent or abusive patients	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
98	With the patient's consent, family and friends should be given the opportunity to be involved in the patient's care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
99	Patients should be on a mixed therapeutic regime (including talking therapies, exercise, lifestyle advice and medication) rather than just a drug regime	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	INTER-PERSONAL CARE : COMMUNICATION	Validity *	Clarity #
100	Health professionals should communicate simply and clearly in language that is easy to understand to **carers** and patients	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
101	As early as possible in the course of diagnosis and treatment, people with mental illness should be given comprehensive information about their condition	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
102	Information on the types of services available to patients with mental health problems should be provided at the first consultation	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
103	A patient's illness, its management and expected outcomes should be explained to family and friends involved in a patient's care with the patient's permission	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
104	Information on the risks and benefits of specific treatments and investigations and their alternatives should be provided to all patients	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
105	Information should be easy to understand and not pejorative	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
106	Patients' views should be recorded in the medical record and signed by them	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
107	Patients should be explicitly involved in decisions about their care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
108	Patients should be given advice about beneficial lifestyle changes (e.g. diet, exercise, sleep pattern, drug and alcohol use)	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
109	Health professionals should explain a patients' rights, consent for treatment, and confidentiality before the patient is asked to sign consent forms	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
110	Where practicable, patient consent should be sought before giving information to **carers**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
111	The PHCT should have guidelines about sharing information with patients and **carers** which are realistic in a primary care setting	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

	EFFECTIVENESS OF CLINICAL CARE : ASSESSMENT	Validity *	Clarity #

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112	Patients with a diagnosis of mental illness should be offered regular appointments to monitor and follow-up treatment, symptoms, side effects and compliance	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
113	Patients with mental health problems should be assessed for their overall: a) physical health needs b) social needs (including family and cultural) c) psychological d) family/cultural/social environment and support, life stressors e) risk assessment	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
114	Assessments should take in to account: a) language issues b) the needs of people with disabilities, including sensory impairment c) ethnic and cultural preferences	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
115	Patients with mental illness should be given a comprehensive general medical as well as psychiatric assessment	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
116	Patients with severe and enduring mental illness should be reviewed by their GP or a member of the mental health team (covering symptoms, side-effects of medication, general health) : a) Annually b) Every 6 months	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
117	Definitions of severe and enduring mental illness should be explicit and standard in the practice	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
118	Physical symptoms should be taken seriously by health professionals and not automatically considered as psychosomatic.	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

	EFFECTIVENESS OF TALKING THERAPIES	**Validity ***	**Clarity #**

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119	Psychological (talking) treatments should be offered to all patients who prefer not to take medication	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
120	Counsellors, psychotherapists and other practitioners of talking therapies should: a) negotiate a contract with the patient at the beginning of a course of therapy b) make the boundaries of the relationship clear c) specify the course of action to be taken if the client wishes to make a complaint	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
121	Psychological therapists (including counsellors) working within the practice should have regular supervision	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
122	Psychological therapists (including counsellors) working within the practice: a) should be appropriately trained b) should hold appropriate qualifications	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9

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	EFFECTIVENESS OF CLINICAL CARE : PROTOCOLS AND GUIDELINES	**Validity ***	**Clarity #**
123	Treatment plans should be individually tailored for each patient	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
124	Clinical guidelines must not be adhered to strictly but tailored to each individual patient	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
125	Practices should ***<u>have developed or follow</u>*** protocols or guidelines for the management of the following mental health problems:		
	a) suicide/risk assessment	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) anxiety/panic attacks	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c) substance misuse	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d) referrals to specialist services	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e) bereavement	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	f) depression	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	g) post-natal depression	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	h) medication management for those on long-term anti-psychotic medication	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	i) treatment of severe and enduring mental illness	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	j) **eating disorders**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	k) dealing with **carers** of patients with mental health conditions	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	l) withdrawal from benzodiazepines	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	m) dementia	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	n) **somatization disorders**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
126	Individual general practice protocols should be written in consultation with patients	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	EFFECTIVENESS OF CLINICAL CARE: REFERRAL	Validity *	Clarity #
127	Patients should be considered for referral to specialist secondary care services if there is uncertainty of diagnosis	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
128	Patients should be considered for referral to specialist secondary care services if: a) there is a risk of suicide b) there is a risk of self neglect c) there is a risk of violent behaviour d) there is a need for therapy unavailable in primary care e) there is a co-morbidity mental illness f) there is substance dependence	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
129	Referral letters should contain sufficient information (i.e. presenting problems, interventions tried and their outcome, what is expected from their referral)	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
130	The practice should have a written protocol for dealing with the management of patients on hospital waiting lists (e.g. prompts to speed-up appointments)	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
131	Patients should be fully informed of the reasons for referral	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
132	Patients should be involved, unless impracticable, in any decisions about referral	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
133	Staff must be aware of the range of services provided by external agencies which meet the individual needs of patients with mental health problems	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
134	In cases where all primary care and voluntary care options have been exhausted patients should be referred to secondary mental health services	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	EFFECTIVENESS OF CLINICAL CARE: REFERRAL (continued)	Validity *	Clarity #
135	Practices should be aware of what realistic alternatives are available locally (e.g. voluntary and self help organisations) for patents who: a) do not meet the acceptance criteria of specialist services b) do not wish to be referred to specialist services	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
136	Patients should be referred as soon as possible according to the need of the individual patient	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
137	Where services are not available locally, general practitioners should be able to refer outside their locality	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	EFFECTIVENESS OF CLINICAL CARE: PRESCRIBING AND MEDICATION	Validity *	Clarity #
138 (a)	Patients must not automatically be prescribed medication	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
138 (b)	Patients who cannot be persuaded to take medication must still be offered consultations	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
139	Patients must not be kept on medication indefinitely without regular review	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
140	Details of currently prescribed medication should be prominently displayed and recorded on the summary sheet in the medical record	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
141	Clear and accessible information should be made available with every psychiatric drug prescribed including information about the potential benefits and unwanted effects that might be caused by the drug	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
142	Prescribing for mental health conditions should be based on up-to-date evidence based data	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
143	No drug should be prescribed unless the health professional understands the potential efficacy and side-effects	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
144	Health professionals should be aware and responsive to patients' concerns about becoming addicted to medication	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
145	All medication should be prescribed at therapeutic doses	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
146	Medication used should be the minimum necessary dosage	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
147	If a patient is suicidal medication should only be dispensed a few days at a time	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
148	Patients undertaking withdrawal from medication should receive information about symptoms to expect and coping strategies	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
149	During withdrawal from any medication patients should be seen regularly for monitoring and support	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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150	Patients who are experiencing difficulties through withdrawal should receive additional support or specialist treatment	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	EFFECTIVENESS OF CLINICAL CARE: PRESCRIBING AND MEDICATION (continued)	**Validity ***	**Clarity #**
151	Medication should be withdrawn slowly	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
152	The choice of medication should be based on individual patient factors including the desirability or otherwise of sedation, previous response to a particular drug including adverse reactions, co-morbid psychiatric or medical conditions, concurrent drug therapy and relative risk of medication in overdose	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
153	Drugs should be prescribed from a restricted list demonstrating selective prescribing	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
154	Patients not responding to first line drug therapy should : a) have their diagnosis reviewed b) have their concordance checked c) be prescribed a different drug or treatment d) be considered for referral to a psychiatrist	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9
155	Prescribing decisions should be based only on clinical issues and not cost	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
156	Practices should review **PACT data** relating to mental health *annually*.	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
157	Patients on repeat prescribing should have their medication reviewed regularly	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
158	All patients should have their medication monitored for side-effects and possible interactions with other drugs	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
159	All patients should have equal access to exercise schemes or gymnasium, art\poetry\painting groups, yoga, etc. on prescription	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
160	Where the responsibility for prescribing medication lies with the general practitioner rather than a mental health professional , the GP should be primarily responsible for the patient's care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	EFFECTIVENESS OF CARE: EVALUATION	Validity *	Clarity #
161	Practice objectives should be developed in consultation with patients and **carers**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
162	Practices should have a continuous and systematic approach to evaluating and auditing the quality of mental health services	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
163	All types of staff (GPs, counsellors, community psychiatric nurses) should undertake regular reviews of treatment in order to ensure that people are happy with the form of therapy or counselling they are receiving, and the person that they are receiving it from	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
164	All relevant stakeholders (e.g. patients, minority groups, health authorities, PCGs) should be involved in setting standards for evaluation	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
165	General practices should have undertaken a patient evaluation of their mental health services (e.g. satisfaction surveys) in the last two years	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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PRIMARY CARE GROUPS AND HEALTH AUTHORITY LEVEL INDICATORS

PART THREE: PRIMARY CARE GROUPS

	PCG: ORGANISATION OF CARE	Validity *	Clarity #
166	PCGs should treat mental health as a priority for **clinical governance**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
167 (a)	All patients should have the right to be registered with a general practice	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
167 (b)	All patients should have equitable access to services offered by any practice	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
168	Local commissioners should determine their own locality's priorities	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
169	Service delivery should be based on agreed service plans and written service agreements	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
170	Where patient care is shared between two or more organisations there should be a jointly written protocol	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
171	Referral criteria to specialist mental health services should be jointly agreed with Hospital **Trusts**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
172	PCGs should ensure that local co-operative and deputising services meet locally agreed standards for the management of mental health crises out of hours	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
173	PCGs should monitor progress of people with **severe mental illness** by setting local protocols with locally agreed targets	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
173 (a)	PCGs should instigate a system of critical event analysis in relation to mental health	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
173 (b)	PCGs should create practice-based lists of patients with **severe and enduring mental illness**.	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	PCG: ORGANISATION OF CARE (continued)	Validity *	Clarity #
174	PCG protocols for mental health care should be written in consultation with:		
	a) Representatives from all local practices	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) Health authorities	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c) Community **Trusts**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d) Local authority social services departments	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e) Local voluntary agencies	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	f) Patient groups	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	g) **Carer** groups	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	h) Health Education Authority	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	i) Secondary care services	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
175	Allocation of finite health care resources should be guided by health need assessment	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
176	Mental health services should be appropriately audited and evaluated to ensure quality and efficiency	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
177	PCGs should set high level performance indicators and standards adhering to the national performance framework and establish monitoring procedures to assess the performance of practices in their catchment area	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	PCG: ORGANISATION OF CARE (continued)	Validity *	Clarity #
178	Service models should be developed at PCG level which ensure that general practices have access to protocols or guidelines, for any practice staff, for the management of the following mental health problems:		
	a) suicide/risk assessment	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) anxiety/panic attacks	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c) substance misuse	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d) referral to specialist care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e) bereavement	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	f) depression	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	g) post-natal depression	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	h) medication management for those on long-term anti-psychotic medication	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	i) treatment of severe and enduring mental illness	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	j) eating disorders	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	k) dealing with **carers** of patients with mental health conditions	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	l) dementia	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	m) somatization disorders	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	n) gender identity disorders	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
179	Service models should be developed at PCG level which:		
	a) manage referrals to specialist services	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) monitor waiting times	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
180	Patients should have access to a 24 hour FREEPHONE telephone help line dedicated to mental health	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
181	PCGs should develop a protocol for enabling patients to obtain free access to the Internet to obtain information about mental health care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	PCG: CONSULTATION	Validity *	Clarity #
182	PCGs should liaise with local self-help groups	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
183	PCGs should have undertaken consultation with advocacy and user/patient groups about mental health services (e.g. meetings) in the last two years	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
184	There should be planned meetings about mental health care, held on a least a quarterly basis, between :		
	a). Members of the PCG and health authority staff	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b). Members of the PCG and local authority staff (e.g. social services, housing)	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c). Members of PCG and voluntary agencies	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d). Members of the PCG and specialist services	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e). Members of the PCG and local police services	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	f). Members of the PCG and **carer** groups	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	PCG: PRESCRIBING	**Validity ***	**Clarity #**
185	With regard to prescribing for mental health problems, general practices should use the following developed at PCG level: a) prescribing guidelines **b) prescribing formulary**	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9	 1 2 3 4 5 6 7 8 9 1 2 3 4 5 6 7 8 9

	PCG: TRAINING	**Validity ***	**Clarity #**
186	PCGs should take a lead in addressing the mental health training needs of health professionals	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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PRIMARY CARE GROUPS AND HEALTH AUTHORITY LEVEL INDICATORS

PART FOUR: HEALTH AUTHORITY LEVEL

	HEALTH AUTHORITY: ORGANISATION OF CARE	Validity *	Clarity #
187	Health authorities, in collaboration with social services and PCGs, should seek to promote mental health for all, working with individuals and communities	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
188	Health authorities, in collaboration with social services and PCGs, should seek to combat discrimination against individuals and groups with mental health problems, and promote their social inclusion	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
189	Health authorities should develop programmes/protocols for promoting the mental health of :		
	a) Victims of child abuse	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) Victims of domestic violence	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c) People who sleep rough/homeless	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d) People with alcohol and drug problems	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e) People at risk (e.g. young, single parents)	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	f) Vulnerable groups (e.g. refugees and asylum seekers)	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	g) People in prison	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	h) Ethnic minority groups	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	i) Children in schools	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	j) Mental well-being in the workplace	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	k) Within the general practice workplace	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
190	Health authorities should ensure that there are sufficient numbers of Section 12 trained doctors available , approved under the **1983 Mental Health Act**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	HEALTH AUTHORITY: ORGANISATION OF CARE (continued)	Validity *	Clarity #
191	Health authorities, in consultation with PCGs and local authorities, should assess health improvement programmes for evidence of activities to:		
	i). promote good mental health in schools, workplaces and neighbourhoods	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	ii). promote good mental health for individuals at risk	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	iii). promote good mental health for groups who are most vulnerable	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	iv). combat discrimination against the social exclusion of people with mental health problems	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
192	Health authorities, in consultation with PCGs and local authorities, should develop policies with long-term perspectives that reflect flexibility and sustainability in a managed mental health system	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
193	There should be formal and effective links between health and local authorities and other agencies to ensure the planning and provision of integrated care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	HEALTH AUTHORITY: CARE PROGRAMME APPROACH	Validity *	Clarity #
194	Each health and social services mental health provider must jointly identify a Lead Officer with authority to work across all agencies to deliver an integrated approach to the Care Programme Approach and Care Management	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
195	Local authorities social services departments should ensure that all **carers** who provide regular and substantial care for a person on the Care Programme Approach should :		
	a) have an assessment of their caring, physical and mental health needs repeated on an at least annual basis	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) have an assessment of their caring, physical and mental health needs repeated on an as required basis	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c) have their own written care plan, which is given to them and implemented in discussions with them	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

	HEALTH AUTHORITY: PRESCRIBING	Validity *	Clarity #
196	Practice and hospital staff should adhere to a commonly agreed (restrictive list) **prescribing formulary**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
197	Practices should not be penalised for over-spending the prescribing budget if prescriptions are clinically indicated/necessary	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	HEALTH AUTHORITY: EVALUATION	Validity *	Clarity #
198	The performance of general practices should be assessed against specified targets as set out in the National Service Framework.	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
199	The implementation of service level agreements should be monitored annually by health authorities	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
200	Protocols should be agreed and implemented at the Health Authority level for the management of :		
	a) suicide/risk assessment	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) anxiety/panic attacks	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c) substance misuse	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d) referral to specialist care	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e) bereavement	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	f) depression	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	g) post-natal depression	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	h) medication management for those on long-term anti-psychotic medication	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	i) treatment of severe and enduring mental illness	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	j) eating disorders	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	k) dealing with **carers** of patients with mental health conditions	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	l) dementia	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	m) somatization disorders	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	n) **gender identity disorders**	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
201	Health authorities should		
	a) set up a local implementation team, led by one person, to identify and engage key individuals, groups and agencies to develop local delivery care plans	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) these plans should be agreed with regional offices of the NHS Executive, and place mental health as a cross cutting priority for all NHS and social care organisations	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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	HEALTH AUTHORITY: EVALUATION (continued)	Validity *	Clarity #
202	Practices should be offered financial incentives to meet externally set quality standards; such as those set by Health Improvement Plans, Regional Health Authority Mental Health Development Plans or the National Service Framework	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
203	Health authorities, in consultation with PCGs and local authorities, should assess the level of performance of local mental health services by measuring:		
	a) the psychological health of the population as measured by the National Psychiatric Morbidity Survey	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	b) the level of suicide rates	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	c) the psychiatric emergency readmission rate	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	d) the prescribing of antipsychotics	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
	e) the integration of Care Programme Approach and care management	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
204	Health authorities should use the NHS minimum mental health dataset to review policy	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

	HEALTH AUTHORITY: TRAINING	Validity *	Clarity #
205	Health authorities should provide mental health training as part of the continuing professional development of primary health care teams	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9
206	HAs and PCGs should work together to support primary care staff through continuing professional development	1 2 3 4 5 6 7 8 9	1 2 3 4 5 6 7 8 9

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GLOSSARY

Term	Definition
Advocacy service	The communicating of expressed needs on behalf of a patient to service providers or other community agencies - statutory or non-statutory.
Agoraphobia	Fear of open spaces, closed or crowded spaces, shopping, crowds, travelling on public transport and social situations which may be associated with panic.
Annual skills audit	A process which attempts to define by questionnaire or interview or observation; specific skills possessed, skills deficits, priorities for training
Annual written business plan	A policy document compiled by all partners involved in the statement of the partnership which sets out a vision for the practice – to look at where the practice is now, where it wants to be in the short and long term and how it is going to get there. The business plan tends to focus on achievement, stating agreed aims and objectives and including measurable targets and standards.
By referral off site	Health professionals or services are not available at the patient's own practice but they are available at other sites (i.e. hospitals, other general practices)
Care programme approach	Health professionals must develop, along with local authority social services departments, individual packages of care (care programmes) for all inpatients about to be discharged from hospital and all new patients being treated by specialist psychiatric services. Care programmes may range from a single health professional undertaking assessment and monitoring for patients with less severe mental health and social needs, to complex assessments and treatment involving several staff.
Carer	A relative or friend of a patient with a mental health problem who is actively involved in their care

Clinical governance	A framework through which primary care groups will be accountable for continuously improving the quality of their services
Community mental health teams	Multidisciplinary team consisting of a range of professionals (drawn from the following: community psychiatric nurses, psychologist, social worker, occupation therapist, support workers, psychiatrist) who provide care for people with mental health problems in the community
Concordance	Agreement with a form of or plan for treatment
Core team	Permanent, essential members, e.g. general practitioners, practice managers, practice nurses and receptionists
Counselling	A form of psychological treatment generally used for less severe problems (e.g. mild to moderate depression) over the shorter term (6-12 sessions on average). It involves a professional, helping relationship whereby a trained counsellor aims to enable the patient to explore his or her concerns and problems of an emotional or interpersonal nature, and to find ways of resolving them. The counsellor actively listens and aims to (a) support the patient through crises and while they attempt to overcome their difficulties, (b) help the patient identify, explore, understand and clarify their feelings and experiences, as well as possible solutions, and (c) make meaningful choices and effect self-determined changes so as to resolve their problems, relieve their feelings of distress, and find more satisfactory and resourceful ways of living.
Counsellor	A person who enters into a therapeutic relationship using specific skills, including listening and responding, which enables the patient, through exploration, to gain understanding and thereby achieve resolution of problems. Counsellors have a wide variety of backgrounds and training
Duty professional	Mental health professional who is ‘on duty’ to deal with emergencies

Eating disorders	Includes anorexia nervosa, where severe weight loss occurs, and bulimia nervosa which both involve fear of fatness with under and over eating
Evidence based therapies	Trained in the range of therapeutic approaches which reflect best available evidence and are used in mental health care (excluding medication and other medical technologies)
Fast tracking service	Rapid access which bypasses routine system
Gender identity disorders	Transvestitism and transexualism
Genetic counselling	Counselling specifically relating to the hereditary implications of illness
Immediate access	Rapid access in crisis: 'immediate' will be defined by the nature of the crisis or emergency and may vary from being seen within the hour to the same day.
Initiated by the GP	Appointment arranged at the request of the general practitioner
Integrated care plan	A plan of care which fully integrates all aspects of care delivery which a clear delineation of which professional is to provide which specific aspect care. This should include reference to the role of primary care, and views of the user and carer
Keyworker	A named primary health care professional who has a defined responsibility for a patient, usually with some responsibility for service provision and monitoring of care
Link-worker	Named mental health professional from specialist mental health services who liaises with practice.

Local resource directory	Directory of resources available locally for people with mental health problems which will include statutory, non-statutory and voluntary sector services and self-help groups with contact information
1983 Mental Health Act	Current mental health legislation
Mental illness	A range of diagnosable mental disorders (that excludes learning disabilities and personality disorder)
Mental illness with genetic implications	Mental illness which may be hereditary
On site	Health professionals or services are available at the patient's own practice
PACT data	Prescribing And Cost data available from the Prescription Pricing Authority on the levels of prescribing per practice by therapeutic category.
Patient[1]	All persons registered with the practice (practice population)
Patient[2]	A person who is experiencing a mental health problem and is receiving mental health care from their general practitioner or other mental health care services
Practice nurse	A registered general nurse who works in a general practice surgery and is normally employed by the GP. The role and duties can vary – in addition to delivering nursing care, practice nurses are likely to be involved in disease prevention (e.g. screening), health promotion and education, and health maintenance. They may also take responsibility for running clinics including those for chronic disease management, and assisting the GP with minor surgical procedures. (HAS)

Prescribing formulary	A restricted list of prescription drugs that health professionals voluntarily agree to use and are expected to select the drugs that they will use
Primary Care Group (PCG)	Organisations which bring together family doctors and community nurses
Primary Care Team	All persons who are attached to/ work within a single practice
Prompted templates	Electronic forms/checklist designed to ensure comprehensive recording of information by prompting health professionals to undertake specific procedures or ask specific questions for a patient with a given diagnosis in order to fulfil criteria set out in a clinical guideline.
Protected time	A temporary arrangement which is initiated by an organisation to cover the replacement costs for an employee to attend a training course. This may also include time engaged in informal study necessary for successful completion of the training course.
Register	An information system to identify and register all severely mentally ill people in a population
Screen	Utilisation of patient's self-report questionnaires to detect mental health problems
Secondary psychiatric services	Hospital or community based and staffed services i.e. not including primary care staff
Section 12 trained doctor	A doctor approved under section 12 of the mental health act who is recognised as having specific experience in assessing people with mental health problems. Can be either a GP or psychiatrist

Self-care plan	A plan, devised by the health professional(s) and patient, detailing action to be taken by the patient to care for their own condition. This may include medication, action to take in a crisis and when to consult a general practitioner or contact any health professional
Self-help groups	Mutual help groups, which enable members to help each other through support, problem-solving and advocacy. Self help groups aim to provide members with peer support as well as to gain strength from shared experiences.
Severe and enduring mental illness	Diagnosis of psychotic illness; inability to care for oneself independently, inability to sustain relationships; inability to sustain work; currently displaying florid symptoms or suffering an enduring condition; frequent crises leading to hospital admissions; significant risk to own safety or the safety of others; dementia; severe neurotic illness; personality disorder; development disorder; schizophrenia; bipolar disorder; paranoid disorder of at least one years duration.
Somatisation	The expression of psychological problems through physical symptoms
Specific training and support for depot injections	A (one day) training course which enables practice nurses to detect changes in mental state, problems with or caused by the medication, and other care needs, and bring them to the doctor's attention (Kendrick *et al*, 1998)
Specific training in mental health	Either 6 months training in psychiatry (not necessarily a hospital job in psychiatry) or attendance at a brief training course in mental health problems as they present in primary care. This may form part of a postgraduate personal learning plan.

Specific training in the recognition and management of post natal depression	A brief training course in the recognition and management of post-natal depression, which will include some training in appropriate counselling and when/if referral to the GP or discussion with a mental health worker such as a CPN is necessary.
Take the lead	Takes responsibility for co-ordinating care.
Trusts	Organisations which provide hospital or community care services
User groups	Support groups for persons who are/have experienced a mental health problem and have used mental health services. Persons belonging to a user group may have accessed such services independently or may have accessed them through their GP or other professionals from statutory organisations. Most groups are involved in consultation and monitoring processes around service provision and practice, and many groups are directly concerned in the creation of advocacy schemes.