MENTAL HEALTH QUALITY DASHBOARD 2017: QUARTER 3

The Mental Health Strategy which launched in 2015 committed to producing a set of measures describing the quality and performance of local services. As a result, a series of workshops were held in 2016 and the Mental Health Quality Report for 2016 and accompanying dashboards were developed and published in May 2017. The Quality Report will be published on an annual basis, with the dashboards being reviewed and updated each quarter.

Attached are the Mental Health Quality Dashboards for Q3 2017, which cover the following areas:

- **Population Outcome Indicators**: This section describes what Islanders think of their own mental health and how they access services.

- **Prevention & Early Intervention:** This focuses on promoting mental health and having services that are able to respond in a timely way to service users of all ages.
    1. Older Adult Primary Mental Health Care Team (PCMHT) – 2 out of 4 GP clusters are live in Q3.
    2. 2 Primary Mental Health Workers (PMHWs) commenced employment in Q3 to complement and extend the overall offer of early intervention services available for children and young people. The CAMHS Clinical Psychologist has been recruited in Q3 and will commence employment in 2018.
    3. Connecting with People training programme - Investigations are taking place as to how to expand the programme and incorporate a community training programme targeting community colleagues.

- **Service Access, Care Co-ordination and Continuity of Care:** This section consists of a set of measures looking at the timeliness and effectiveness of services.
    1. A 6 month Community Triage pilot will go live in October and the Listening Lounge previously the 'Crisis Centre' is in detailed planning and anticipated to begin in early 2018.
    2. Mental Health Estates feasibility undertaken by IBI Architects to identify a suitable site option for an overall mental health inpatient and outpatient facility is ongoing in preparation for a Strategic Outline Business Case.

- **Social Inclusion & Recovery:** This considers social factors such as housing, employment and isolation, and how they can influence mental health and well-being. It also considers the work of the Recovery College.
    1. Jersey Recovery College is progressing with its third and final semester of the year. It appointed a fourth Peer Trainer in Q3 and is continuing to grow the courses it offers and the number of students it can support.
    2. Mental Health Network; Jersey Recovery College have agreed to be provider to undertake the project to establish the Network.

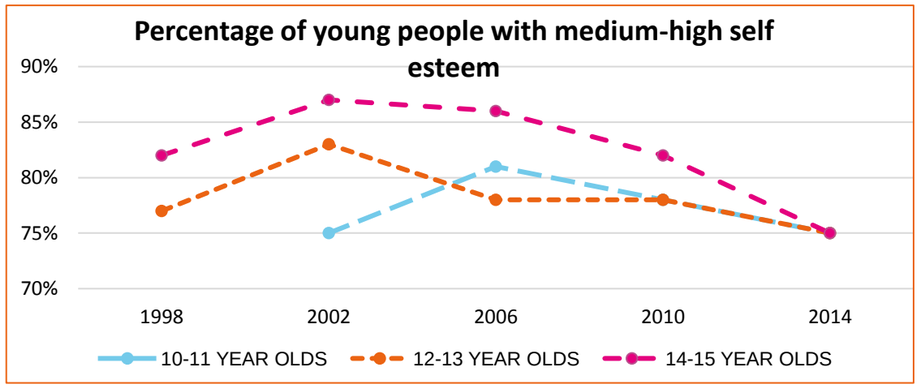
- **Quality Improvement, Leadership & Innovation:** Reported here are measures relating to value for money and quality, as well as data on sickness and absence rates and vacancies. Lastly, consideration is given to wider socio-economic issues which can have an effect on mental health.
    1. Engagement Day was held, the quality report and dashboard was published in May 2017.
    2. The collection of data has been submitted to the NHS Benchmarking Network in Q2 and the final report will be available in Q4.

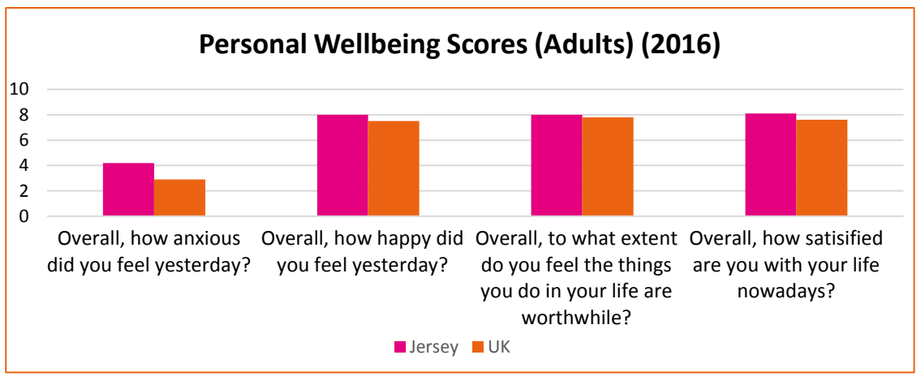
Towards the end of the document is a table of data descriptions explaining where the data is sourced from and what it tells us. Further information on the development of the dashboard, details around the selection of each of the measures and plans to further develop the dashboard are found in the 2017 Mental Health Quality Report, available at https://www.gov.je/government/pages/statesreports.aspx?reportid=2835.

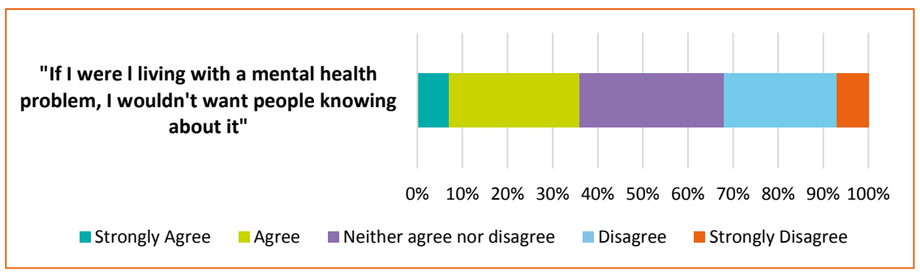
POPULATION LEVEL

Publish Date:
November 2017

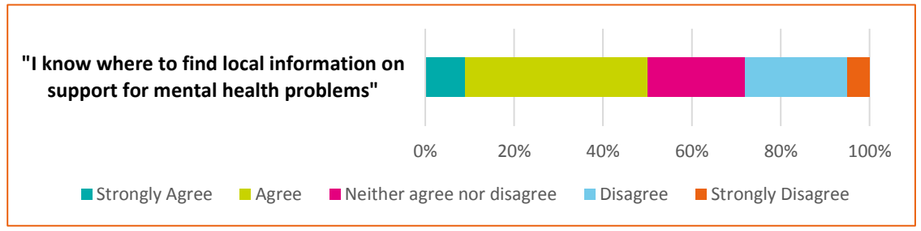
ISLANDER'S PERCEPTION OF MENTAL HEALTH



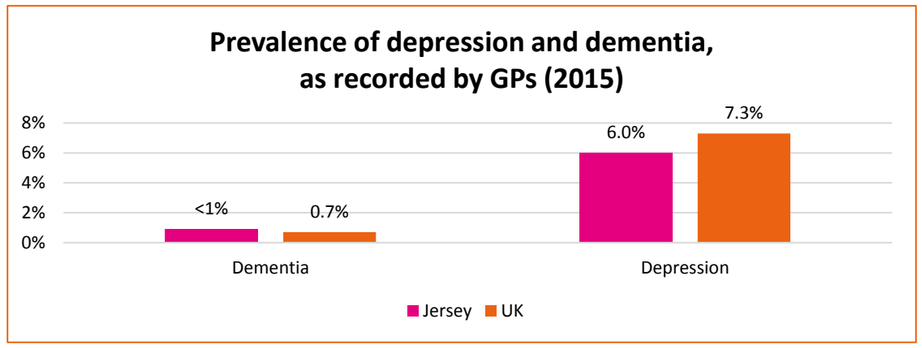


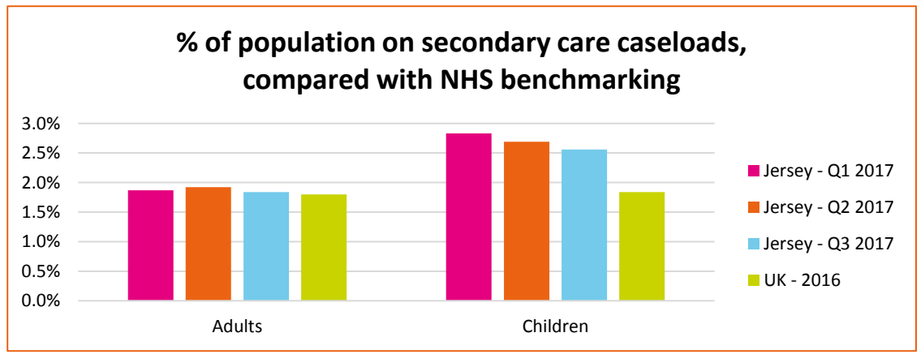


SIGNPOSTING TO LOCAL SERVICES



LEVEL OF NEED BEING MET BY SERVICES



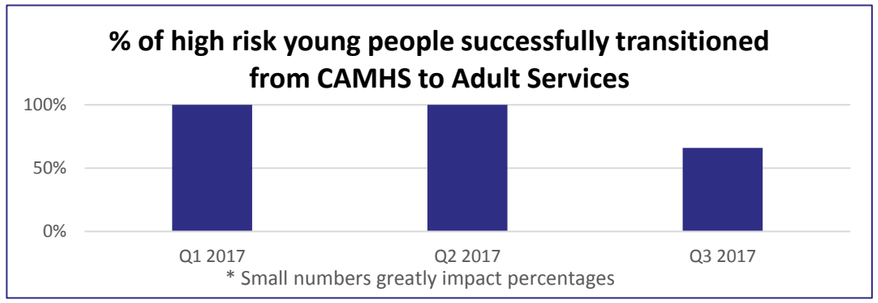


PREVENTION AND EARLY INTERVENTION

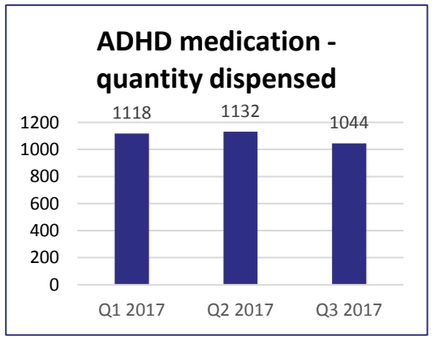
Publish Date:
November 2017

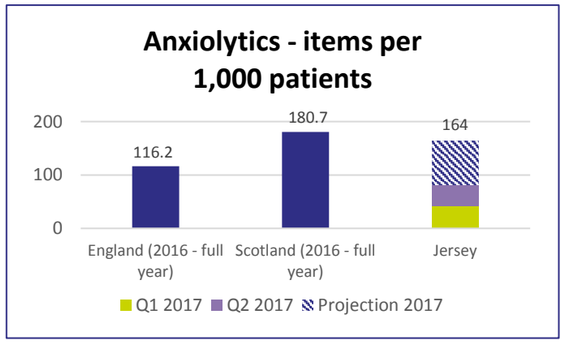
PROMOTING MENTAL HEALTH IN CHILDREN AND YOUNG PEOPLE

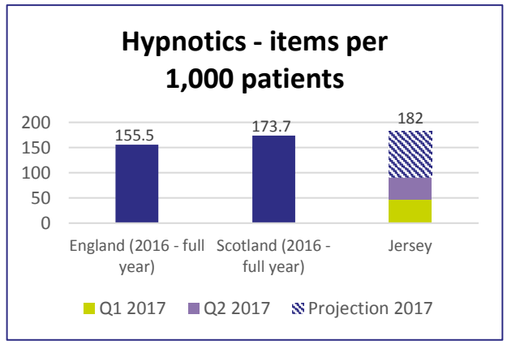
June 2017 saw the introduction of two new Primary Mental Health Workers (PMHW) to the Educational Psychology and Well-being Team, as part of a joint initiative between Inclusion and Early Intervention and CAMHS. All Jersey schools now have a link PMHW.
A telephone consultation line has been introduced, to offer weekly support to any professional/member of school staff who wants to discuss mental health queries, and a weekly CAMHS triage clinic has been in operation since the summer, offering consultation opportunities to families to explore the best form of agency support and streamline intervention, when appropriate.

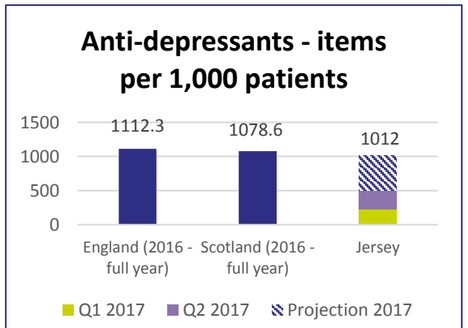


PRESCRIBING ACTIVITY

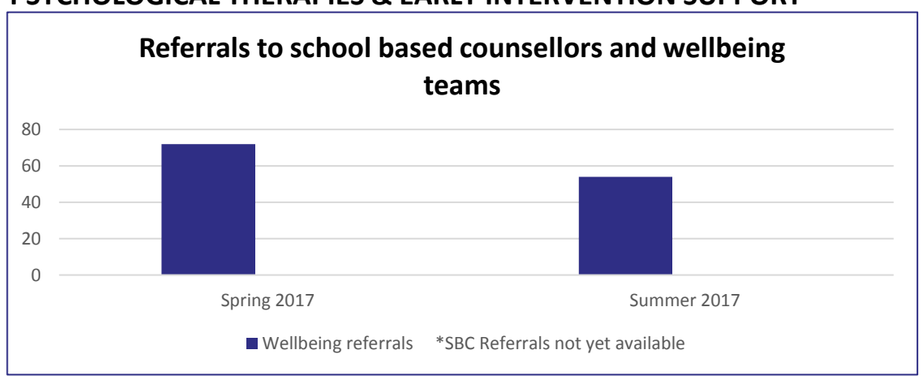


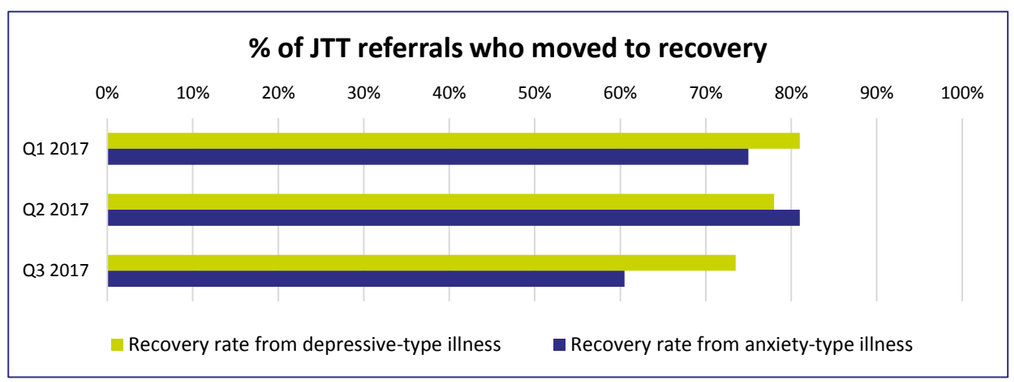






PSYCHOLOGICAL THERAPIES & EARLY INTERVENTION SUPPORT

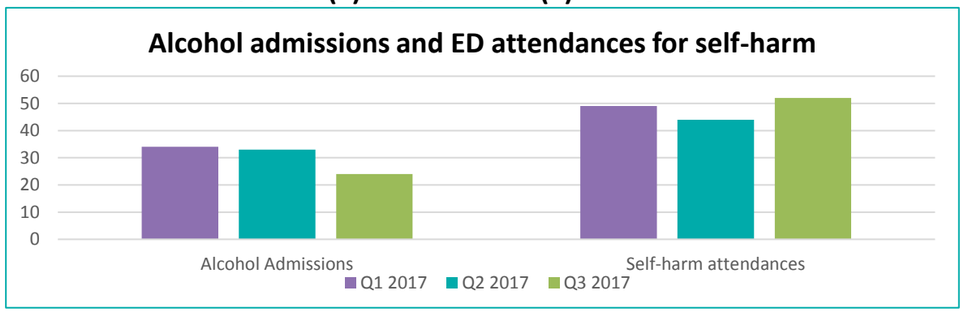




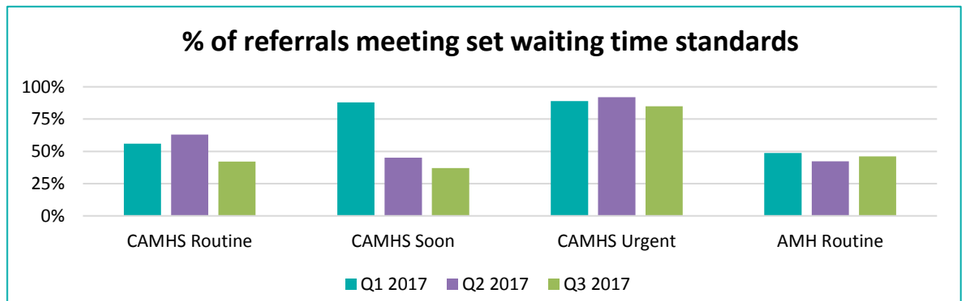
SERVICE ACCESS, CARE CO-ORDINATION AND CONTINUITY OF CARE

Publish Date:
November 2017

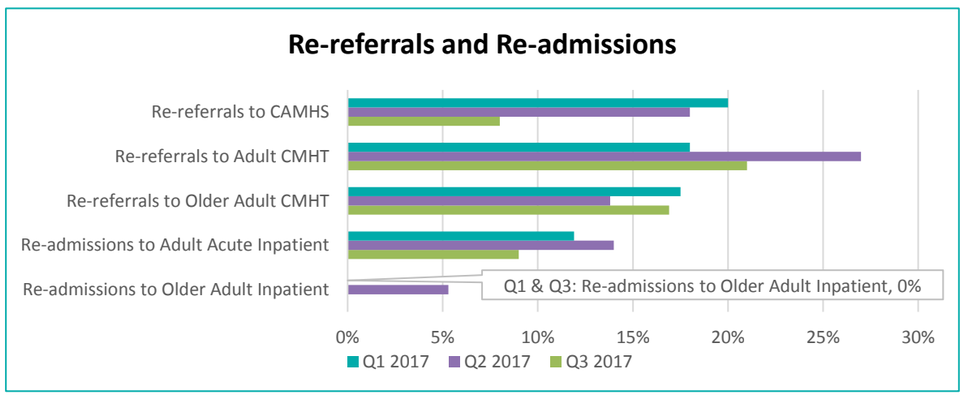
REDUCING THE RISKS OF (1) SUICIDE AND (2) HARM FROM ALCOHOL



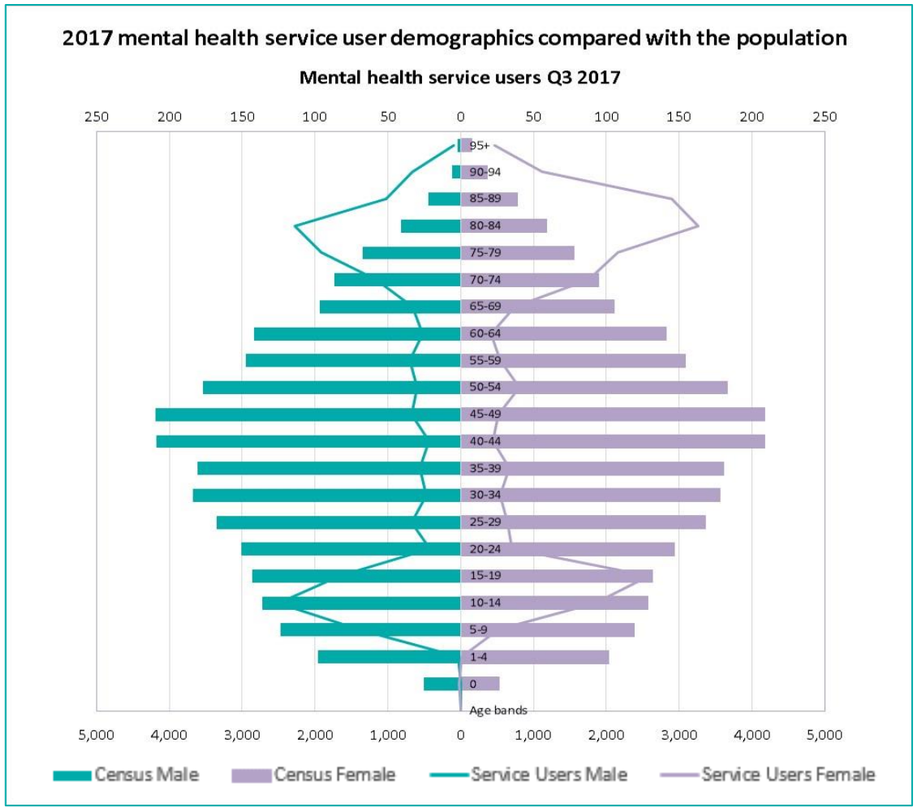
TIMELY ACCESS

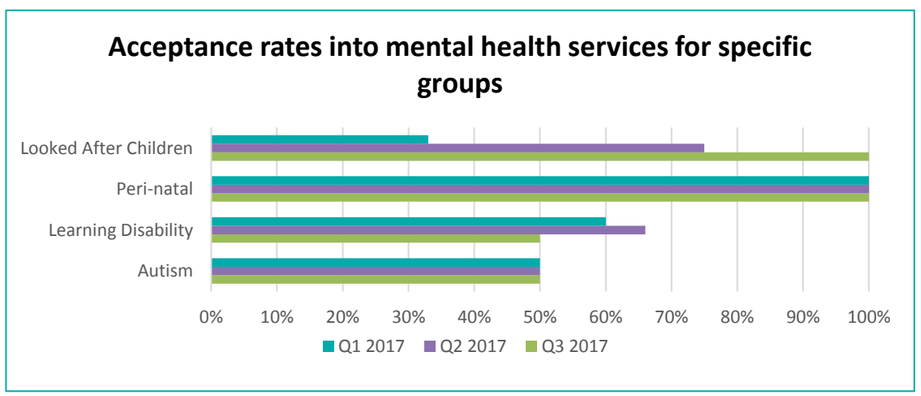


SAFER SERVICES



ACCESS FOR ALL



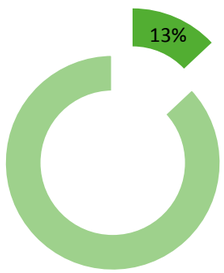


SOCIAL INCLUSION AND RECOVERY

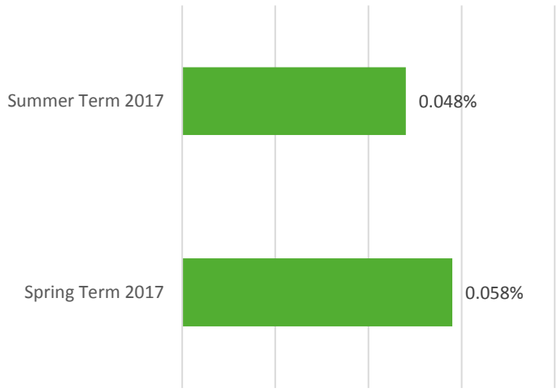
Publish Date:
November 2017

SOCIAL ISOLATION

% of 16-24 year olds not in Education, Employment or Training (NEET) (2016)

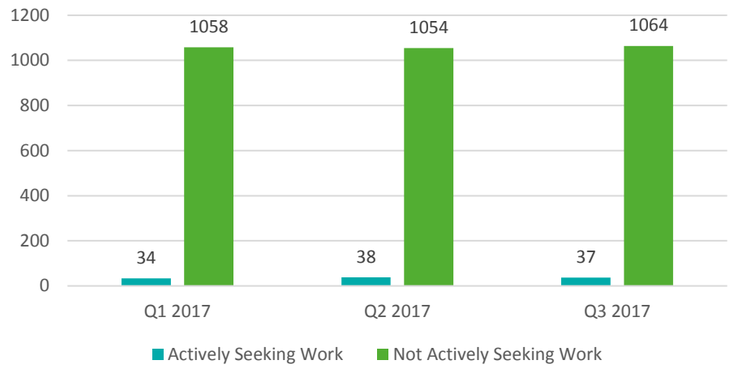


School days lost to exclusion



EMPLOYMENT

Long Term Incapacity Allowance claims with a mental health element



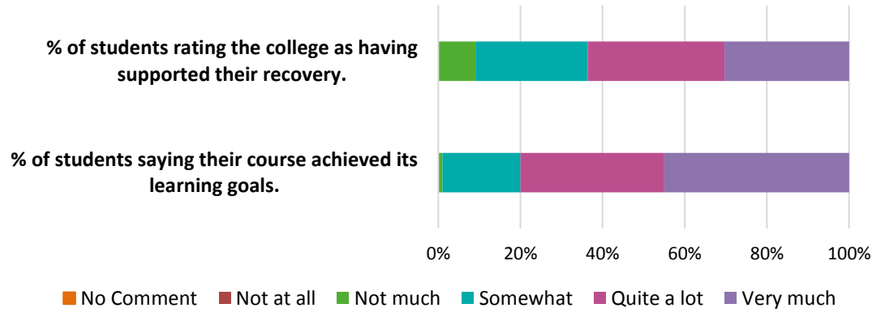
ACCOMMODATION

8 "Staying Put" Assessments have been completed to date in 2017

In November 2016, Environmental Health and Social Security introduced the "Staying Put" initiative. This is a free service for tenants aged over 60 who live alone in St Helier (with planned roll-out to other parishes), and are in receipt of housing benefit. The aim is to provide support for any housing quality concerns such as safety and heating, and to share information about local services and make referrals where appropriate. Letters have been sent to all those meeting the criteria, and all requests forwarded to Environmental health.

EFFECTIVE RECOVERY

Recovery College Outcomes (Semester 2 2017)



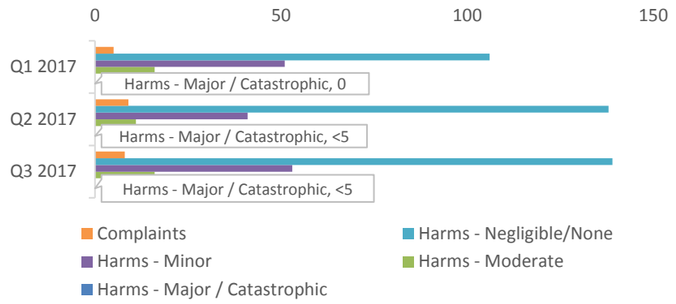
In it's second semester in Summer 2017, 106 people attended the Recovery College.

Publish Date:
November 2017

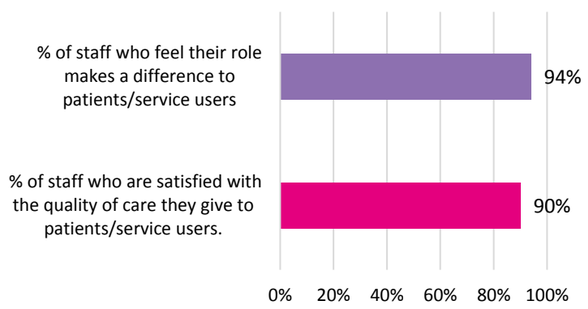
QUALITY IMPROVEMENT, LEADERSHIP AND INNOVATION

VALUE FOR MONEY & QUALITY

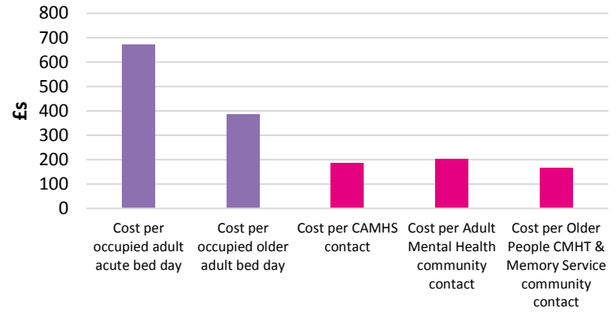
Safety Incidents & Complaints 2017



Staff Satisfaction 2015

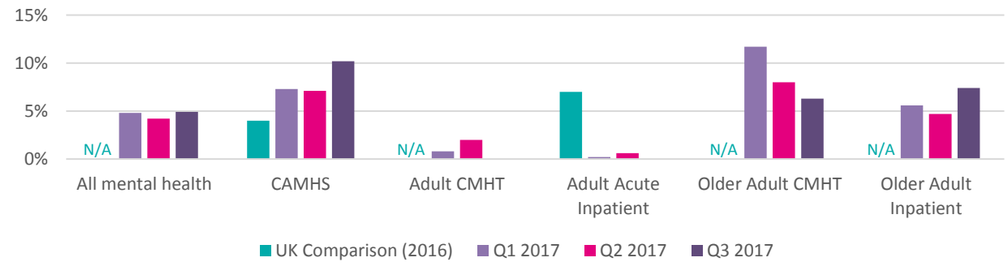


Value for Money 2016

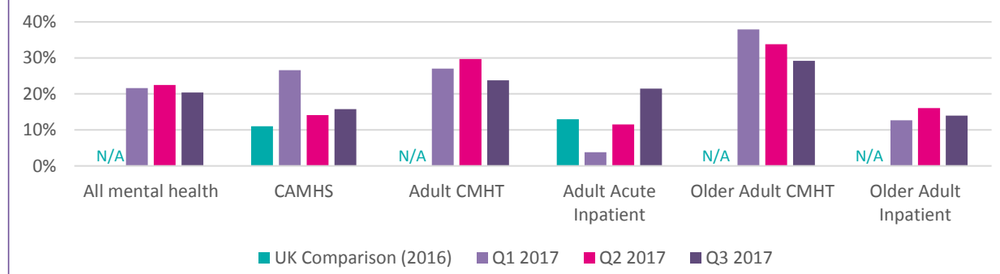


SYSTEM-WIDE FUNCTIONING

Sickness & Absence Rates

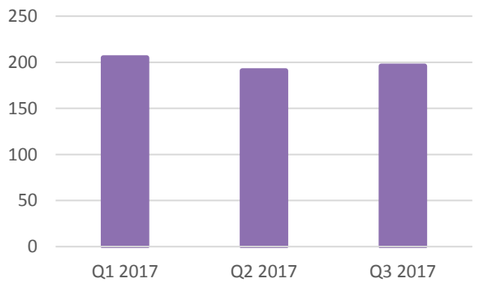


Staff Vacancies

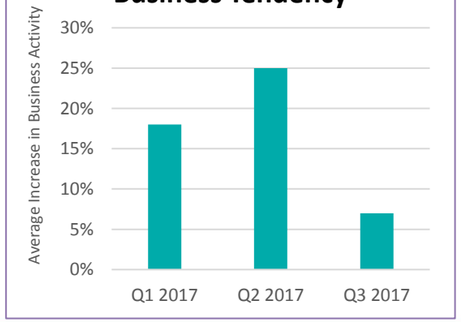


WIDER SOCIO-ECONOMIC CONTEXT

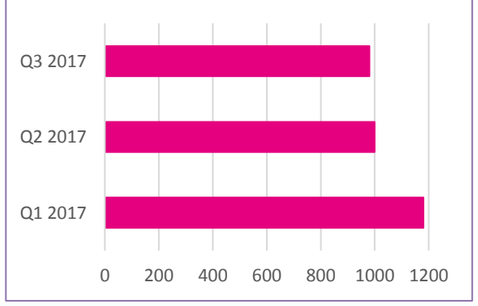
Domestic Violence Incidents



Business Tendency



Actively Seeking Work



Unemployment

POPULATION LEVEL

Indicator	Measure	Source	What does it tell us?	What doesn't it tell us?
Islander's perception of mental health	% of young people with medium-high self-esteem	A Picture of Health Jersey 2014	This measurement is derived from the responses to a set of nine statements taken from a standard self-esteem enquiry method developed by Denis Lawrence (Lawrence, 1981). The scale is based on social confidence and relationships with friends. Local data has been routinely collected every four years, with the last collection in 2014.	Data collection is every four years. We do not have UK data to compare with
Islander's perception of mental health	Personal wellbeing scores	Jersey Health & Life Opportunities Survey 2015	The Office for National Statistics have been using the four personal wellbeing questions since 2011. Locally, this data was collected for the first time in September/October 2015, and will be included in the Jersey Opinions and Lifestyle Survey 2017.	The question was asked for the first time in 2015, and as such no trend information is available.
Islander's perception of mental health	% of people who would not want others to know if they had a mental health problem	Jersey Opinions and Lifestyle Survey 2016	Respondents were asked to indicate the level to which they agreed with the following statement: "If I were living with a mental health problem, I wouldn't want people knowing about it". This indicates the level of stigma associated with mental health issues locally.	The question was asked for the first time in 2016, and as such no trend information is available.
Signposting to services	% of people who know where to find information about local mental health services.	Jersey Opinions and Lifestyle Survey 2016	Respondents were asked to indicate the level to which they agreed with the following statement: "I know where to find local information on support for mental health problems". This explores local knowledge on which support services are available for mental health issues.	The question was asked for the first time in 2016, and as such no trend information is available.
Level of need being met by services	% of people with mental health problems identified in primary care versus expected prevalence	2016 Health Profile for Jersey	The local data is for 2015 and is taken from the GP Central Server (EMIS web). Provisional disease prevalence is available for specific medical conditions outlined as part of the Jersey Quality Improvement Framework. We can currently consider only depression and dementia, and these numbers have been rounded to the nearest 100 to account for data quality concerns. From January 2017, GPs are being asked to maintain a register of patients with schizophrenia, bipolar affective disorder and other psychoses, and patients on lithium. Public Health England data is for 2014-15 financial year.	We are currently not able to determine the percentage of people with mental health problems identified in primary care to compare with expected prevalence, although as the GPs recording becomes more consistent to satisfy JQIF, we will be able to report on a wider range of conditions.
Level of need being met by services	% of people seen in secondary care versus expected prevalence	Care Partner - the Community and Social Services IT system.	The numbers used here are based on active mental health service caseloads on 30/09/17. NHS benchmarking comparison data is as at 31/03/16. In future it is anticipated that this will be broken down further to take into account expected prevalence of specific mental health diagnoses. Diagnosis is currently insufficiently recorded to allow for this.	Workshops identified that it would be of interest to break the data down into specific age ranges, but we do not have comparison data available from the NHS benchmarking.

PREVENTION AND EARLY INTERVENTION

Indicator	Measure	Source	What does it tell us?	What doesn't it tell us?
Promoting mental health in children and young people	Number of school based staff accessing mental health awareness training	Education Department	There are a range of mental health training opportunities available for school based staff, which are run both internally and externally.	Data has not been captured centrally, so it is anticipated that a greater number of course are being attended. A training records system is now being developed which will be available towards the end of 2017.
Promoting mental health in children and young people	% of high risk young people successfully transferred into adult services.	Care Partner - the Community and Social Services IT system.	CAMHS have identified high risk clients who reached or were over the age of 18 who they attempted to transfer to Adult Mental Health. This list has then been compared against Adult Mental Health data, and where they have had two or more contacts with Adult Mental Health they are considered to be successfully on the caseload.	This does not capture any individuals who were discharged from CAMHS and later sought support from Adult Mental Health. A number of individuals would have been discharged from CAMHS and referred to an alternative service e.g. YES, JTT, university services, and there is no way to track these individuals. The figures on this indicator can be highly affected by small numbers causing spikes or dips in the transition percentages.
Prescribing Activity	Number of items of ADHD medication per 1,000 population	HSSD Pharmacy IT system	Number of packs of medication dispensed (not the number of patients or the number of prescriptions).	
Prescribing Activity	Number of anti-depressant items prescribed per 1,000 population	Social Security data	This measure captures the number of anti-depressant items prescribed in primary care. The projection for Q3 and Q4 2017 is based on the average per Q1 and Q2 2017.	The use of item numbers can be misleading as one item may be for any number of doses. The reporting for Q3 is not available at the time of this dashboards publication, and will be included in the Q4 dashboard.
Prescribing Activity	Number of items of anxiolytics prescribed per 1,000 population	Social Security data	This measure includes anxiolytics (only benzodiazepines). The projection for Q3 and Q4 2017 is based on the average per Q1 and Q2 2017.	The use of item numbers can be misleading as one item may be for any number of doses. The reporting for Q3 is not available at the time of this dashboards publication, and will be included in the Q4 dashboard.

Prescribing Activity	Number of items of hypnotics prescribed per 1,000 population	Social Security data	This measure includes hypnotics (benzodiazepines and non-benzodiazepines (sometimes known as z-drugs). The projection for Q3 and Q4 2017 is based on the average per Q1 and Q2 2017.	The use of item numbers can be misleading as one item may be for any number of doses. The reporting for Q3 is not available at the time of this dashboards publication, and will be included in the Q4 dashboard.
Psychological Therapies and Early Intervention Support	Outcome measures for Jersey Talking Therapies	Local data collection	These measures use scores obtained from the Personal Health Questionnaire (PHQ) for depressive-type illnesses and Generalised Anxiety Disorder (GAD) assessments. Scores from these tests indicate whether an individual has severe enough symptoms to be regarded as a clinical case. An individual moves to recovery if they were defined as a clinical case at the start of their treatment and not a clinical case at the end of their treatment. The recovery rate is the percentage of eligible referrals who move to recovery.	JTT recovery data is not directly comparable with UK equivalent, IAPT (Improving Access to Psychological Therapies) as the services offered differ. The local recovery rate will be monitored across time to ascertain any trends.
Psychological Therapies and Early Intervention Support	Number of new referrals accepted to school based counsellors.	Local data collection	This data is collated at the end of the academic year, and will be available for the next version of the dashboard.	It is anticipated that all schools will be able to report school counselling data in the future.
Psychological Therapies and Early Intervention Support	Number of new referrals accepted to school wellbeing teams.	Local data collection	The wellbeing team works in primary schools, providing support for pupils with low-level emotional and wellbeing needs.	

SERVICE ACCESS, CARE CO-ORDINATION AND CONTINUITY OF CARE

Indicator	Measure	Source	What does it tell us?	What doesn't it tell us?
Reducing the risks of suicide and harm from alcohol	Alcohol admissions to hospital	Trakcare	This shows all admissions to in-patient wards (excluding DSU and Aubin endoscopy suite) where an alcohol-related condition was the primary diagnosis.	The data does not include any secondary diagnoses, so for example if an individual sustained injuries as a result of a fall whilst intoxicated, the injuries would form the primary diagnosis and patient episode would not be included here.
Reducing the risks of suicide and harm from alcohol	ED attendances for self-harm	Trakcare	This shows all attendances at ED where the patient's diagnosis category was recorded as attempted suicide or deliberate self-harm. In addition, some individuals had a diagnosis category of psychiatric, where the more detailed ED Diagnosis field showed that some self-harm had occurred (for example where the main concern was psychiatric, but lacerations were also recorded)	Anecdotally, it's reported that the actual numbers for self-harm attendances at ED may be higher than those captured in the data and it is anticipated that numbers may increase as data quality improves.
Timely Access	% of referrals meeting set waiting time standards	Local data collection	CAMHS referrals are assigned to one of three urgency categories: urgent (to be seen within 48 hours), soon (to be seen within 14 days) and routine (to be seen within 4 weeks). For adult mental health, when a referral is received, an opt-in letter is sent to the individual concerned. The ambition is for the first appointment to occur within 10 working days of the opt-in form being returned.	
Safer Services	Re-referrals and re-admissions	Trakcare and local data collection	Emergency re-admissions to inpatient units are counted as any re-admissions within 30 days of discharge. For CAMHS and adult mental health community teams, re-referrals are within 12 months. At present, the older adult community mental health team re-referrals include any re-referral, regardless of the length of time since their last involvement with the service. Data collection methods are being reviewed to enable us to report on re-referrals within 12 months.	
Access for all	Gender and age profiles of accepted patients against overall population	Care Partner - the Community and Social Services IT system.	This chart plots the age and gender of all mental health service users at the end of Q3 2017 against the population pyramid. Where the lines extend out beyond the bars, this highlights an age/gender mix that requires more support for mental health problems. The Older Adult accepted patients has grown in the last quarter, this is likely due to the new OA Primary Care team acceptance numbers and their growing caseload. For Q3 the maximum value for the Service Users axis (axis at top of graph) has been increased from 150 to 250, to better line up with the census axis.	We are unable to include ethnicity in this section at present, as the data is not routinely collected.

Acceptance rates into mental health services for specific groups	Acceptance rates for autism into mental health services	Care Partner - the Community and Social Services IT system.	This measure looks at all any individuals known to the Jersey Adult Autism Service (JAAS) who were referred to the Adult Mental Health team.	There may be a range of reasons why a referral is not accepted, for example the referral may have been inappropriate, or the individual may have been adequately supported within JAAS.
Acceptance rates into mental health services for specific groups	Acceptance rates for learning disability into mental health services	Care Partner - the Community and Social Services IT system.	This measure looks at all any individuals known to the Learning Disabilities team (C&SS) who were referred to Adult Mental Health.	There may be a range of reasons why a referral is not accepted, for example the referral may have been inappropriate, or the individual may have been adequately supported by the C&SS Learning Disabilities team.
Acceptance rates into mental health services for specific groups	Acceptance rates for perinatal into mental health services	Care Partner - the Community and Social Services IT system.	This measure considers everyone who was referred to adult mental health, where the reason was "perinatal", and determines the proportion of individuals accepted into the service	Perinatal clients may be accessing other teams, such as JTT or CAMHS, but it is not possible to report on this activity.
Acceptance rates into mental health services for specific groups	Acceptance rates for Looked After Children into mental health services	Local data collection	This measure counts any Looked After Children who were referred to CAMHS.	

Indicator	Measure	Source	What does it tell us?	What doesn't it tell us?
Social Isolation	% of 16-24 year olds not in education, employment or training (NEET)	Census 2011	This is calculated from the census data in 2011, which recorded everyone's employment status for those aged 16 and above. Work has commenced to calculate the NEET rate for the cohort who left school in summer 2016 (at compulsory school age and after A-Levels or equivalent). This method follows UK methodology and tracks sustained destinations for a true picture of whether an individual is NEET. The data will be published in autumn 2017.	This method only takes account of those in full time education, whereas official UK NEET figures prepared by the Office for National Statistics would allow for those in part-time education or training to be counted as in education or training. Similarly, the ONS would count someone waiting to take up a course, or having finished a course in the last 4 weeks as being "in education". The local census asks for employment status on census day, whereas the ONS method would count anyone who did any paid work in the previous week as being in employment.
Social Isolation	% of school days lost to exclusion	Education Department data	These numbers incorporate primary, secondary and special States schools. Exclusions are counted in sessions, where there are two a day, morning and afternoon. The number of sessions excluded are divided by the total sessions to give an exclusion rate.	Alternative provision is not included here, and the final half term of year 11 is also excluded as the majority of that term is spent on study leave.
Employment	% of adults on long term incapacity award where the primary reason is mental health	Social Security data	A defined list of mental health ailments was agreed and compared against the LTIA database in order to calculate the proportion of adults in receipt of LTIA where the primary reason is mental health.	LTIA is a benefit based on a work history. To make a claim (as with general "sickness" benefit STIA) you need to have paid your contributions in the relevant quarter (i.e. been working enough to pay your social Security contributions, roughly six months before claiming), so if you were out of work or too young to have a work history you won't be able to claim LTIA. This is likely to skew the demographic of people claiming this benefit. In Jersey there is a strong link between being registered as ASW and claiming Income Support. So, people who don't qualify for Income Support on grounds of household income, or residency, are much less likely to be registered as ASW, although if they don't

				qualify on grounds of household income they may be more likely to get LTIA because they might be more likely to have been working regularly. This means that the crossover between these two benefit areas is more complicated than can be expressed through this data. Social Security does not hold data on the numbers of people who are seeking work but not registered with us or claiming Income Support.
Accommodation	Uptake of "Staying Put" assessments	Environmental health data collection	"Staying Put" is a joint venture between environmental health and social security. It seeks to identify and assess the quality of housing that vulnerable people are living in and provide advice to help rectify problems. It focuses on people living alone in privately rented accommodation in St Helier, and who are in receipt of housing benefit.	
Effective Recovery	Number of people attending the Recovery College	Recovery College attendance register	The data reported here is for the second semester of 2017.	
Effective Recovery	% of people attending Recovery College who meet their personal attainment goals	Recovery college feedback	This measure has been split into two areas, based on the end of course feedback forms. 1) The % of each answer given by students when asked if their course achieved it's learning goals. 2) The % of each answer given by students when asked if they believed the college has supported their recovery, particularly when asked if their course has helped them feel more supported and connected to other people.	

Indicator	Measure	Source	What does it tell us?	What doesn't it tell us?
Value for Money & Quality	Cost per occupied bed day	HSSD Finance figures	The cost per occupied bed day is based on 2015 data, and this will be calculated annually. It is anticipated that a new Person Level Information and Costing System will enhance the accuracy of this data.	It is not appropriate to compare cost data against NHS data due to higher cost of living locally and economies of scale.
Value for Money & Quality	Cost per community contact	HSSD Finance figures	The cost per community contact is based on 2015 data, and this will be calculated annually. It is anticipated that a new Person Level Information and Costing System will enhance the accuracy of this data.	It is not appropriate to compare cost data against NHS data due to higher cost of living locally and economies of scale.
Value for Money & Quality	Staff Satisfaction	HSSD Staff survey 2015 - mental health sector	The staff survey was conducted in 2015, with 75 mental health staff responding.	
Value for Money & Quality	Incidents	Datix - HSSD system for recording incidents, complaints and risks	This counts the number of incidents reported, and the level of harm associated with each of those incidents as follows: - Negligible/None: minimal injury requiring no/minimal intervention or treatment - Minor: minor injury or illness requiring minor intervention - Moderate: Moderate injury requiring professional intervention - Major: Major injury leading to long-term incapacity/disability - Catastrophic: Incident leading to death or multiple permanent injuries/ irreversible health effects	
Value for Money & Quality	Complaints	Datix - HSSD system for recording incidents, complaints and risks	The total number of complaints relating to C&SS mental health services	
System-wide functioning	Sickness & Absence rate	HRIS - The HR system used by Health & Social Services	The mental health staff sickness absence rate is calculated by dividing the total sick hours by the sum of FTE standard hours. Where available, these figures have been compared against data obtained from the NHS benchmarking network (01/04/15 - 31/03/16)	
System-wide functioning	Vacancies	HRIS - The HR system used by	The mental health staff vacancy rate is calculated by dividing the sum of actual FTE by the sum of budgeted FTE employees. Where available, these figures have	

		Health & Social Services	been compared against data obtained from the NHS benchmarking network (01/04/15 - 31/03/16)	
Wider Socio-Economic Context	Unemployment rate	Registered Actively Seeking Work December 2016	The International Labour Organisation unemployment rate for Jersey is measured by the Annual Social Survey, the Household Spending and Income Survey and the Census. The number of individuals Actively Seeking Work is reported on a quarterly basis.	
Wider Socio-Economic Context	Business confidence survey	Business Tendency Survey December 2016	Now known as the Business Tendency Survey, this is a quarterly survey. The specific indicator reported here looks at the total amount of work undertaken in Jersey and businesses are asked if this has increased, stayed the same, or decreased in comparison with three months previously	
Wider Socio-Economic Context	Number of domestic violence incidents	Police data	This is the number of domestic violence incidents recorded by the police, regardless of whether they resulted in an offence being recorded.	