

Delivering the Five Year Forward View for Mental Health: Developing quality and outcomes measures

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1. Introduction and context

The [Five Year Forward View for Mental Health](#)¹ calls for a fresh mindset and seeks strong leadership to tackle unwarranted variation in mental healthcare quality and outcomes. It proposes 58 recommendations for NHS arm's length bodies to meet the needs of the increasing numbers of people using mental health services. Welcomed by government, the strategy outlines four priority areas for system-wide change, namely:

1. promoting good mental health and helping people lead the lives they want to live
2. delivering integrated physical and mental healthcare
3. providing the right care, at the right time and in the right place, and a seven-day mental health service
4. hard-wiring mental health across health and social care.

The Five Year Forward View for Mental Health is clear that there must be a move to payment approaches which have transparency around quality and outcomes, and these should be in place by 2017/18 for adult mental health services. It states that a similar scheme should be introduced across services for children and young people as soon as possible. It recommends **national and local outcomes measures should be used as part of the payment system**. It also sets out the need for a leading role for people with lived experience (and their families) in assuring that services are assessed based on quality and the outcomes that are valued by the people who use them.

2. Purpose of this document

This document has been developed as a guide to support local footprints to develop a suite of quality and outcomes measures, and implement routine measurement and continuous quality improvement. This will help build the foundations to support outcomes-based payment for mental health services in local areas.

This support material has been developed through consultation with a wide range of stakeholders, including a clinical reference group made up of representatives of multi-professional bodies and experts-by-experience, with more than 100 attendees at engagement events. This document is intended for people who use, commission and provide core adult mental health services.

¹ www.england.nhs.uk/mentalhealth/taskforce/

The scope of this document does not extend to child and adolescent mental health (including specialist eating disorders), learning disabilities, forensic and perinatal mental health, because it accompanies the payment guidance² for adult and older adult services. However, the principles of outcomes measurement should be consistent across the life course and outcomes linked to payment should be in place for these services as soon as possible. Adult improving access to psychological therapies (IAPT) has a separate framework, with work underway to integrate psychological therapies within the care of long-term conditions and include robust outcomes measurement in all relevant pathways.

3. A framework approach to quality and outcomes measures

3.1. The framework approach

A framework approach is proposed to allow local areas to tailor quality and outcomes measures so they are relevant to individuals, clinicians and match the needs of the service in terms of timeliness, benchmarking and use as an improvement tool.

Careful consideration should be given to when a measure is both clinically and practically appropriate. A benefit of increased frequency of recording and feedback is that it improves data quality and usefulness as part of the clinical process. At a minimum, services need to record pre- and post-intervention outcomes for each person. Paired scores³ should be used to analyse outcome data. Characteristics of local populations need to be considered and factored in. Care needs to be taken to distinguish between population-based measures and individual measures, and appropriate analysis and interpretation of these data is critical.

Local areas will need to ensure the **suite of quality and outcomes measures** developed through this framework approach reflects objectives/views of all key stakeholders and should be:

- clinically relevant, so that they are seen to add value for clinicians as a routine part of their clinical practice and continuous quality improvement
- reflect what people who use the service (and their families) want
- culturally appropriate and culturally reliable
- aligned with system-wide objectives
- measurable using metrics with established reliability and validity.

² <http://www.gov.uk/government/publications/nhs-national-tariff-payment-system-201617-a-consultation-supporting-documents>

³

<http://www.rcpsych.ac.uk/traininpsychiatry/conferencetraining/resources/honos/generalinformation/faq.aspx>

Appendix 1 describes a range of quality and outcomes measures that are being used, based on existing data resources. These include personal and clinical outcomes, carer outcomes, and service and productivity measures. In developing a local framework **effective use should be made of all available information**, such as Mental Health Services Data Set (MHSDS), Office for National Statistics, NHS data catalogue, emergency services (eg police and fire), employers and local communities.

Agreement should be reached on how measures will be used in benchmarking and improving services, including red lines for when they won't be used. A checklist for developing a local framework can be found in Appendix 2.

3.2. Evidence-based pathways and pillars of quality: clinical effectiveness; patient experience and safety

The Five Year Forward View for Mental Health outlines the vision for a comprehensive set of evidence-based treatment pathways in place by 2020/21. Over the next five years, NHS England will deliver a programme for development of the pathways (outlined in Appendix 3) and the National Collaborating Centre for Mental Health is developing more robust metrics which are pathway specific.

Local areas are encouraged to align their framework with outcomes linked to specific mental health conditions or pathways of care. It is proposed that these measures should reflect the three pillars of quality, namely: clinical effectiveness, patient safety and experience (and, where appropriate, carer experience). The effectiveness of interventions is measured through patient-reported outcomes measures (PROMs), alongside clinician-reported outcomes measures (CROMs).

The Early Intervention in Psychosis (EIP) expert reference group has recommended three outcome tools to be used in EIP services, namely Health of the Nation Outcome Scales (HoNOS), Process of Recovery Questionnaire (QPR) and DIALOG.⁴

3.3. Clinical flexibility to personalise outcomes measurement

Clinicians are being asked to use outcomes measures routinely, as a standard part of all therapeutic work. Extra time may need to be built into the assessment process to ensure outcomes are measured and recorded. Outcomes measures should help measure the effectiveness and safety of the service; the effectiveness and safety of interventions; as well as take account of the personalised goals of the person receiving care, their experience and their carer's experience, where appropriate.

This will require a combination of measures which have a reliable change index and a normed statistical (clinical) cut off, together with individual, patient-owned

⁴ www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf

outcomes which measure change towards personalised, therapeutic goals. This combination, with flexible selection, can reflect the specific, individual needs of the person receiving care while enabling the quality of service/treatment to be monitored and benchmarked against other, similar services.

4. Essentials for developing local framework

4.1. Combination of national and local measures

The Five Year Forward View for Mental Health recommends a combination of national and local measures:

- **National measures:** may measure the impact of services, allow for national benchmarking and include measures that are nationally mandated, such as access and waiting time standards, tools recommended as part of national guidance.
- **Local measures:** may measure service quality improvement and build on existing examples of best practice. They should include a wide menu of measures to reflect the needs and priorities of the local population (eg access for Black and Asian Minority Ethnic (BAME) groups)⁵.

4.2. Including physical care and social care measures

The Five Year Forward View for Mental Health is clear that the information gathered by the NHS should integrate physical and mental health and reflect social, as well as clinical, outcomes. Local areas should promote physical care measures such as those set out in the [Commissioning for Quality and Innovation \(CQUIN\) guidance](#)⁶ and measures reflecting life goals of the person receiving care such as employment, education and housing status. These measures can be more meaningful than clinical outcomes, such as being 'symptom free', which may help to reduce the risk of unintended consequences that may arise from a limited focus on treatment, process or outcomes measures alone.

4.3. Access and waiting time standards for evidence-based care

The Five Year Forward View for Mental Health priority for '**right care, first time**' requires increased and timely access to evidence-based care that is in line with National Institute for Care and Health Excellence (NICE) quality standards. **Services must deliver the introduced mental health access and waiting time standards,**⁷ as well as measure and benchmark against those scheduled for development over the next five years in the evidence-based treatment pathways programme of work

⁵ Guidance for NHS Commissioners on Equality and Health Inequalities Duties
<https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/>

⁶ www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf

⁷ www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf

(Appendix 3). The ambition for 2020/21 is that services will provide clear data about access and waiting times and payment will be linked to the interventions delivered and the outcomes achieved.

4.4. Co-production

The Five Year Forward View for Mental Health places a strong emphasis on adopting a collaborative and co-production approach, with experts-by-experience, clinicians and relevant voluntary sector organisations. This can ensure services or interventions are accessible and appropriate for people of all backgrounds, ages and experience. This strategic emphasis recognises that the process of co-production itself **enables the development of a common, shared vision** and can lead to system wide buy-in, which may support achievement of outcomes.

5. The foundations which support outcome-based payment

5.1. Outcomes culture

Implementing The Five Year Forward View for Mental Health vision for payment will require routine collection of quality and outcomes data as part of an organisational culture, underpinned by robust/reliable data. This can be supported by embedding quality improvement methodologies to drive achievement of better outcomes.

Principles for developing and sustaining outcome-based payment include:

1. leadership and engagement
2. transparency
3. rationalised reporting
4. improving and learning-focused NHS.

These are described in more detail, with recommendations for application, in Appendix 4.

5.2. Licensing

For both digital and paper-based outcomes measures, appropriate permissions and licence requests will need to be in place. Ensure these are recorded correctly through access to digital tools and/or appropriately trained support staff.

5.3. Making recording easy and digital maturity

Digital technology plays a vital role in enabling routine outcomes monitoring and continuous quality improvement, and their use in planning services. The National Information Board sets out an ambitious agenda for the transition to a fully digital

NHS, encouraging rapid progress.⁸ This is supported by the [Digital Maturity Assessment](#)⁹ which provides a framework for assessing the extent to which healthcare services are supported by the effective use of digital technology. It is expected to feed into clinical commissioning group (CCG) local digital roadmaps, which in turn feed into Sustainability and Transformation Plans. The digital maturity baseline assessments are completed and each organisation's status for the three main themes of the self-assessment (readiness, capabilities and infrastructure) has been published on MyNHS. Local areas should ensure that mental healthcare providers are included in local digital roadmaps.

Consideration should be given to whether provider informatics, performance departments and clinical leaders have arrangements in place to embrace opportunities for digital enablement such as creating accessible dashboards (see Case study 7.3).

Make recording and feedback of outcomes measures as easy as possible

A recognised weakness of the use of outcomes measures can be the time lapse from collection to being available to clinicians and other frontline staff, who need access to historical and real-time data and analysis during the treatment process. Availability of electronic patient records (EPRs), either through digital dictation or via a 4G enabled laptop or hand-held tablet, which can allow real-time recording and scoring of outcomes, can greatly help in this.

Staff must be trained to record outcomes data effectively and know how data analysis and outputs will benefit their work. Recording of measurement can be made easier by employing techniques which allow outcomes to be digitally recorded, either via SMS or an app, and/or embedded in the EPR.

The lack of digital enablement does not mean that services should not provide routine clinical outcomes or data or feedback. Alternative arrangements must be sought to support routine outcomes measurement.

⁸ www.gov.uk/government/publications/personalised-health-and-care-2020

⁹ www.england.nhs.uk/digitaltechnology/info-revolution/maturity-index/

6. Further work

1. Commissioners should outline in Sustainability and Transformation Plans how they will use outcomes (alongside but separate from outputs and process measures) to drive standards and quality in accordance with the Five Year Forward View for Mental Health principles underpinning payment approaches (Appendix 5).
2. NHS England and NHS Improvement are delivering a series of regional workshops. Recognising that some local health economies are more advanced in developing outcomes-based contracts, this offers the opportunity to share experience and facilitate shared learning.
3. NHS England will ensure strong links with the Strategic Clinical Networks and other improvement networks to support leadership and expertise for implementation.
4. NHS England is developing more robust metrics as part of the evidence-based treatment pathways programme of work. Each pathway will have associated set of outcomes which areas are expected to include in the local outcomes framework.
5. The National Quality Board is initiating a review of quality measures and processes, and the mental health community will need to input and respond to this emerging programme and its recommendations.¹⁰
6. NHS England will produce a **Mental Health Five Year Forward View Dashboard** that identifies metrics for monitoring key quality and outcomes data.
7. NHS England is supporting the **Mental Health and Dementia Intelligence Network** to develop a source of high quality data to underpin intelligent commissioning. It is intended that this will include population needs and outcomes measurement; prevention and the development of community assets; benchmarking of local levels of access; quality standards; outcomes and value; data linkage across public agencies; effective commissioning and the implementation of new integrated evidence-based treatment pathways as they come online.

¹⁰ www.england.nhs.uk/wp-content/uploads/2015/12/nqb-oct15-2.pdf

7. Case studies

7.1. Outcomes-based commissioning model for mental health – Oxfordshire Clinical Commissioning Group

This case study is an example of the successful implementation of a payment component linked to achievement of agreed quality and outcomes measures. This is expected to ensure mental healthcare provision is evidence based and centred around the needs of the people receiving services.

Oxfordshire CCG has worked with providers (including Oxford Health NHS Foundation Trust), experts-by-experience and third sector partners (Mind, Restore, Response, Elmore and Connections) to develop an outcomes-based commissioning model. Their aim is to “deliver better outcomes for service users while maintaining financial stability for the local health economy”. Within this model “the success of healthcare provision is measured by the outcomes that are most meaningful to service users, rather than by activity”.

Outcomes selected include: people living longer, people improving their level of functioning, people receiving timely access to assessment and support, carers feeling supported in their caring role, people maintaining a role that is meaningful to them, people continuing to live in stable accommodation, and people having fewer physical health problems related to their mental health.¹¹

7.2. Feeding back clinical outcomes to frontline teams – Central and North West London Foundation Trust (CNWL)

This case study is an example of engaging frontline staff in the outcomes process, thereby improving clinical effectiveness and service delivery. The result is a more responsive and better quality of mental healthcare for the people who use the services.

CNWL has sought to embed the routine measurement, analysis and feedback of clinical outcomes in frontline teams to improve clinical effectiveness through reflective practice, shared learning, identifying gaps in service, training needs, etc.

CNWL has undergone service re-organisations, with the resultant loss of data and changing priorities. The trust and CCG jointly developed a CQUIN to promote the use of outcomes measurements. This has ensured the trust devoted resource from the information team to develop analyses of the information. CQUINs were used developmentally over several years, initially to require recording of HoNOS scores at certain events, eg acceptance to service, admission, discharge, care plan approach

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<https://www.gov.uk/guidance/outcomes-based-payment-for-mental-healthcare-an-introduction>

(CPA) review, etc. Later CQUINs required pairing of scores, analyses and most recently, evidence that outcomes analyses were actively fed back to teams as part of a session on reflective practice.¹²

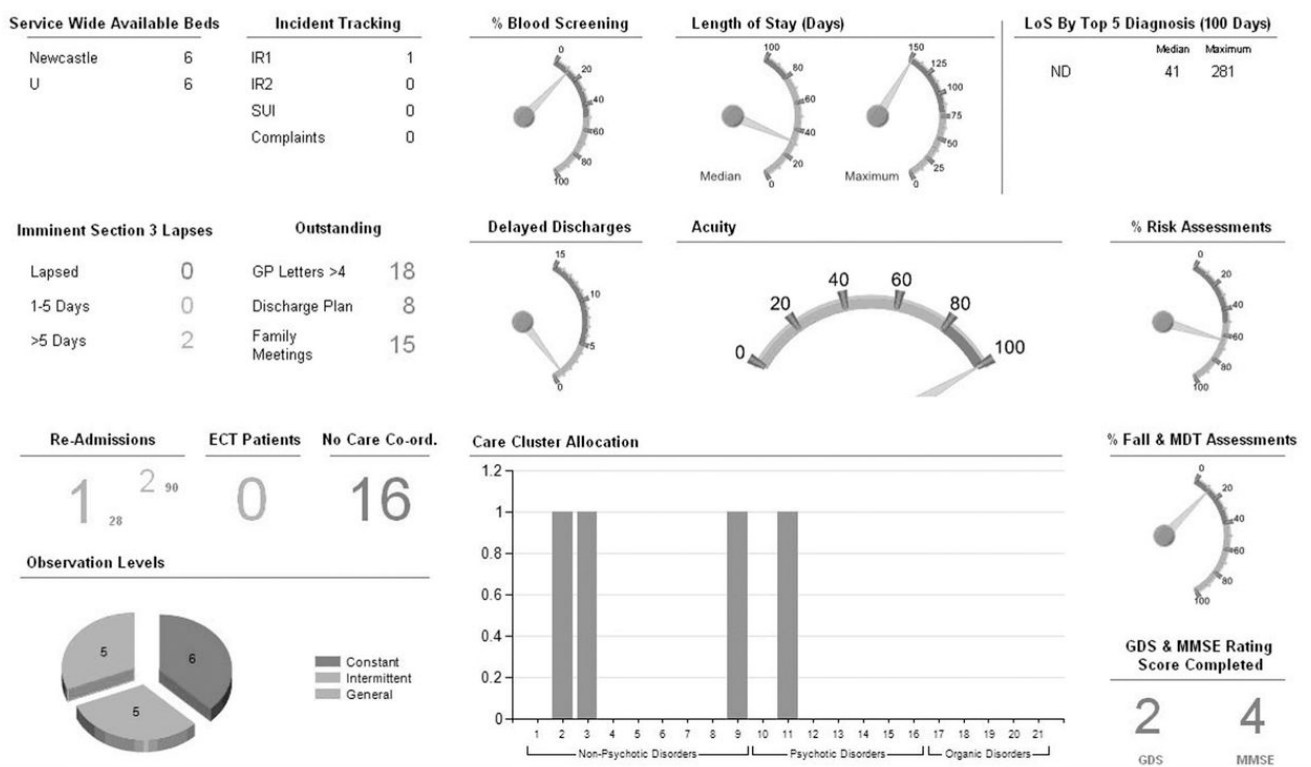
7.3. Use of clinical dashboards in outcomes reporting – Northumberland, Tyne and Wear NHS Foundation Trust (NTW)

This case study is an example of how digital enablement can improve the quality of data and improve information sharing, which contribute to better care for people who use the services.

NTW developed a new clinical dashboard system (see Figure 1) and the introduction of the clinical dashboard in older adult mental health services promoted better data availability and quality. Metrics were identified from the Royal College of Psychiatrists' Accreditation for Inpatient Mental Health Services – Older People (AIMS-OP); these were tracked from baseline to six months.

Staff were surveyed about the benefits, and this demonstrated a positive impact on: access to information; communication and information sharing; staff awareness; data quality.¹³

Figure 1: The inpatient clinical dashboard



¹² www.ukrcom.org/Proceedings_data/22nd%20January%202015.htm

¹³ Daley et al (2013) The Psychiatrist Online 37:85–88

Appendix 1: The example framework

Tables 1 and 2 utilise measures gathered by Health & Social Care Information Centre and are based on existing data resources, some of which are proxy measures and may change over time.

Table 1: Example framework of personalised outcomes measures used in mental health (2016/17)

Domain	Measure
Clinical effectiveness Clinician-reported outcome measure (CROM)	<ul style="list-style-type: none"> Health of the Nation Outcome Scale (HoNOS)
Clinical effectiveness Patient-reported outcome measure (PROM)	<ul style="list-style-type: none"> DIALOG Short Warwick & Edinburgh Mental Well Being Scale (SWEMWBS) Questionnaire about the process of recovery (QPR)
Patient experience Patient-reported experience measure (PREM)	<ul style="list-style-type: none"> Friends and Family Test

Table 2: Example framework of existing population outcome and process measures used in mental health (2016/17)

Domain	Measure
Clinical effectiveness (wellbeing, recovery, quality of life)	<ul style="list-style-type: none"> Emergency re-admissions within 30 days^a Percentage of staff receiving job-relevant training, learning or development in past 12 months^a Recommended by staff^a Adult Social Care Outcomes Framework^c
Clinical effectiveness (physical health)	<ul style="list-style-type: none"> Premature mortality in adults with serious mental illness (SMI)^b National Audit of Schizophrenia data^a CQUIN 2015/16 data Proportion of people receiving physical health advice and support from community services^a SMI smoking rate (eg Quality Outcomes Framework indicator – SMOK 02^d) National CQUIN for Mental Health and Physical Wellbeing
Patient experience	<ul style="list-style-type: none"> Overall views and experience^a

Domain	Measure
	<ul style="list-style-type: none"> • Recommended by staff^a • PLACE (patient-led assessment of the care environment): condition, appearance, maintenance^a • PLACE: privacy, dignity, wellbeing^a • Care planning^a • Delayed transfers of care^a
Access	<ul style="list-style-type: none"> • Mental health access and waiting time standards (eg IAPT/EIP) • National CQUIN for Mental Health and Physical Wellbeing • Access to CBT for people with schizophrenia^a • Access to family interventions for people with schizophrenia^a • Physical health checks for people with schizophrenia^a • Concurrent contact with mental health services and substance misuse services for alcohol misuse 2014/15^b • Black or Black British ethnic group proportion: % of population who identify their ethnicity as Black or Black British^b
Efficiency	<ul style="list-style-type: none"> • Use of A & E for people using mental health services (eg Emergency Hospital Admissions for Intentional Self-Harm^b) • Percentage of people with access per CCG (eg access to psychological therapy^b) • People in contact with mental health services per 100,000 population^b • Bed occupancy rate^a • Proportion of admissions gate-kept by CRHT team^a • Help out of hours^a • Proportion of people on CPA with a crisis plan in place^a • Delayed transfers of care^a
Safety	<ul style="list-style-type: none"> • Age-standardised mortality rate from suicide^b • People on CPA followed up within seven days of an inpatient discharge^a • Open and honest reporting^a • NHS England patient safety notices^a

^a Reported on MyNHS: www.nhs.uk/Service-Search/performance/search

^b Accessible via Community Mental Health Profiles: <http://fingertips.phe.org.uk>

^c The Quality and Outcomes Framework (QOF): www.hscic.gov.uk/qof

^d Adult Social Care Outcomes Framework: <http://ascof.hscic.gov.uk/>

Department of Health supported work

- 1) The Department of Health (DH) has commissioned a report from the Royal College of Psychiatrists, providing a review of existing outcomes measures and mapping these to pathways. This is expected to be a useful tool to inform the development of local frameworks.
- 2) ReQoL is a generic outcome tool which is commissioned by DH in the context of increasing the use of outcomes which measure quality of life and recovery across a range of conditions. It has been developed using a rigorous, mixed methods framework, involving extensive input from experts-by-experience at each stage of the development. The robust methodology applied, indicates it has the potential to be a useful, generic tool for measuring recovery.

Appendix 2: Local framework checklist

Checklist to ensure a robust framework:

1. **Defined by what the person using the service wants to achieve.**
2. **Supported by appropriately-trained clinicians** with access to sufficient time and resources, able to effect change within their care settings.
3. **Agreed by, and sets realistic objectives for, all organisations** involved in care.
4. **Backed by appropriate infrastructure** – IT systems that facilitates work at a clinical level up to national data sharing, eg digital enablement or appropriately skilled support staff, to facilitate the collection and analysis of data.
5. **Driven by good leadership** – that facilitates and mandates the roll-out and best quality use of data.
6. **Underpinned by relevant quality improvement methodology** to ensure continuous feedback and effective roll-out and use of measures.

Appendix 3: The Five Year Forward View for Mental Health: development of evidence-based treatment pathways 2015–2020

The proposed programme aims to ensure that a greater number of people have timely access to care that is fully NICE-concordant, as a core part of co-produced care plans that are recovery- and outcomes-focused. The Five Year Forward View for Mental Health refers to the ‘right care, first time’.

Mental health Taskforce-FYFV Roadmap for Outcome based pathways

<https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

Proposed mental health pathway and infrastructure development programme

Pathway	2015/16	2016/17	2017/18	2018/19	2019/20	
Referral to treatment pathways	Psychological therapy for common mental health disorders (IAPT)	█				
	Early Intervention in psychosis	█				
	CAMHS: community eating disorder services	█				
	Perinatal mental health		█			
	Crisis care		█			
	Dementia		█			
	CAMHS: emergency, urgent, routine		█			
	Acute mental health care		█			
	integrated mental and physical healthcare pathways (IAPT / Ialson / other integrated models)			█		
	Self harm			█		
	Personality disorder			█		
	CAMHS: school refusal			█		
	Attention deficit hyperactivity disorder				█	
	Eating disorders (adult mental health)				█	
	Bipolar affective disorder				█	
Autistic spectrum disorder (jointly with learning disability)				█		
Recovery pathways	Secure care recovery (will include a range of condition specific pathways)			█		
	Secondary care recovery (will include a range of condition-specific pathways)				█	

Appendix 4: Principles to support outcomes-based payment

Principle 1 – Leadership and engagement

Identify a clinical lead for outcomes implementation both within the provider and CCGs. Local areas should convene a **mental health outcomes steering group**, with membership including experts-by-experience and relevant third sector organisations. To promote ownership and accountability, ensure shared leadership between clinical commissioners and providers.

Chief clinical information officers

The Chief Clinical Information Officers (CCIO) Network¹⁴ promotes the development of CCIOs across the NHS. This leadership role acts as translator between clinical, informatics and performance teams to enable the best use of information and technology to improve the quality of care.

Clinical engagement

To improve the accuracy and robustness of data collection, it is vital that information is fed back to frontline staff because they are responsible for a large share of the data collection related to mental healthcare. Data collection and use should be carefully communicated to services and clinical staff to aid understanding and their support for the process, and steps should be taken to explicitly involve them in generating options for outcomes measurement.

This will drive consistency in how measures are used across the professional workforce and is important to maintain data quality, ensuring that new clinical staff are fully trained and existing staff kept up-to-date.

Leadership role for experts-by-experience

To support the recommendations for the leadership role of experts-by-experience and co-production of payment approaches, the Five Year Forward View for Mental Health proposes the application of the 4PI framework of 'Principles, Purpose, Presence, Process and Impact' developed by the National Survivor and User Network.¹⁵

The people who use the services can drive the system by being empowered to self-monitor and expect services to be interested in their feedback and outcomes.

¹⁴ More information available at www.digitalhealth.net/CCIO

Principle 2 – Transparency

Within the priority to hardwire mental health into the wider healthcare system, the Five Year Forward View for Mental Health highlights the need for robust data and leadership, and encompasses the vision that all mental health services routinely collect and publish outcomes data by 2020/21.

Transparency regarding the achievement of outcomes and quality levels acts to support patient choice, enables benchmarking of care services and supports workforce planning and effective resource use.

Principle 3 – Rationalise reporting

Local health economies should consider the burden of introducing additional data collection for providers and attempt to rationalise requests where possible. This is emphasised in the NHS Standard Contract Technical Guidance for 2016/17¹⁶ which reinforces the NHS Standard Contract Service Conditions: “a provider need not supply any information locally for which the commissioner cannot demonstrate purpose and value in connection with the discharge of its statutory duties and functions”.

CCGs contracting from the same provider, regardless of whether they are contracting as a collaborative body, should explore working together, where practically possible, to co-produce outcomes and ensure commissioning colleagues in the local authority are included. This will help ensure consistency across the health economy and avoid excessive data collection arising from multiple contracts with varying quality and outcomes measures.

The mental health statutory sector uses a range of quality measurement processes in addition to the core requirements of professional registration bodies and professional regulators. These include: the seven pillars of clinical governance (ie clinical effectiveness, clinical audit, openness, education and training, research and development, and risk management); two national audits (ie psychosis, and depression and anxiety); a national confidential inquiry into homicides and suicides; 24 peer accreditation network schemes, with four quality observatories, and all provider organisations produce annual quality accounts. This volume of reporting requirements for mental health providers highlights the importance of rationalising further reporting requests.

In the Five Year Forward View for Mental Health, the National Information Board has been charged with the task of conducting a national stock take of mental health data to ensure they include the most meaningful measures, which align with national

¹⁶ www.england.nhs.uk/wp-content/uploads/2016/04/2-nhs-fill-length-1617-scs-apr16.pdf

priorities, and that collecting them does not place undue pressures on clinicians and service managers.

Principle 4 – An improving and learning-focused NHS

Routine outcomes measurement should support an improving and learning-focused NHS for both individuals and organisations providing care. Feedback from quality and outcomes measures should be incorporated into regular team, continuing professional development and management processes, and ensure these are valued within the organisation.

Clinical outcomes measurement should be embedded in reflective, clinical practice and routine clinical processes. To enable this, systemic feedback of relevant data to clinical teams and individual clinicians should become the norm, and the data used routinely in clinical supervision/peer review and to develop practice. Clinicians should also be encouraged to benchmark their results.

Health and care professionals already make use of a range of quality indicators, and working with people to achieve their goals and to improve their wellbeing is at the heart of clinical practice. This pre-existing culture should provide a good foundation for the adoption of routine outcomes monitoring into clinical practice.

Operation management and service redesign

Evidence shows quality and outcomes measures are most effective where they are “used as instruments in support of more comprehensive strategies to improve quality and strengthen health service delivery”.¹⁷

[The NHS Standard Contract, Service Conditions](#)¹⁸ outlines the requirements for providers to use quality and outcomes in the management and redesign of services.

¹⁷ Cashin et al (2014) *Paying for performance in healthcare*. OECD/WHO

¹⁸ www.england.nhs.uk/nhs-standard-contract/16-17/

Appendix 5: The Five Year Forward View for Mental Health: Principles underpinning payment approaches in mental health

1. There must be no more unaccountable block contracts for mental health.
2. Providers should never be entirely rewarded for providing a number of days of care within a particular setting, but instead be rewarded for delivering whole pathways of care with achievement of defined outcomes or meeting local population need, as appropriate.
3. Both national and local outcomes measures should be used as part of the payment system; these should be co-produced and developed by all stakeholders with a leading role taken by people with lived experience of mental ill health (and their families).
4. Where integrated care is needed, payment should similarly be integrated. For example, for urgent and emergency mental healthcare, the payment approach should be embedded within the wider urgent and emergency care payment approach, and payment for mental healthcare within physical care pathways should be similarly integrated.
5. Payment approaches should include access standards, where these are developed, to drive achievement of improved access to timely, evidence-based care with routine outcomes measurement.
6. Payment approaches should be developed with experts-by-experience, reward engagement and access to excellent care for particular groups, where this is appropriate. This may include BAME populations and people with co-morbidities, such as substance misuse or diabetes.
7. Outcomes should be holistic and reward collaborative working across the system (eg stable housing, employment, social and physical health outcomes).
8. Payment systems must promote transparency and increased provision of high quality, relevant data that can drive improvement.
9. Payment systems should support improved productivity, value, efficiency and reduced costs, where possible.
10. Payment systems should support pathways through services, rewarding and incentivising step down to lower-intensity settings and a focus on care in the least restrictive setting. They should aim to reduce avoidable crises, admission and detentions, while protecting against any misalignment of incentives that might give rise to cherry-picking or other risks that might impact negatively upon those people with mental health problems who are 'hardest to reach'.
11. National guidance should support commissioners to commission effectively using appropriate payment approaches.

12. Additional support should be provided to commissioners to build leadership, capacity and capability in commissioning services, including for the use of new payment approaches that will necessarily require new skills and competencies.

Glossary and definitions

Biopsychosocial approach

This recognises “the importance of biological factors, psychological factors and social factors”. Wade DT *Holistic health care: What is it, and how can we achieve it?* Oxford Centre for Enablement¹⁹

Co-production

Co-production is essentially where professionals and citizens share power to plan and deliver support services together, recognising that both partners have a vital contribution to make.

CROM

Clinician-reported outcomes measure.

DIALOG

An outcomes measure to support structured conversation between experts-by-experience and clinician focusing on their views of quality of life, needs for care and treatment satisfaction.

Expert-by-experience

People who experience or have experienced mental distress. The term is broader and more descriptive than ‘mental health problems’. Its underlying assumption is that mental distress is a meaningful human experience, and that it is for the individual to make sense of their own experiences within the context of their personal story. It positions the person as having expertise in their own experience. Equivalent term ‘lived experience’.²⁰

HoNOS

Health of the Nation Outcome Scales.

Outcome

“Outcomes are the results people care about most when seeking treatment, including functional improvement and the ability to live normal, productive lives.” The International Consortium for Health Outcomes Measurement (ICHOM).²¹

Outcome measure

Outcome measures should identify “how does the system impact the values of patients, their health and wellbeing”. IHI: Science of Improvement: Establishing Measures.²²

¹⁹ <http://www.ouh.nhs.uk/oce/research-education/documents/HolisticHealthCare09-11-15.pdf>

²⁰ www.mhe-sme.org/policy-work/glossary

²¹ www.ichom.org/

²² www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx

Personalised or 'idiographic' outcome measures

These measure the movement towards a personalised therapeutic goal that is negotiated between the patient and therapist and is personal to the individual patient.

Process measure

Process measures should identify "the parts/steps in the system performing as planned". IHI: Science of Improvement: Establishing Measures.²¹

PROM

Patient-reported outcomes measure.

QPR

Questionnaire about the process of recovery.

Recovery model

In mental health, 'recovery' means the process through which people find ways of living meaningful lives with or without ongoing symptoms of their conditions'.

Implementing Recovery through Organisational Change (ImROC).²³

Standardised or 'nomothetic' outcomes measures

Measures that are validated and normed, and track change in a standardised way.

SWEMWBS

Short seven-item version of the Warwick-Edinburgh Mental Well-Being Scale, developed through RASCH analysis of WEMWBS.

²³ www.imroc.org/

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

Guidance for NHS Commissioners on Equality and Health Inequalities Duties
<https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/>

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