Routine Clinical Outcomes Measurement and Outcomes Based Commissioning

How to manage commissioner expectations for outcomes data.

UKRCOM at CANDI
July 6th 2016
What is routine clinical outcome measurement (RCOM) and how to deliver it?

Routine measurement of

“A change in the health of an individual, group of people or a population which is attributable to an intervention or series of interventions”.

**NSW Health Department (1992)**

*Change measured using instruments with acceptable psychometric properties, such as the Health of the Nation Outcome Scales (HoNOS)*

*(Note recent commissioner proposal for a cut and paste approach to PROM development ‘to cover all our needs’)*

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<table>
<thead>
<tr>
<th>This is what LSLC commissioners want</th>
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<tbody>
<tr>
<td>Regular reports of fully contextualised and robust analyses of RCOM data delivered at 6-12 month intervals.</td>
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<tr>
<td>Robust clinical analyses of data, not numbers on a spreadsheet.</td>
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<tr>
<td>Evidence that the data are representative of provider activity i.e. high rates of CROM/PROM pairs recorded during treatment episodes.</td>
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<tr>
<td>Reports cut by diagnosis / service type / clinical pathway.</td>
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<td>Reports cut by CCG.</td>
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<tr>
<td>A commentary explaining how the Trust is using RCOM data to drive improvements in service delivery.</td>
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<tr>
<td>Ability to benchmark against other Trusts data.</td>
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Delivery requires an experienced implementation team.
No triangulation of HoNOS with PROMs or process measures yet.

No benchmarking against other MH Trusts.
Can commissioner needs be met by central reporting by HSCIC?

<table>
<thead>
<tr>
<th>Issues –</th>
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<tbody>
<tr>
<td>What is the base unit for benchmarking?</td>
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<tr>
<td>Diagnosis? Service type? Care Cluster? Pathway?</td>
</tr>
<tr>
<td>How is context added to HSCIC outputs to ensure appropriate comparisons? e.g. Initial severity, diagnosis, gender, ethnicity</td>
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<tr>
<td>How to estimate whether data are representative?</td>
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All are problematic for HSCIC currently
Can commissioner needs be met by central reporting by HSCIC?

- The structure / format of data reported to HSCIC.
- Capture of diagnosis or service type. Cluster DQ.
- Comparisons must be robust or risk ridicule and clinical disengagement.
- Comparison requires evidence that data samples are representative of activity e.g. Samples with 80%+ paired completion rates.
- How will data be controlled for point of assessment to ensure robust comparisons between MH Trusts e.g. Admission and Discharge, without large data attrition?
Temptation - the KISS approach
(Keep It Simple Stupid)

- A design principle adopted by the US Navy in 1960
- ‘Most systems work best if they are kept simple rather than made complicated. Therefore simplicity should be a key goal in design and unnecessary complexity should be avoided’

Problem

- RCOM is complicated!
- Simplistic analyses and/or data comparisons bring RCOM into disrepute, lead to clinical disengagement and ultimately generate meaningless data from which poor commissioning decisions are likely to follow.
What can we learn from history and from the recent past?
“End Result Cards"

‘Containing basic demographic data on every patient treated, with the diagnosis, the treatment rendered, and the outcome of each case.

Each patient was followed up for at least one year to observe long-term outcomes.

By tracking outcomes longitudinally Codman identified clinical misadventures that served as the foundation for improving the care of future patients.

Rigorous measurement of outcomes identifies the procedures which add no value for the patient.’
A recent history of RCOM in the UK
High Quality Care For All: 
NHS Next Stage Review (2008)

‘shift the focus of care delivery from process outputs and targets to the measurement of outcomes’

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<thead>
<tr>
<th>High Quality Care for All 2008</th>
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<tr>
<td>Outcomes</td>
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<td>Quality and Outcomes Framework</td>
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<td>Clinical Outcomes</td>
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<td>Improving Outcomes</td>
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<td>Patient Reported Outcomes</td>
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National policy context

- 2009 HoNOS-PbR tool
- Required due to CPPP breach of HoNOS copyright with changed severity anchor points in SARN tool.
- Following evaluation, the DH published a new Booklet with the original HoNOS anchor points intact.

**BUT**

the severity descriptions for the clusters are still based on an altered HoNOS scale!
Key issues in MHCB not addressed
National policy context

Implementing the MH PbR Currency Model
Costing guidance and overview of the MH PbR Currency Model

June 2010
Care Pathways and Packages Project

June 2010.
National policy context

moving away from – ‘centrally driven process targets which get in the way of patient care’ and ‘a relentless focus on delivering the outcomes that matter most to people’

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<th>Equity and Excellence 2010</th>
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July 2010
### National policy context

#### No Health without Mental Health 2011

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National policy context

Mental Health Clustering Booklet
(V2.02)
(2011/12)

Complex and contradictory tool
60 pages..... but ‘guidance light’

Mental Health Clustering Booklet
(V5.0)
(2016/17)

Another version due for publication
but in many Trusts MHCT training
has been cut or diluted with e-
learning of variable quality and utility.
National policy context

NHS Outcomes Framework

‘focus on health outcomes not process’

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<th>NHS Outcomes Framework for 2014/15</th>
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National policy context

NHS Outcomes Framework

ReQoL

‘focus on health outcomes not process’

Domain 1
Preventing people from dying prematurely

Domain 2
Enhancing quality of life for people with long-term conditions

Domain 3
Helping people to recover from episodes of ill health or following injury

Domain 4
Ensuring people have a positive experience of care

Domain 5
Treating and caring for people in a safe environment and protecting them from avoidable harm

CROM PROM

PREM

Process
‘Payment by Results’ in Mental Health morphed into ‘National Tariff Development’

- Change focus from measurement of ‘outputs’ to ‘outcomes’

- MH payment mechanisms / currency development

- No block contracts in MH

- Cluster based currency model

- Cluster assignment via MHCT assessment

- Continuing poor data quality

- How to cost clinical activity without PLICS?
National policy context

‘A vision of a better NHS, the steps we should now take to get us there’.

Five Year Forward View 2014

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Development of payment for MH

- A number of different components need to be in place to enable and support the transition towards the new models outlined in the Five Year Forward View
- The sector needs to innovate and locally drive the changes that are needed to support new models of care
National policy context

New Payment Models

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Local payment examples
Mental healthcare: a capitated approach to payment with outcomes and risk share components

www.gov.uk/monitor

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2016
Proposed payment models

What would these proposals look like?

i. No unaccountable block contracts or payment for cluster days in 2016/17
ii. Local payment arrangements would be based on either episodic/year of care OR capitation
iii. Each payment option will support a different care model:

Where MH care is provided by different organisations on a more standalone basis...

Episodic/year of care with outcomes
- Year of care/episodic payment based on clusters
- Outcomes based element (e.g., Staffordshire)

Where there is integrated MH care provision, or wider integration of care across the local area...

Capitation with outcomes
- Capitated component based on clusters
- Outcomes based element across one or more providers

Developing outcome measures
Gain & loss sharing
Learning system
Support for PACS & MCP

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What is the proposed ‘outcomes based element’?

Where is RCOM as we know it in this agenda?
Why the lack of focus on **clinical** outcomes in so many significant policy documents?

- The RCPsych has rolled out HoNOS Training (Health of the Nation Outcome Scales) nationally over many years.
- HoNOS ratings are mandatory returns in MHMDS since 2004.
- HoNOS is international / widely used / many translations.
- HoNOS ratings are embedded in MHCT ratings to identify Clusters. (First 12 of the 18 scales)
- Development and use of HoNOS variants for different service types HoNOS65+, ABI, Secure, LD, HoNOSCA.
- Influence of UKRCOM – A Club involving many MH Trusts who share knowledge of RCOM and PbR.
- [www.ukrcom.org](http://www.ukrcom.org)
To date, the only concession to reporting clinical outcomes by DH / NHSE / Monitor was...

- The 4 Factor Model of HoNOS
- Challenges to universality of proposed factor structure
- Robustly resisted by providers with expertise in HoNOS data analysis
- Only one publication of 4 Factor HoNOS data by HSCIC in Jan 2015.
- Negative feedback from providers
- Data of limited clinical utility
- Negative impact on RCOM e.g. DQM32 edict (100% data collection, so data must be invented)
What deters Monitor / NHSE from a rigorous focus on clinical outcomes measurement?
A renewed national initiative to use RCOM data for commissioning.
‘It may be in the future that Outcome Measures are increasingly used to benchmark services’

‘Delivering the Five Year Forward View for Mental Health requires use of quality and outcomes measures for payment’

‘A framework is being agreed to include outcomes and quality measures in an outcome based payment approach for core adult services’
‘There is a tension between simplicity and complexity with the potential for different measures for different clinical conditions, personal preferences and treatment goals’. (Only a problem when central reporting / benchmarking is the primary aim)

‘This is the rationale for proposing a framework approach with a few core outcome measures that will be useful for measuring the impact of services as a whole, along with a wider menu of measures from which appropriate tools can be selected’.
‘Decisions to be made on core mandated measures that should be used for national benchmarking and local service quality improvement work in 2016/17’

Decisions orchestrated centrally where RCOM expertise is limited.

Reliant on a KISS model i.e. limited focus on a small number of clinical outcome measures i.e. HoNOS, Dialog, sWEMWBS and QPR

Implicit assumption that central reporting by HSCIC can adequately contextualise RCOM data and deliver robust comparisons of Trusts’ clinical outcomes

Feedback was invited following the January conference
Reported concerns

- ‘Clinical outcomes measurement was possibly permanently tarred with a top-down, performance and finance management ethos that damaged its fledgling status as a tool for reflective clinical practice by teams’.
Reported concerns

- ‘At SLaM we are not persuaded that by keeping the framework simple we shall advance RCOM.
- Despite our desire to the contrary, outcomes measurement is actually complicated and difficult, so the temptation to slide attention towards easier process measurement is strong’.
- ‘If we are to make progress in outcomes measurement we must be mindful of this temptation, especially if, by blurring this distinction, we confuse people about our intentions’.
**Reported concerns**

- Mandating measures is dangerous because it is likely to deter clinical disengagement.
- **Ignorance of Goodhart's Law is dangerous** (When a measure becomes a target, it ceases to be a good measure).
- **Benchmarking without proper context is dangerous** e.g. the extent to which the sample is representative of all activity, initial severity in sample, case-mix / diagnosis, etc.
- The absence of training in proposed measures will lead to unreliability.
- Reliance on a single analytic approach with HoNOS data is very dangerous.
- Reliance on HSCIC as the sole data source for commissioners to understand service outcomes has severe limitations.
Central Planning and Reporting

If national benchmarking of Trusts’ outcomes data is required for commissioning purposes, the methods used must be fit for purpose.....

The current direction of travel risks crossing the bridge to nowhere, to the land of unintended consequences.
A major transit point on the Pan-American Highway in southern Honduras. A beautiful silver bridge crosses the Choluteca River into the city.

This bridge was a gift from the nation of Japan to Honduras, and was constructed using the most modern technology available.
In 1998, the Hurricane Mitch devastated the Honduras in less than four days.

More rainfall in Choluteca than any other place affected by the hurricane.

The bridge was so well built that it was left in near perfect condition after the storm.

BUT......
Massive flooding caused by the hurricane caused the Choluteca River to carve a new channel that no longer flowed beneath the bridge at all. The roads on either end of the bridge completely vanished leaving no visible trace of their prior existence.
‘It is essential to emphasise the primary function of RCOM, which is to support reflective clinical practice’

Or as Professor Michael Porter puts it ‘to document problems that need to be studied and addressed’.

‘Other aims are secondary e.g. Managerial, Financial (VBH), Commissioning (OBC), Political etc’.
Outcomes are the true measures of quality in health care.

Outcome measurement is fundamental to improving the efficiency of care.

Understanding the outcomes achieved is critical to ensuring that cost reduction is value enhancing.

One of the most powerful tools for reducing costs is improving quality.
‘Reason has always existed, but not always in a reasonable form’

- If the primary purpose of RCOM is to promote reflective clinical practice then by definition clinicians must be engaged in this process......

- And not all recent attempts to engage clinicians have been successful......
Clinical engagement – The ‘How Not To’ Guide.
Clinical engagement – The ‘How Not To’ Guide.

The junior doctors strike is still not resolved. Damage to RCOM may prove irreparable.
2016
Road improvements?
MH Outcomes Programme

- ‘The Department of Health leads for the Secretary of State Information Transparency Programme and Dr Geraldine Strathdee, the National Clinical Director for Mental Health have also asked the College to develop the next stage of outcome indicators.

- We are pleased to announce that we have appointed Dr Jane Carlile, a clinical director at Northumberland, Tyne & Wear NHS Foundation Trust to undertake some focused work on this’.
MH Outcomes Programme

- ‘Need for a clear consensus across clinicians, professionals and patients/carers on outcome measures to be used as part of clinical practice mental health pathways, and the College has been given a central role to play in this.

- The overall aim of the mental health outcomes programme is to develop outcome measures covering all stages of the lifecourse for the commissioning and provision of the 16 mental health care pathways.

- The College has been very engaged in this, and the Chair of our Informatics Committee, Dr Jonathan Richardson, has been seconded part time to NHS England to work on it.’
MH Outcomes Programme

- ‘The use of outcome measures should enable learning from individual clinicians to the boards of provider organisations.
- An ongoing challenge is using measures that reward delivering high quality care to those with the most complex needs & avoiding perverse incentives to focus on those with more circumscribed needs.
- A focus on recovery & patient set goals is essential. The inclusion of more physical health outcomes is vital.
- The value of diagnosis in helping capturing complexity should not be under emphasized.’
‘Outcome measures need to incorporate clinician rated outcome measures (CROMs), patient reported outcome measures (PROMs) & patient reported experience measures (PREMs). This triangulation of measures helps encompass the many facets of outcome measurement.

Outcome measures are tools that need to be incorporated in a wider strategy to collect outcome measures that truly matter including death, suicide, re-admission to hospital, offending & employment.’
The ‘How To’ Guide

Engage clinical teams in RCOM implementation and deliver information to support commissioning decisions

Requirements
Continuous Q.I. cycles

- Outcomes data constitute a business critical source of health intelligence which can be used to drive service improvements.
- Implementation is a cyclical process involving staff training, data capture, data extraction, data analysis and contextualisation, reporting and feedback to clinical teams for reflection and comment. This process engages most clinicians.
- A comprehensive, systemic approach is necessary to embed RCOM at all levels in MH Trusts, from Board reports to clinical service delivery.
Implementing RCOM is a cyclical process, all phases are necessary, none sufficient
Data Extraction and Analysis

- Data extract specification.
- SQL capacity to interrogate EPR system.
- Develop, test and maintain data extraction procedures.
- Complex clinical outcomes data analysis by clinical staff.
- Contextualisation of RCOM data.
- Triangulation of CROM, PROM and process measures of outcome (LOS, re-admission rates, mortality).
- Focus on Porter’s Hierarchy of outcomes.
‘Comprehensive measurement of outcomes provides the evidence that will finally permit evaluation of whether care is actually benefitting patients and which treatments are most effective for each medical condition’.
The SLaM model for measuring clinical outcomes

**Context**
Initial severity, diagnosis, ethnicity, gender, age, service type, cluster etc.

**Outcome**
Comparison of measured health status at first and last HoNOS rating in team level treatment episodes

Plausibly suggest a relationship between outcome and intervention

**Intervention**
Medication, behavioural programme, psychotherapy etc.

Broadbent 2001
Principles

• ‘Feedback to clinicians is essential’.

• ‘Active feedback to busy clinicians is the only feasible way of getting clinicians to see their data. When they do, they want to make it more accurate and useful’.

• ‘Therefore we try to ensure that secondary demands on RCOM data are only satisfied once the clinicians have first digested them, confirmed the accuracy of activity and added context’
Facilitated clinical data feedback presentations to clinical teams.
Where appropriate, compare data from similar teams.
Wrap context data around the outcomes data e.g. Initial severity, gender, ethnicity, diagnosis, age, LOS, service type.
Assess the extent to which the outcomes data are representative of the team’s activity.
Ask the team to confirm accuracy of activity data.
And consider whether the presentation provides evidence of clinical effectiveness and why?
Feedback enables clinicians to add context that is not known to the presenter / data analyst.
Analysis of HoNOS data

There is no international consensus regarding a most reliable or clinically meaningful method to evidence change in the HoNOS family of outcome measures and how much change represents clinically significant change.


The Australians are international leaders in mental health outcomes measurement.

Burgess et al recommend trialling two approaches using ‘Effect Size’ and ‘Classify and Count’

(Burgess P and Pirkis J. Key Performance Indicators for Australian Public Mental Health Services. Modelling Candidate Indicators of Effectiveness. June 2008. AMHOCN).
The SLaM approach to data analysis

1. Measure change in Total HoNOS score using error bar charts (parametric) in aggregated, team level closed episodes.

2. Profile the average (mean) change between first and last HoNOS rating on each scale and estimate magnitude of change with effect size statistics. (parametric)

3. Categorical change – a version of ‘classify and count’ reveals the percentage improvement, deterioration and absence of change on each scale, between first and last HoNOS ratings. (non-parametric)

- By presenting teams’ data using multiple methods of analysis strengths and limitations of each method are identified.
- Reinforcing the point that no 'gold standard' method of HoNOS data analysis exists.
How to generate meaningful outcomes data for commissioners?

* Not by ever more data spread-sheets containing process metrics and performance data without robust analyses of clinical outcomes data.
* HSCIC reports are unlikely to meet local commissioning needs.
* Commissioners require evidence of clinical effectiveness, value and Q.I. as they move inexorably towards outcomes based payment mechanisms.
* Commissioners often have little understanding of the complexity of outcomes measurement or the nuances of outcomes data analyses.
Resources and CQUINs

- A small implementation Team with the skills required to meet the needs of clinicians, management and commissioners. **TINA**
- Recurrent budget to support implementation.
- Team engagement with commissioners recommended to set achievable and useful objectives.
- Transparency generates confidence and trust.
- Use CQUINs to drive completion rates for RCOM measures to a level that is representative of activity.
- And expand the RCOM programme at a pace commensurate with resources.
- Counter any institutional KISS bias or tokenism.
KISS?

- Promote the development of **Local Outcomes Frameworks** in collaboration with clinicians, service users and commissioners.
- Agree CROMs, PROMs, PREMS and process measures for each pathway.
- Choose **multiple** measures considering their psychometric properties, clinical utility, service user preference, ease of completion and relevance to pathway.
- One size does not fit all.
Benefits of Local Outcomes Framework development

- Mutual understanding and respectful engagement between providers and commissioners.
- Freedom to choose clinically useful measures of outcome that are meaningful to patients and clinicians.
- Opportunities to generate high grade local health intelligence which drives service improvement and creates a foundation for clinical research.
‘Provider organizations understand that, without a change in their model of doing business, they can only hope to be the last iceberg to melt.

Facing lower payment rates and potential loss of market share, they have no choice but to improve value and be able to prove it.’

(M. Porter and T. Lee. The strategy that will fix health care)
Example

A Medium Secure Unit where 71% (55/77) of closed episodes have HoNOS pairs recorded
The error bar chart suggests statistically significant change with large effect size (1.26)
Change in Total HoNOS score by diagnostic category (n=55)

Suggests pts with a depression diagnosis make more improvement than those with NAP.

Context!
Only 2 patients!!
Elevated behavioural problems (BEH), psychotic symptoms (HAL) and relationship problems (RELS) at first rating. Large and medium ES stats recorded for reduction in severity on many scales at last rating.
Effect size statistics indicate magnitude of change on each scale at repeat measurement

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<td>.27</td>
<td>.59</td>
<td>.16</td>
<td>.54</td>
<td>.11</td>
<td>.18</td>
<td></td>
</tr>
<tr>
<td>12 OCC</td>
<td>55</td>
<td>.40</td>
<td>.76</td>
<td>.16</td>
<td>.57</td>
<td>.24</td>
<td>.31</td>
<td></td>
</tr>
</tbody>
</table>

a. compgroup Team = active Scenario or episode is active at extraction date = .00 Discharged at date of extraction
Categorical Change

- The SLaM Categorical Change method is a version of ‘classify and count’ originally proposed by Prof. Paul Lelliott and recommended by Burgess and Pirkis.
- This method de-limits the five HoNOS anchor points in two categories, ‘Low Severity’ and ‘High Severity,’ with the categories separated at the 2/3 severity anchor points.
- Change is measured by boundary transition at repeat HoNOS rating.

<table>
<thead>
<tr>
<th>Severity Band</th>
<th>Score</th>
<th>HoNOS Anchor Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>0</td>
<td>No problem</td>
</tr>
<tr>
<td>LOW</td>
<td>1</td>
<td>Minor problem</td>
</tr>
<tr>
<td>LOW</td>
<td>2</td>
<td>Mild problem</td>
</tr>
</tbody>
</table>

Transition boundary

| HIGH          | 3     | Moderate problem          |
| HIGH          | 4     | Severe problem            |
Categorical Change

No change in low severity

Significant Improvement

Significant Deterioration

No change in high severity
Critical Context

- Treatment started before MSU admission.
- Extended LOS and low patient turnover means small numbers of MSU discharges each year which is significant for data analysis.
- Parametric statistics (change in mean / ES stats) are unreliable in small samples. Last HoNOS ratings never assume a normal distribution so large samples are required for reliable analyses (central limit theory).
- Change in Total HoNOS score does not identify where improvement occurred.
- A large ES can be achieved based on categorical change in only 18% of patients – See BEH scale.
- Do not rely on any single method of HoNOS data analysis. Each has its strengths and limitations.
It has been my privilege to work with Professor Alastair Macdonald during the decade 2006 - 2016.

His opinions, knowledge and comments are mercilessly plagiarised in this presentation.

Kevin Smith.
Ex - Clinical Outcomes Lead
South London and Maudsley NHSFT.
July 2016.
Cohen’s ‘d’ is an effect size statistic used to assess the magnitude of the treatment effect. (Cohen J. Statistical Power Analysis for Behavioural Sciences. Hillsdale, N.J.: Erlbaum, 1987)

Cohen’s ‘d’ is the ratio of the difference between pre and post-treatment scores to the standard deviation of the pre-treatment score.

The following clinical significance levels are traditionally agreed cut offs for this effect size statistic.

<table>
<thead>
<tr>
<th>Effect Size</th>
<th>Magnitude</th>
<th>Clinical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.2</td>
<td>SMALL</td>
<td>Small change</td>
</tr>
<tr>
<td>0.5</td>
<td>MEDIUM</td>
<td>Change of moderate clinical significance</td>
</tr>
<tr>
<td>0.8</td>
<td>LARGE</td>
<td>Change of critical clinical importance</td>
</tr>
</tbody>
</table>

This method of evidencing change can be applied to Total HoNOS score or to change in individual scale scores.
Delivering the 5 year forward view for mental health
Use of quality and outcomes measurement for payment

<table>
<thead>
<tr>
<th>Domain</th>
<th>Nationally captured Outcomes and indicators (to be used for national benchmarking)</th>
<th>Other indicators that commissioners may wish to consider (*reported on MyNHS website)</th>
</tr>
</thead>
</table>
| Clinical effectiveness (including Wellbeing, recovery, Quality of Life, CROMS PROMs) | • HoNOS  
  • DIALOG  
  • SWEMBS  
  • QPR | • Attainment of personalised goals  
  • Pathway specific  
    - Outcomes compendium appendix 1  
    - NCCMH groups appendix 2  
    - CRG recommendations appendix 3  
  • Emergency re-admissions within 30 days*  
  • Safety metrics  
  • Percentage of staff receiving job-relevant training, learning or development in past 12 months*  
  • Recommended by staff*  
  • Adult Social Care Outcomes Framework data HSCIC |
| Clinical effectiveness (physical health)) | • Premature mortality*  
  • SMI smoking rate  
  • Suicide | • Proportion of people receiving physical health advice and support from community services*  
  • Physical health checks for people with schizophrenia*  
  • National CQUIN and NAP |
| Patient Experience (PREMS) | • Friends and Family Test | • Overall views and experience*  
  • Recommended by staff*  
  • PLACE patient led assessment of the care environment: condition, appearance, maintenance*  
  • PLACE patient led assessment of the care environment: privacy, dignity, wellbeing*  
  • Care planning*  
  • Delayed transfers of care* PEQ (Patient Experience Questionnaire – IAPT) |
| Choice | | • Access to CBT for people with schizophrenia*  
  • Access to family interventions for people with schizophrenia*  
  • Physical health checks for people with schizophrenia* |
| Access | • National access standards as these launch (currently IAPT, EIP)  
  • CQUIN scores | • % People with access per CCG (Fingertips)  
  • Quality of physical checks to reduce prem mortality (QOF, MHMDS)  
  • People in contact with mental health services per 100,000 population* |
| Efficiency | • use of A and E for people using mental health services | • Bed occupancy rate*  
  • Proportion of admissions gate-kept by CRHT team*  
  • Help out of hours*  
  • Proportion of people on CPA with a crisis plan in place*  
  • Delayed transfers of care* |
| Safety | | • People on CPA followed up within 7 days of an inpatient discharge*  
  • Open and honest reporting*  
  • NHS England patient safety notices* |