

# Measuring Outcomes in Adult Psychiatry: the busy clinician's perspective.

**Michele Hampson**

Chair General and Community Faculty Executive

Member DH Mental Health

Quality and Outcome Group

*Jobbing psychiatrist*

Background: Growing demand for measures of quality and activity (in England & Wales).

- **College Policy Committee** noted need for outcome measures 3+ years ago as good practice.
- **Revalidation / appraisal / supervision:** need robust comparative data - value in IAPT studies
- **Payment by Results development MH** - need quality measure or know cost and volume / activity only.
- **Commissioning.**
- **The Coalition: our programme for Government** - focus on quality and clinician involvement.
- **Service re-design:** need similar measures to compare services

**Can a simple pragmatic clinical approach help?**

# Principles applied to process.

- Minimise need for new data collection
- Use existing data as effectively as possible - make sure clinicians receive it to improve clinical care.
- Link to PbR clusters
- Consider how to bring separate data strands together to give full picture.  
e.g. balanced scorecard, spider plots, quality observatory

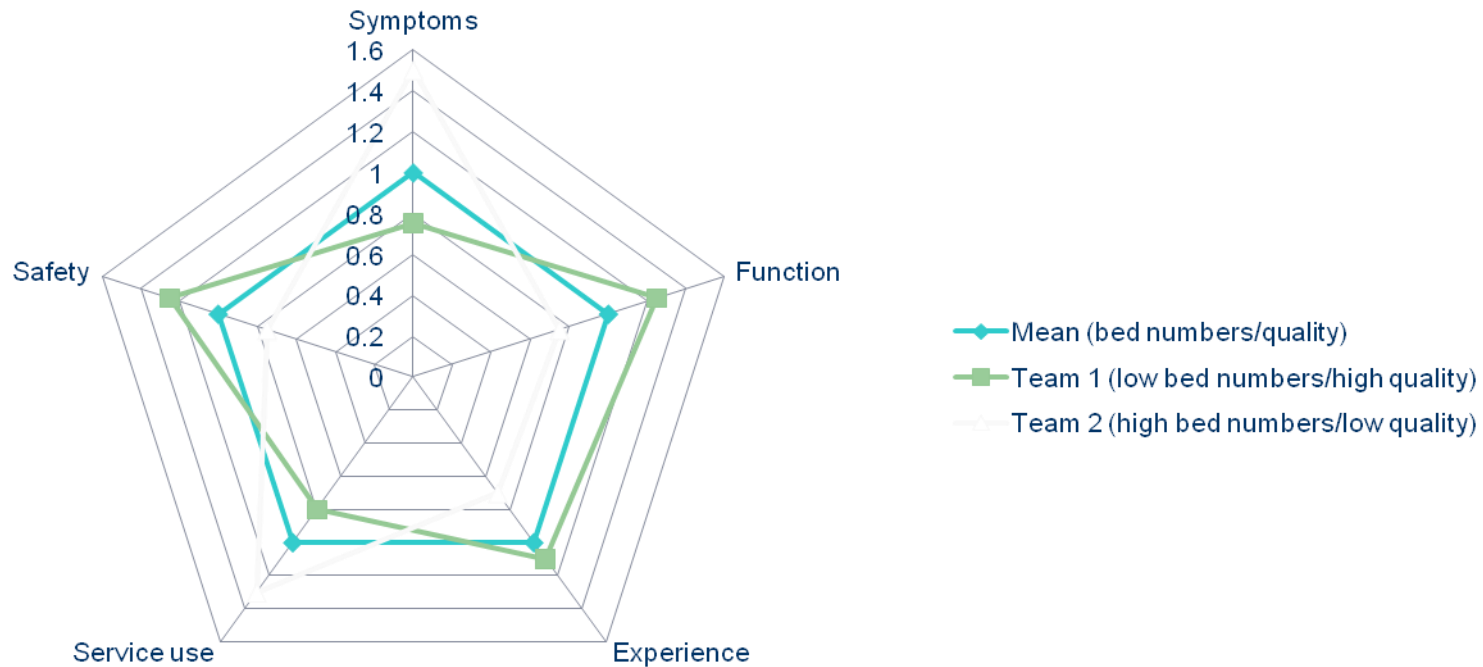
## Process in General and Community Faculty:

Draft with questions → External Stakeholders & Exec → Revision  
→ Exec. member survey → DH group and College Council →  
**College document to which other faculties are adding their specific measures** → members informed → ongoing consultation and review.

# Outcomes as dimensions.

1. **Symptoms** - mental & physical health .
2. **Level of functioning / quality of life.**
3. **Patient-related outcome measures (PROMs)**  
Both general and personal aspiration and goals.
4. **Service utilisation.** Need to know associated cost.
5. **Interventions.** What delivered & by whom.
6. **Patient rating of experience** of care provided. Also carer.
7. **GP / referrers survey** and
8. **Staff survey:** impact of delivering care

# Using a multidimensional approach



# 1. Symptoms.

- **Minimum.**

- HoNOS PbR.**

- Already collected as need it to identify PbR cluster.

- When:** entry to service, transfer between teams or discharge, including admission to / discharge from hospital.

- Uses:** clustering tool, monitor patient progress, supervision/appraisal, caseload monitoring-individual and team.

- Use of sub-scales: not just total score.**

- Change in attitude?**

- 2004: 200 respondents to Faculty survey on CPA

- 71%** HoNOS unhelpful at initial assessment

- 89%** HoNOS unhelpful in reviews.

# 1. Symptoms: PbR clusters.

## Suggestions from Faculty Executive.

- **Clusters 1-8**

Depression / anxiety: PHQ9 (in line with IAPT, used by GPs)

OCD: Y-BOCS

Eating disorder: Eating Disorders section to determine

ADHD: Adult ADHD Self-Report Scale

Psychological therapies: CORE-OM?

- **Clusters 10-15**

F20: PANSS more support than SSPI & KGV but payment

Bipolar: Altmann- self rating scale but we didn't compare with Mood disorder Questionnaire, (NICE 2006).

**BUT :**

Evidence for extra monitoring? Not for schizophrenia (NICE).

Suggest pilot before agreeing need for these.

Duration untreated psychosis?

# Symptoms: drug & alcohol misuse physical health

- **Drug and Alcohol**

80% Exec respondents supported use specific tool.

Need guidance as to which. Suggestions are:

AUDIT - Alcohol Use Dependence Identification Tool

MAP - Maudsley Addiction Profile

- **Physical health**

- Cigarettes / day, alcohol units, drug use.

- BP

- BMI / waist circumference – need advice as to which.

- Lipids HbA1C.

- Not FBC, LFT, U&E unless specific reason

- ECG – only if required

*Diet and activity level - but how to standardise?*

**SMR of those on GP SMI register?**

## 2. Level of function. Quality of Life

- **QALY measure. EQ5D/SF12**

Impact illness on wellbeing.

Would need copyright and ideally for it to be used for physical health too.

- **Employment status - in employment.**

- **Housing status: stable.**

- **Personal goal setting.**

After 1 year in care - using 5 point scale.

Not routine use of Camberwell Assessment Need

STAR- support users, third sector. Time consuming, not yet validated. Help assessment and engagement.

### 3. Service Utilisation – community teams.

- Number seen - new & follow ups by diagnosis, gender, ethnicity & age.
- Cluster score for PbR
- Total caseload
- Waiting list
- New referrals & discharges, contacts & DNAs per team & team member.
- No. admissions incl. what type of ward and whether in locality, length of stay, use MHA incl. CTO
- Interventions - need classification
- Serious Untoward Incidents
- Staff Sickness

### 3. Service Utilisation – in-patients.

- Number of beds on ward.
  - No. admissions, length of stay, discharge/transfer & readmissions
  - Route into hospital e.g. CRHT, Community team, s136 etc
  - Bed occupancy
  - Demographics as per community service
    - MHA use % detained, CTO use
    - with info re diagnosis, gender ethnicity and age range
  - Serious untoward incidents –subdivide by violence and self harm.
  
  - Staff sickness
  - Use of bank and agency staff
- Accreditation status with AIMS-quality

**Overall:** relative cost of in-patient v. community care.

## 4. Interventions

- **Need glossary of interventions**
  - so know what care delivered giving what outcome at what cost
  - linked to NICE-esp quality standards.

# Patient Experience, GP, staff survey

- Patient Experience

No support for Client Satisfaction Questionnaire, CUES or Carer Wellbeing Scale. Too long for routine use. (CUES used West Midlands).

Need for simple scale – CQC community

- GP survey – cf CQC patient surveys

- Staff survey – as at present - need to separate out response separate teams - at least in-pt / community team type.

## Additions for revalidation / appraisal.

- Review audit findings and changes resulting from complete cycle.
- Accreditation status.
- National audits e.g. POMHs, NICE compliance
- Use of drugs sub-divided by type e.g. clozapine.

# Workload?

- HoNOS PbR mandatory for PbR
  - **Drug and Alcohol** – if agreed
  - **Physical health**- often in CQUIN, shared with Primary Care.
  - **SF12** or equivalent and **annual brief personalised scale**
  - Housing / employment as of now
  - Service utilisation – as of now
  - **Interventions**
  - Patient survey, staff survey - as of now - standardise
  - **GP survey**
- BUT: need IT set up to give data to clinical teams regularly.**  
In turn will improve data reliability.

# DH: Measures under discussion.

## 1. Symptoms

- HoNOS-PBR or MHCT HoNOS
- IAPT- current measures e.g. PHQ9
- Offered smoking cessation
- BMI or waist circumference

*Should it be:*

*reduction cigarettes smoked*

*% with BMI outside normal range?*

- Duration of untreated psychosis.

*What is the reliability of this measure?*

## 2. Function

- Employment
- Housing

Currently collected. May relate to certain clusters only.

Recovery Star

Not QALY.

## 3. Service Utilisation

- Equality of access-e.g. ethnicity, gender, age.
- Waiting times
- % on CPA & % on CPA reviewed annually
- CRHT episode rates ([link to CPA?](#))
- Admission rates, mean LoS, bed days / year
- Readmission rate
- Detention rate (subdivide eg CTOs, S136, s2-4)
- % followed up in 7 days – current measure
- Serious Untoward Incidents

[How compare eg bed utilisation?](#)