



*National Institute for  
Mental Health in England*

# Outcomes Measures Implementation Best Practice Guidance

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## Purpose of this document

Summary of the work of the Outcomes reference group in order to provide best practice guidance for local implementation of routine outcomes measurement.

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## VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
Version 1.0	23.12.04	Final Gateway Approved Version	Simon Pearson

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**The Mental Health Outcome Measurement Initiative:  
Best practice guidance for local implementation adapted from the Report from  
the Chair of the Outcomes Reference Group**

**Adapted from the Report from the Chair of the Outcomes Reference Group**

**April 2005**

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## **Foreword**

Continuous improvement of mental health services is dependent on a range of factors including collaboration with service users and carers, the investment of appropriate resources, training for staff, and reflective practice built in to everyday work. The latter requires continuous improvements in measuring the things that matter, particularly users' experience and outcomes so that key questions can be answered and improvement properly tracked and reviewed.

There are currently a number of developments supporting this including the Mental Health Minimum Data Set, the National Programme for Information Technology, new standards for the NHS, and the better metrics project (an initiative to develop more clinically relevant measures of performance). An integral part of this work is the continued evolution of the use of MH outcomes measures; already included within the MHMDS are the required elements of HoNOS (Health of the Nation Outcomes Scale). Many MH service providers have expressed an interest in using other outcomes measurement tools as part of their own local benchmarking programmes which are not included as part of the MHMDS. In order to support this a report was commissioned by the Department of Health and NIMHE to provide best practice guidance to Trusts who wish to expand their use of outcomes measures above that already included within the MHMDS.

The resulting report is the work of the Outcomes reference group, chaired by Peter Fonagy. This group examined the evidence from four pilot and three exemplar sites who have worked to implement various outcome measurement tools within their normal working practice. The report highlights the significant issues that these Trusts experienced as part of their own implementation process, and which were identified as being fundamental to the success of any implementation. As such these steps are included in this document in a way which highlights their significance for any Trust planning to take forward their own implementation process.

It is hoped that the content of this report will help Trusts in developing an approach to outcomes measures that will facilitate the work of the Healthcare Commission along with the implementation of their own benchmarking initiatives. Emphasised within the report is the vital role of front line staff in the use and development of these routine outcome measures, and it is to be commended to all working in the field of Mental Health.

The 'Benefits Pyramid' reflects what can be achieved from different levels of use of measures and the intention is to have DH, NIMHE, and the Healthcare commission working together to support Trusts that choose to take forward such benchmarking initiatives that enable them to reflect upon and improve the services they deliver. .

Those Trusts embarking on the implementation of Outcomes measures initiatives are encouraged to make use of the guidance included in this report, which addresses the issues identified by the Trusts involved in the original pilot process. It should be noted that as HoNOS has already been included within the MHMDS implementation, these data can be seen as a starting point for an implementation that can evolve and grow according to local requirements.

**Professor Louis Appleby**  
**National Director for Mental Health**  
**Department of Health**

## **The Mental Health Outcome Measurement Initiative: Adapted from the Report from the Chair of the Outcomes Reference Group**

This document summarises the work of the Outcomes Reference Group established by Professor Louis Appleby, National Director for Mental Health and chaired by Professor Peter Fonagy of University College London. This report is based on the full report of the Outcomes Reference Group.

The document is made available to Foundation Trusts for information only to enable them to make use of this best practice guidance should they decide to take forward an outcomes measures implementation.

### **Introduction**

*Routine outcomes measurement is central to the drive towards improved quality and accountability of services. Routine outcomes measurement offers a means of providing information on health outcomes in an accessible and common format for all stakeholders including service users and carers, the public and health care commissioners.*

In common with many other organisations in the public sphere, health services and those involved in their provision are increasingly being called to account for their activities. The call for greater accountability has several different elements including improvements in the information available to health care commissioners and the public about the nature and consequences of healthcare interventions. Routine outcomes measurement is one means of addressing this call for greater accountability through the introduction of standardised outcome instruments and processes for recording patient outcomes routinely through the course of health intervention.

In December 2002 a national programme was set up to lead the introduction of routine outcome measurement in NHS mental health services in England. A panel of experts oversaw the programme, and its first phase comprised pilot work in four mental health trusts, and a programme of visits to three exemplar sites that had already made progress in this area. With the conclusion of the pilot work in the spring of 2003 the Outcomes Reference Group was formed to advise on the development of best practice guidance to the implementation of Mental Health Outcomes measurement by addressing the major barriers to a successful implementation as highlighted by the pilot Trusts.

### **Production of this report**

The Reference Group was comprised of representatives encompassing a broad range of perspectives and expertise: service user and carers, the professional bodies, the pilot and exemplar sites, instrument developers, informatics experts, the Department of Health and the organisations commissioned to evaluate the national pilot (IT Perspectives and Mental Health Strategies). A full list of contributors is given in Appendix 1.

The recommendations in this report are based on a comprehensive review of the evidence and wide-ranging views presented to the Reference Group during the seven sessions in which it met. Throughout the work of the Reference Group great care was taken to ensure all views were heard and accurately recorded. This document is a summary of the work of the Reference Group and therefore does not fully capture the complexity and range of views expressed but rather draws out the key themes that emerged.

It must be stressed that this document is not seen as a mandate to Trusts for the implementation of Outcomes measures, its aim is to highlight their benefits, and to provide the best practice approach for a successful and robust implementation. The various elements

have been included on the basis that both pilot and exemplar sites and the wider Reference group saw them as fundamental considerations for those Trusts who wish to successfully take forward local benchmarking practices.

### **Measuring outcomes**

*There are a number of ways in which quality of care may be measured and improved. In the recent past management of quality within the NHS has focused on structure and process based targets. However, developments in outcome measurement, particularly when considering a broader range of outcomes, including social functioning and quality of life, mean that routine outcome measurement now has the potential to measure the quality of health care.*

Health services are increasingly being required to demonstrate continuous improvements in quality of care and greater accountability to service users and other local stakeholders. Quality of care can be influenced in many ways, perhaps the simplest being to place targets on structures (such as the availability of psychological treatment) and processes (such as waiting times). Process measures have a valuable contribution to make in enhancing quality and it is this enhanced quality that is the focus of the core standards set out in the Standards for Better Health<sup>1</sup>. However, structure and process based measures are only indirect measures of the ultimate aim and concerns of improving health outcomes that applies to all stakeholders of mental health services, from service users and carers to clinicians to those managing and commissioning services.

Outcome measurement has been constrained by a lack of clarity concerning the nature of the outcomes themselves, for example many early outcome measures focused on symptomatic improvement but neglected other areas such as social functioning or satisfaction with services. More recently the importance of other perspectives including those of service users and carers and the importance of new concepts, such as recovery, have forced a re-evaluation of the nature of the outcomes that need to be considered.

However, there have been a number of significant developments in mental health outcome measurement and related fields, which now mean that mental health services are better placed to address the demands within the NHS for effective outcome measurement. These include the development of a range of outcome measures that address not only symptom improvement but also areas such as quality of life, social functioning and satisfaction. In addition, with the implementation of the Mental Health Minimum Data Set, a data set now exists which allows for the proper contextualisation and hence better understanding of any outcome data that is made available.

### **Why routine outcome measures ?**

*The introduction of routine outcome measurement is particularly timely given current changes in the inspection and review of services towards continuous self-assessment and the substantial changes to the NHS informatics structure being taken forward through the National Programme for IT.*

Continuous improvement in the quality of services is aided greatly by providing services (and individual clinicians and teams) with a means of evaluating their performance over time in meeting locally determined needs, and where appropriate in being able to compare their performance with other local and possibly national services.

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<sup>1</sup> Department of Health (February 2004) 'Standards for Better Health: Health care standards for the NHS'.

The adoption of a measure that would enable such a comparison would also be compatible with the new methods of inspection and review, carried out by the recently formed Healthcare Commission and the Commission for Social Care Inspection (CSCI).

Substantial changes to the informatics infrastructure within the NHS are underway with the development of the National Care Records Service (NCRS), which is designed to provide a central repository of high quality, patient-centred data to support clinical practice and care delivery. If as indicated by the Trusts involved in the research for this report the implementation of outcomes measures is seen as vital by service providers, then in order for them to be successful it is fundamental that the elements required for routine outcome measurement are integrated within this initiative.

### **Implementing outcomes measurement – national and international experience**

*The national outcomes pilot has highlighted the importance of building incentives into outcome measurement at all levels in order to engage service users, carers, clinicians and managers for successful implementation. The most effective means of building positive incentives is to help them develop an understanding of the benefits of outcome measurement and how these benefits evolve over time.*

International experience, such as the two most developed state-wide outcomes initiatives within Victoria (Australia) and Ohio (USA), has illustrated very clearly how the success of routine outcome measurement depends critically on incentives: the positive and active engagement of all stakeholders with outcome measurement, particularly the service users, clinicians and carers on whom the burden of actually completing the outcome measure ratings falls.

However, incentives are likely to be localised depending on the specifics of funding, IT infrastructure, the existing clinical practice and management ethos and the values and expectations of service users and carers. Mindful of these contextual features of incentives, the purpose of the national pilot of outcome measures was to understand the potential challenges and difficulties to be encountered in introducing routine OM within the specific context of the NHS.

The pilot sites spanned four mental health trusts and were selected to provide a diverse cross section, in terms of prior experience of using OM, and sophistication of the existing IT infrastructure (Leeds, Nottingham, South London and Maudsley and West Hampshire). Four different outcome measures were employed spanning clinician ratings of morbidity (FACE - Functional Analysis of Care Environments and HoNOS - Health of the Nation Outcome Scale)<sup>2</sup>, service user and carer ratings of satisfaction (CUES - Carers' and Users' Expectations of Services) and service user ratings of quality of life (MANSA - Manchester Short Assessment of Quality of Life). The pilots ran in each site to allow for approximately 6 months of data collection.

Much valuable information was obtained from the pilots and this is documented in the two major reports commissioned by the Research and Development Directorate of the Department of Health.<sup>3</sup> The task of the Outcomes Reference Group was to identify potential barriers to robust implementation of routine outcomes measurement and the basic steps that would need to be in place when beginning an implementation.

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<sup>2</sup> The FACE core assessment form is available from [www.facecode.com](http://www.facecode.com) and further information about the HoNOS measure and key domains is available from [www.rcpsych.ac.uk/cru/honoscales](http://www.rcpsych.ac.uk/cru/honoscales).

<sup>3</sup> IT Perspectives (2003) 'Mental Health Outcomes Measurement System Pilot: Evaluation Report'. Mental Health Strategies (2003) 'Routine Outcome Measurement in Mental Health: Review of Pilot Sites Staff Views and Experiences' both reports were prepared for the Research and Development Directorate of the Department of Health.



The main barrier to successful implementation identified by the Reference Group was the need to gain the positive engagement of the service users, carers and clinicians. These key groups are most likely to engage with the initiative where they have a clear understanding of the benefits of outcome measurement to themselves and services as a whole. The potential benefits of outcome measurement are diverse but the most sophisticated uses (and highest levels of benefits) are built up over time. The benefits pyramid was developed by the Reference Group to explain the developmental nature of outcomes measurement, the range of potential benefits and from this how positive incentive structures and engagement of stakeholders could be generated.

### **What are the benefits of routine outcome measurement?**

*Collecting outcomes data alone has limited value, it is only when it is interpreted and translated into positive changes in practice that it will yield improvements in the quality of services. Skills in interpreting outcomes data are best evolved locally and require the active involvement and goodwill of all responsible for collecting and interpreting outcomes data within each local trust. Evidence gathered for this report has shown that implementation of outcomes measurement is best achieved by following a developmental path that allows sufficient flexibility to encourage local innovation and initiative.*

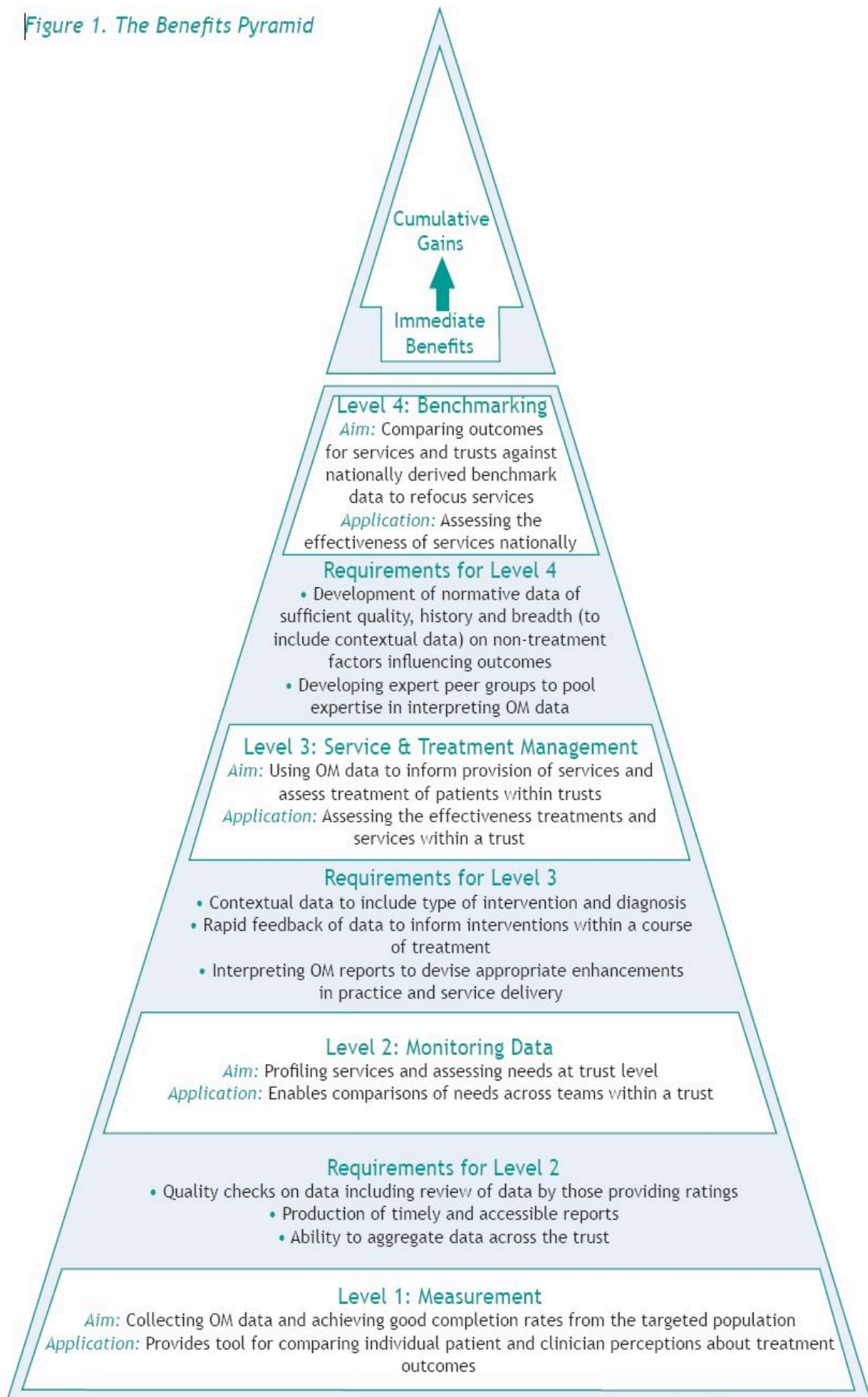
Effective implementation of outcome measurement follows a developmental path. The core benefits of routine outcomes measurement accrue from providing the data to enable reflective practice of individual clinicians and teams. However there is little value in Trusts collecting this data for their own use without taking into account the need for adequate expertise and systems to enable local interpretation, and the effective use of this intelligence to inform changes in local service delivery. It is not until these core benefits have been established that higher level uses of outcomes data can evolve such as benchmarking.

The developmental nature of routine outcomes measurement is summarised within the benefits pyramid diagram [figure 1]. The benefits pyramid should be viewed from the base up. Shaded areas denote critical factors in the realisation of the higher level benefits presented in the pyramid. The pyramid shape is indicative of the fact that lower level benefits provide the essential foundation for higher-level benefits, and that the total effort involved is greatest at the base.

The base tiers of the pyramid, comprising level I and II benefits, are those in which clinicians can begin to reflect on OM results: to try to understand the divergence between clinician and service user and carer completed measures and to tease out the implications for their own practice. It is this reflection and self-correcting learning, at the level of individual teams, clinicians and service users that is fundamental in realising higher level benefits. Without these foundation skills teams and services will be at a loss as to how to interpret the results of benchmarking and translate these into meaningful developments in services.

Each tier of the pyramid is illustrated with a case example from a pilot or exemplar site. **Case examples are selected to provide a good illustration of the factors involved in achieving a particular level of benefit and are not necessarily reflective of overall progress within the trust.** It is also important to note the case examples given may only apply to part of the trust mentioned.

Figure 1. The Benefits Pyramid



## Case examples

### Level I - Measurement

Bedford and Luton CAMHS introduced HoNOSCA in December 2000 together with a suite of measures that were completed by service users (the children) and their parents or carers. Particular attention was paid to ensuring that key data was fed back to clinicians, children and their parents and carers in an accessible format. Response rates for the clinician rated measure (HoNOSCA) are somewhat higher than those for service users (64% and 14-17% respectively). Completion rates and inter-rater reliability are being regularly monitored before these outcomes data are used routinely to inform service profiling and assessment of needs.

### Level II - Monitoring data

Tameside and Glossop introduced a locally developed morbidity measure in 1993 and later introduced HoNOS alongside this. Data is fed back and reviewed annually and is being used to profile services to assess needs and inform the allocation of resources across services.

### Level III - Treatment management

South London and Maudsley NHS Trust Older Adult Services have employed HoNOS 65+ for over 6 years and have used this to inform treatment protocols, for example, the effect of different medication regimes across wards and the effect on outcomes. This experience confirms that effective use of OM relies critically on the availability of adequate data to properly characterise the service, of which diagnosis and interventions provided represent the minimum requirements.

SLAM have recently agreed a set of measures for psychological interventions which are more diagnostically specific and have these been used to inform the course of individual treatment contact by contact within psychological services.

### Level IV - Benchmarking

Benchmarking data for the CORE OM measure has been derived from a network of secondary-care sites that make some use of this measure. Wakefield and Pontefract Community Health is one example of how such data has been used for benchmarking of services.<sup>4</sup>

The benefits pyramid sets out a developmental model of how the generic benefits of OM evolve. The benefits to the system as a whole, however, are not experienced in the same way by all those who participate in it. At each level of the system, from individual user to the regional manager of a service, the perceived benefits and realistic uses of the OM system will differ. The recognition and integration of these differing perspectives is a fundamental aspect of implementation if their perceived relevance is to be achieved.

## Recommendations

*Given the phased approach recommended in this document, implementation requires a careful balance between the use of the national minimum standard (MHMDS) while*

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<sup>4</sup> Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J.; Evans, C., Benson, L., Connell, J., Audin, K. and McGrath, G., (2001) 'Service Profiling and Outcomes Benchmarking Using the CORE-OM' *Journal of Consulting and Clinical Psychology*, 68(2):184-196.

*nationally providing a supporting framework that will help those Trusts that wish to go beyond these minimum standards and develop and innovate in their use of outcomes data.*

A summary of the key recommendations is given below and the full recommendations and specific action points are given in appendix 3:

1. A statement from the National Director for Mental Health supporting local initiatives in routine outcome measurement implementation, and the benefits which can be expected as a result.  
NB. This statement is included in the form of a forward at the beginning of this guidance document.
2. Integration of outcomes measurement within the national IT investment in electronic record systems with the development of the National Care Records Service (NCRS).
3. Clinician rated morbidity measures would provide the most practical starting point for the introduction of outcomes measures HoNOS (Health of the Nation Outcomes Scale) provides a developmental anchor, through its inclusion in the MHMDS, and as such sets the minimum domains which need to be covered for the relevant population. Specifically, mental health trusts are encouraged to consider implementation of HoNOS for all service users on enhanced care, integrating measurement with relevant CPA meetings, involving service users where possible in the completion of the measure and that at least one measurement is taken each year. Some trusts have adopted or developed more detailed morbidity measures and where this has happened trusts are advised to be able to generate an appropriate HoNOS equivalent scores both for its inclusion in the MHMDS return and to enable them to carry out comparisons with other trusts. Trusts are encouraged to also explore the use of other clinician rated and self-report measures, including quality of life measures, in order that relevant domains across all the populations served can be appropriately measured.
4. Trusts and other provider organisations intending on using outcomes measures are encouraged to develop an implementation mechanism supported by robust project management methodology which takes into account:
  - The integration of outcome measures with existing care processes and IT systems.
  - A phased introduction within trusts taking into account local IT infrastructure, capacity and resources.
  - An understanding of the cost implications of an effective implementation.

Although there is much positive experience to be built on from the pilot studies and associated work some significant limitations to existing outcome measures were identified. The three principal concerns are listed below.

- The lack of measures, which fully represent the experience of people from Black and Minority Ethnic groups. The needs and experience of black and minority groups of mental health services would be an early priority within any implementation..
- For all service users and carers the lack of consensus around service user and carer measures of quality of life and satisfaction was identified within the pilot programmes, a key development focus for outcome measures should be on developing more acceptable versions of these measures.
- Many trusts lack effective systems to promote feedback, interpretation and understanding of outcome measurement and without these any national or local programme is unlikely to be effective. Therefore a key priority for the programme is that trust clinical governance mechanisms be established to aggregate and analyse

the data, so that outcome measurement can fully contribute to the understanding of the nature of the care provided and its general improvement.

## **Appendix 1: Contributors to the Outcomes Reference Group**

The following lists members of the Reference Group. Advisors and contributors to the Reference Group are also listed under the respective organisations or roles and are identified by asterix:

\* Advisors that provided advice but did not attend Reference Group meetings

\*\* Contributors that provided advice/presentations and attended one or more Reference Group meetings.

Chair:

Professor Peter Fonagy

Sub Department of Clinical Health Psychology, University College London

Pilot Sites:

Leeds Community And Mental Health Services Teaching NHS Trust

Bridget Barr, Project Manager

Peter McGinnis, Director of Nursing and Workforce Development

Nottinghamshire HealthCare Mental Health NHS Trust

Diane Doran, Project Manager

Paul Smeeton, Head of Health Informatics\*

Gareth Staton, Applied Information Manager\*\*

South London and Maudsley NHS Trust

Dr Mathew Broadbent

Prof Alastair Macdonald

Carmel de Silva, Project Manager

Professor David Clark\*\*

West Hampshire NHS Trust

Clare Palmer, Project Manager

Andy Clapper, Director of Information & Corporate Services\*

Exemplar Sites:

Bradford District Care Trust

Dr Simon Baugh, Medical director

Pennine Care NHS Trust

Rochelle Hunt, Head of IM&T

John Archer, Chief Executive\*

Susan Bennett Head of Clinical Governance\*\*

South Essex Partnership NHS Trust

Janette Buck, Director of Information

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Professional Bodies:

The Royal College of Psychiatrists

Dr Susan Bailey

Dr Andrew Fairbairn\*

Dr David Roy\*

British Psychological Society

Dr Roger Paxton/Professor Michael Wang

Royal College of Nursing  
Cris Allen, Mental Health Adviser

College of Occupational Therapists  
Sally Feaver  
Sue Merchant  
Sheelagh Richards, Chief Executive\*

Association of Directors of Social Services  
George O'Neill, Director of Mental Health Services for Exeter and East Devon and Director of Social Care\*

Instrument Developers:

Professor Michael Barkham, University of Leeds, CORE OM

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Professor Peter Huxley, Institute of Psychiatry, MANSA

Mick James, Royal College of Psychiatrists Research Unit, HoNOS  
Dr Paul Lelliott, Royal College of Psychiatrists Research Unit, HoNOS\*

Professor Stefan Priebe, Unit for Social & Community Psychiatry, East Ham Memorial Hospital, MECCA

National Collaborating Centre for Mental Health:  
Steve Pilling, Co-Director  
Rosa Matthews, Research Fellow

User & Carer, and Black and Minority Ethnic Expertise:

Piers Allott, NIMHE Fellow for Recovery

Professor Kam Bhui, Barts & The London Medical School and Queen Mary University

Albert Persuad, Department of Health, Senior Policy Adviser

Professor David Sallah, University of Wolverhampton, School of Health\*

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Informatics Expertise:

Dr Martin Elphick, NHS Information Authority

Professor Gyles Glover, Centre for Public Mental Health, Durham University

Simon Pearson, Department of Health Information Policy Unit

David Daniel, Department of Health Statistics Division\*

Evaluation of the national outcomes pilot

Dr Heather Heathfield, IT Perspectives

Mark Johnson, Mental Health Strategies

Department of Health:

Dr Alan Glanz, Department of Health Health Service Policy Research and Development

Carolyn Merry, SSI East Midlands & Mental Health Group Director Social Care

Professor Cathy Borowy, Department of Health Policy Lead\*\*

Dr Anna Higgitt, Department of Health\*

Andy Nash, Joint Director of Mental Health Social Care, Department of Health Mental Health Group\*

CHI:

Dominic Ford, Mental Health Development Manager\*\*

Children Services/NSF:

Dr Robert Jezzard, Department of Health

Dr Miranda Wolpert, NIMHE CAMHS Fellow, Consultant Clinical Psychologist Dunstable Health Centre

NIMHE:

Jackie Ardley\*



## **Appendix 2:**

### **CHECKLIST OF MINIMUM RESOURCE REQUIREMENTS FOR IMPLEMENTING LEVEL 1 AND 2 BENEFITS WITHIN A TRUST.**

These requirements represent necessary conditions for robust local implementation of outcomes measurement. These requirements are drawn directly from UK experience within the pilot and exemplar sites. These requirements are not exhaustive because aspects of the programme such as service user and carer measures were not comprehensively piloted, as evidenced by the low completion rates for these measures. Each requirement is listed together with the benefits level to which it pertains. Trusts' OM implementation mechanisms are advised to include details of all elements at level 1 and 2 and some information about how level 3 items will be addressed going forward.

#### **RESOURCES CHECKLIST**

1. Gaining Stakeholder Support
  - A senior member of the Trust executive will ideally be responsible for development of the local OM implementation plan. Level 1
  - The Trust's management are advised to advertise and explain the purpose of the initiative and the potential benefits to all local stakeholders. This is fundamental in gaining the active engagement of stakeholders, and can be of particular benefit to service users and carers for whom the concept of OM can be less familiar. Level 1
  - Developing a strategy to communicate with service users and carers, mental health professionals, specific care should be taken to ensure that the communication is appropriate for individuals from black and minority ethnic groups. Level 1
  
2. Feedback and reporting of data
  - Feeding back OM data on a timely basis to those providing the scorings will provide the best opportunity to enable basking review and checking of data. Level 2
  - Translating raw data into locally relevant intelligence is important for feeding back to stakeholders in a meaningful way. Trusts are advised to spend time developing reporting formats that are shaped to the needs of these stakeholders. Peer review and collaboration across Trusts has been shown to assist this process. Level 3
  - For clinician rated data either administrative or clinician data entry is possible. Providing easy access to data for review is important and ideally such data should be available online, Suggested minimum requirements for the IT infrastructure are:
    - i. Access to terminals to input data
    - ii. IT literacy among staff
    - iii. Adequate ongoing support for staff
    - iv. Ability to produce timely and accessible reports of OM for review by staff users and carers.
  
3. Training and Protocols
  - Training should cover the technical aspects of rating as well as providing clear guidance on the various tools that are available nationally.

- The provision of top up training for each of the morbidity outcome measures and for facilitators for the carer and user measures (depending upon the choice of carer and user measure and allied protocols) is important in ensuring that they are being used most effectively. Cascade training models are unlikely to be adequate for staff or other raters that tend to be transient such as agency staff. Level 1
- Clear protocols for collection of ratings are fundamental. These would ideally encompass the following:
  - i. Who scores – single, joint or facilitated and if facilitated, by whom.
  - ii. When – at what points within the care pathway scores should be recorded.
  - iii. How – most pertinent for carer and user rated measures and whether ratings are collected during clinical time, prior to clinical appointments or completed at home.

In the absence of clear protocols data quality and the ability of Trusts to carry out comparisons with one another would be severely compromised. Level 1
- The provision of an ongoing Trust contact point in order that any queries from teams about interpretation can be speedily resolved is an important consideration. Level 1

#### 4. Integration of OM within existing care pathway and local initiatives

- Any roll-out should be integrated and phased with other major local initiatives and priorities, for example the local introduction of electronic patient records and approved developments in the mental health minimum data set. Failure to integrate would create unnecessary confusion and stress for staff and patients. Trusts are strongly advised to consider the other major initiatives (especially those pertaining to IT infrastructure) that are being undertaken and how these will be integrated with any outcomes initiative they decide to undertake. Level 1
- To achieve best practice the collection of OM should be integrated with the process of care. In particular clinician rated measures can be embedded within pre-existing structured assessment processes such as CPA interviews. Level 1

#### 5. Ongoing development of OM

- Implementation would most effectively be supported by ongoing engagement with clinical teams and users and carers via a project manager role. This would be important until OM had been sufficiently embedded within the culture of the organisation to be self-sustaining, which in the pilot Trusts was shown to be in excess of 18 months. Level 1

## **Appendix 3: Full Recommendations**

### **The Department of Health**

1. Any central work on Outcomes measures would benefit from having clearly stated and publicised purposes. This would entail public recognition of the developmental nature of OM. First, that the principle benefits accrue from supporting clinician's reflective practice and collaborative review of treatment goals and priorities with service users and carers. Second, that national benchmarking could proceed when data of sufficient depth, breadth and quality is built up.

**Principles:** Clarity about the nature, purpose and scope of any national work on outcomes measures is essential for building the confidence and support of all stakeholders.

**Action:**

- A statement from the National Director for Mental Health supporting local initiatives in routine outcome measurement implementation, and the benefits which can be expected as a result.  
NB. This statement is included as a forward at the beginning of this guidance document.
- Publication and dissemination of this report, dissemination of the key findings through the media, publication of accessible lay guides for outcomes implementation and articles in key professional journals.

2. Outcomes measures can make an important contribution to the process of performance management in the modern NHS. Their effective implementation at a local level reflects a wider move towards a more intelligent use of information that can accurately reflect the quality of the service offered to patients.

**Principles:** Trusts require clear information about how OM information can potentially be used to evaluate the quality of services.

**Action:**

- Information about the introduction of OM from its sponsors (the Department of Health and NIMHE) should make clear how outcome measures can potentially be used to contribute to the evaluation of the quality of services.

### **Trusts**

3. Dissemination of the purpose and scope of any outcomes initiative within trusts, across service users and carers, clinicians and managers is strongly encouraged, together with gathering stakeholder views about how this should be implemented locally.

**Principles:** Effective implementation at trust level is responsive to local context and perspectives. Trusts are advised to engage local stakeholders in devising local implementation mechanisms to build local incentives and ownership of OM.

**Action:**

- When implementing outcomes measures Trusts are advised to develop an implementation mechanism that follows recognised project management methodology. The processes required to achieve a core of a basic outcomes

measures implementation will ideally be outlined in this mechanism along with any steps to reach the higher level uses of OM as set out in the benefits pyramid.

4. The introduction of OM is occurring at a time that systems communicating information about patients electronically are under development within the NHS. It is self evident that the data elements to support OM will form an important part of the wealth of information held within the patients record. It conveys essential information about the patient's health status as well as response to treatment that is essential for the development of effective treatment plans for that individual across settings or across time within the same setting.

**Principles:** OM data needs to be integrated with the information flow under development both at national level and at all levels of local implementation. Without this integration the essential data required for contextualising and interpreting outcomes data will not be available. At present such contextual data should be provided through the Mental Health Minimum Data Set, but going forward a richer set of contextual data should be provided via the National Care Records Service.

**Action:**

- National Programme for IT Local Service Providers (LSPs) will be required by commissioning Trusts to incorporate approved OM data collections into their data acquisition, processing and reporting systems.

5. To be truly effective outcomes measurement will be integrated into existing care processes and wherever possible OM ratings would ideally be embedded within pre-existing structured assessments. For example, for clinician-rated morbidity measures in many of the core domains will already be covered within the course of structured assessments. CPA and other forms and processes can be adapted to capture standardised data (HoNOS or HoNOS equivalent scores delivered through another OM) within agreed Trust assessment protocols.

**Principles:** Integration of OM within existing processes will minimise the impact of data collection.

**Action:**

- Trusts are encouraged to include the specific means by which OM will be integrated within standard care processes within a local OM implementation mechanism.

6. The principles which set out the minimum requirements for the administration of OM should ideally be included as part of a Trusts implementation mechanism. Trusts are strongly advised to develop local protocols based on these principles.

**Principles:** These principles will ideally include the following.:

- Who provides a rating (user, carer or clinician individual scoring or joint completion).
- When the rating is taken within care pathway.
- How ratings are collected, (e.g. within treatment session or sent by post for the user to complete in their own time) and what arrangements can be made to facilitate service user and carer completion where language, literacy or other support is required.
- Initial suggested approaches to analysis of data, and yardsticks for anticipated results, where possible related to important aspects of patients' presenting problems.

**Action:**

- Each Trust's local implementation mechanism would ideally include how these local protocols will be established and monitored to ensure that they comply with the principles adopted by the Trust.

7. Each outcome measure would ideally be introduced in phases beginning with those areas of Trusts with the most developed patient information systems and/or OM expertise

**Principles:** Simultaneous implementation of too many aspects of OM will overload services. Implementation should begin from those portions of trusts with the strongest infrastructure to support OM, so that local expertise is built up to inform roll out to other parts of the trust.

**Action:**

- The Trusts implementation mechanism will ideally include the steps required in a phased implementation, specifically identifying the services or teams that will be adopting OM initially
- This first wave of services will ideally meet the criteria set out in the level I and II requirements checklist (see Appendix 2).
- The OM implementation mechanism will ideally include a schedule of when and how OM will be implemented throughout the rest of the organisation.

8. A phased approach to the introduction of specific outcomes measures is most effective, and should begin with the introduction of the most mature and psychometrically robust measures. These comprise the morbidity measures for various populations. The suite of HoNOS measures (to include HoNOSCA, HoNOS65+ and HoNOSLD) could provide a developmental anchor setting the minimum domains for a number of the key populations. However, Trusts have the option of adopting different measures for morbidity, generating where appropriate a HoNOS equivalent score.

**Principles:** Implementation cannot await the production of a 'perfect' measuring tool. There is a need to identify a default suite of measures that provide for comparability while covering the key domains for distinct populations such as child and adolescent, older people and learning disabilities. Trusts that have already implemented relevant measures should not be hampered by having to duplicate effort by implementing the generic measures along side more comprehensive and locally favoured OMs. For example, South Essex Partnership NHS Trust adopted the FACE measure for local use and derived a HoNOS score for national reporting within the mental Health Minimum Data Set.

**Action:**

- Trusts may use HoNOS or provide a HoNOS equivalent rating delivered through an alternative measure. However, it is important that the non-HoNOS measure can be calibrated to produce a HoNOS equivalent rating, to ensure its inclusion within the MHMDS.
- Responsibility for setting minimum requirements and principles for calibration of measures should fall to a national body such as the proposed National Mental Health Observatory, taking into account the requirements of DH, Healthcare Commission etc.
- In order to avoid duplication of effort, collaborative initiatives should be supported between trusts.

## **Developmental tasks to be co-ordinated nationally**

9. The feasibility, acceptability and utility of all the piloted measures have not been comprehensively assessed for black and ethnic minority groups. It is a matter of urgency that this is addressed.

**Principles:** Attempts to validate a single measure across diverse and evolving cultures across black and ethnic minority groups would be fundamentally flawed. As the paper commissioned by the Chair of the Reference Group highlights<sup>5</sup> culturally valid measures have to be constructed from an understanding of the cultural value base as to what constitutes distress for particular groups. Further, whatever metrics are developed must be buttressed with qualitative methods such as focus groups and interviews. Further, whatever quantitative metrics are developed it is probably that in the majority, if not all cases, they will need to be buttressed by a range of qualitative methods.

**Action:**

- Continue the current work in full acknowledgement of the limitations of existing measures.
- Develop a battery of complimentary outcome measures to buttress the standard measures that apply nationally.
- Local trusts need to be aware of the specific challenges in developing OM for local black and ethnic minority groups. As part of an initial implementation mechanism they are advised to specify and implement an OM project for BME targeted at gaining an understanding of specific local cultural values about mental health outcomes and BME groups experience of care.

10. No consensus emerged about service user or carer measures from the Reference Group although the measures that were piloted (CUES and MANSA) are often used in clinical practice. However, a consensus did emerge as to the principal domains that should be included within such a measure:

- Symptom distress
- Social functioning
- Quality of life
- How well services met perceived needs
- Whether the individual felt adequately informed
- Whether the individual felt engaged in care planning and given choices about treatment
- How the individual felt about the nature of their relationship with key healthcare professionals

**Principles:** Some independence in capturing and interpreting service user and carer views is essential to avoid actual or feared contamination of service user and carer views by clinician perspectives. Simple satisfaction with services measures generate levels of satisfaction that are not well correlated with the quality of the treatment and care received and where possible criterion-based satisfaction measures should be adopted that focus on specific aspects of the patient experience. Survey methods alone are not adequate to capture the complexities and nuances of service user and carers' views of services and must be supplemented by other more qualitative methods. Trusts are encouraged to develop service user and carer measures that are sensitive to local context, in particular the local ethnic and cultural profile. Given the great diversity of perspectives across service user and carers trusts must be given considerable local discretion in developing locally relevant OM.

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<sup>5</sup> Persaud, A., Bhui, K. and Sallah, D. (2003) 'Black and Minority Mental Health: Cultural Adaptation and Development of Mental Health Outcome Measures' briefing paper prepared for the Chair of the Department of Health Outcomes Reference Group.

**Action:**

- Trusts will be encouraged to adopt two of the following methods for eliciting service user and carer views: survey, focus groups, systematic reviews of complaints, consulting the user forum and interviews with subsets of user and carers. This should be outlined within the Trusts local implementation mechanism.
- At least one of the adopted methods would ideally be administered independently (e.g. not by staff).
- NHIME may wish to consider adapting existing measures, or commissioning the development of another survey-based measure, to provide those trusts with a default satisfaction and quality of life survey-based measure.
- Trusts will be given the option of developing local measures, provided these tap the minimum span of domains represented by the default survey-based measure.

**Trust Audit**

11. For those Trusts that wish to use this information to shape provision at Trust level, they are advised to adopt a set of specified comparisons, using the measures that they have chosen. Trust information, clinical governance, or audit staff would be well placed to organise the collection and presentation of data at this level. Discussion and evaluation of the results is an important stage and Trusts are encouraged to take this forward via their clinical audit committee to gain clarity over what the data indicates before taking this forward as part of their ongoing clinical governance arrangements.

**Principles:** Health care practitioners would benefit from using the results of the OM work, ideally they would be supported by clinical governance staff conversant with local data collection, and the results interpretation guidance for their Trusts outcomes measure of choice.

**Action:**

- Clinical governance staff, in collaboration with their clinical teams are encouraged to establish annual work programmes for collation and interpretation of OM data.
- Trusts are encouraged to feedback this work to Trust boards on an annual basis to support quality assessments and appropriate service development.

12. Any national comparison of service outcomes data would only be able to go ahead on a substantial body of local work. National infrastructure for comparative analysis can be put into place as experience grows and the numbers of Trusts producing data in comparable forms develops to a point where true national comparative yardsticks can reasonably be determined. Initially, once a significant number of Trusts begin to participate at levels two and three, the natural model to support development of national comparisons will be that of benchmarking clubs. These will be able to emerge as a natural organic development, with the proposed National Mental Health Observatory potentially assisting this work by providing internet-based analysis and presentation facilities for anonymised data from sites participating with any of the supported outcomes tools.

**Principles:** While developing their own systems in-house, Trust Clinical Governance teams are advised to keep abreast of developments elsewhere. Benchmarking clubs provide the obvious approach for this type of development. These would ideally be led by senior staff and will be relatively few in number.

**Action:** Having determined the outcome instruments their Trusts will use and having established a sufficient data set, Clinical Governance teams are encouraged to affiliate with an appropriate benchmarking club supporting the use of these scales.