

Royal College of Psychiatrists Consultation Response



DATE: 30th September 2010

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: Transparency in Outcomes: A framework for the NHS

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. The lead author for the consultation was Dr Laurence Mynors-Wallis: Registrar and prepared by Richard Meier of the College Policy Unit.

This consultation was approved by: Dr Laurence Mynors-Wallis- Registrar

For further information please contact: Claire Churchill on 020 7235 2351 ext.6293 or e-mail cchurchill@rcpsych.ac.uk

Response to Transparency and Outcomes: A Framework for the NHS

1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework?

The principles are uncontentious. The use of internationally comparable measures is of value but should not take precedence over focusing on what is important to patients and clinicians within the NHS.

2. Are there any other principles which should be considered?

Other principles that are of importance include ensuring that the measures chosen are simple, easy to collect, verifiable and supported by an appropriate IT system. The measures chosen should include those that are of value to patients and clinicians, and be suitable for being fed back immediately and so inform and improve patient care.

3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?

The outcomes framework will only be able to achieve these ambitions if it ensures that data on particular outcomes (see the College's suggestions for these in our answer to question 33) is measured for vulnerable/marginalised groups and/or particular conditions (e.g. common mental disorders, severe and enduring mental illness, learning disabilities).

Over and above this however, outcomes cannot be considered in isolation or be divorced from the process and cost of care. Although outcomes are of more importance than the processes of care, there is

an overlap between them and commissioners must ensure they provide services in all areas that are likely to deliver the outcomes required and fund capacity which reflects the needs of the local area. There is a danger that a perverse incentive may develop to focus on conditions that will produce good outcomes rather than conditions of great need and complexity where good outcomes are far harder to achieve.

4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?

This is an area where the process of care cannot be separated from the outcomes. Individual bodies required to provide and monitor services need to be fully accountable for those services. A mechanism needs to be established whereby where there are disputes between, for example, health and social care, these can be resolved. For example, in mental health, there remains an inequality about patients who require suitable accommodation in the community not being a priority for the Local Authority. The Local Authority has a financial incentive to ensure that patients in general hospitals are moved to suitable accommodation as soon as it is necessary. However, no such incentive exists for patients with mental health problems and hence hospital stays are unnecessarily prolonged with the inevitable consequence of institutionalisation, demoralisation for staff and frustration for patients and their carers. It is important to look across care pathways in their entirety so that, for example, supported accommodation services are available for people ready to step-down from other parts of adult mental health pathways.

The National Dementia Strategy identifies the need for clear responsibility for people with mental health problems who are in general hospitals and there is an equal need for someone to oversee the various strands of care including primary care when dealing with people with

dementia in care homes. The identification of key individuals with overarching responsibilities would go some way to ensuring that integrated care happens.

Given the diverse nature of child mental health problems, ranging from discrete episodes of illness to enduring disabilities such as autism, and where system and family factors as well as treatment can influence outcome, it is vital that any outcomes framework can take appropriate account of complexity; it is also important that any outcomes framework is able to take account of the different agencies which may be involved in the CAMHS pathway.

The Criminal Justice System is a key partner agency and effective joint working will be required for a number of health outcomes. For example, the Ministry of Justice can cause delays in transferring prisoners to hospital (by insisting on a clinically inappropriate level of security) or in discharging them from hospital. Where prisoners are located in the prison estate can hamper effective planning of future health care outside of prison. It would be helpful if the Criminal Justice System was named in the document as a potential partner agency. Applying a similar framework for outcomes across all the agencies involved, social services, criminal sentencing, etc. may assist in all agencies being focused on the same goals.

5. Do you agree with the five outcome domains that are proposed in Figure 1 as making up the NHS Outcomes Framework?

The domains chosen are suitably broad and all encompassing.

Regarding domain two, a key issue is what is meant by enhancing quality of life since this will have a different meaning to different groups.

While the College appreciates the sentiment contained in domain five, there is a risk that as currently phrased the domain might encourage paternalism. Some degree of risk taking is a normal feature of life, e.g. when dealing with an older mentally ill person - particularly one with cognitive impairment - there needs to be a balance between the benefits of letting them live with some risk in an environment which may not completely avoid exposure to harm and the potential detriment of depriving them of liberty by seeking placement in institutional care. 'Risk avoidance' must not replace 'risk management'. Similar examples can be provided in adult mental health. An addition to the domain title could include the phrase 'while seeking to maximise independence'.

6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?

Yes.

7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

While the College understands the rationale for proposing mortality amenable to healthcare as its overarching outcomes indicator, it has concerns (see answer to question 8) about the effect of this. Similarly, the College has concerns (see answer to question 9) about the five improvement areas outcome indicators which would be derived from this overarching outcomes measure.

Regarding the proposed 150 quality standards, the College believes that there is a great danger of this structure being viewed by clinicians as a new set of top-down targets, especially if it proves to be the case that these proposed quality standards contain within them several more standards (thus resulting in hundreds of quality standards that the NHS

in England will then be required to monitor). No doubt many of the outcome indicators and quality standards will be of value. However, the College is concerned that there will be too many of them and that others of potential value will not be included and hence be neglected. There is a danger that a bureaucracy will build up around the structure. There is also a danger of this process being seen as a continuation of top-down - rather than local clinician-led - management. Careful evaluation of the effect of these standards should guide what is appropriate for future standards in other health areas.

8. Is mortality amenable to healthcare an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?

The question here is the definition of healthcare, which should explicitly include public health as many of the major improvements preventing people dying prematurely will come from public health measures and preventive measures rather than improving interventions once physical illness has occurred.

The College understands the rationale for employing the concept of 'mortality amenable to healthcare' in regard to the first domain ('Preventing people from dying prematurely'); however, it is concerned that while appropriate on a population-wide level, this overarching outcome indicator will do little to address the substantial premature mortality of vulnerable groups with severe mental illness (see response to question 9).

9. Do you think this is an appropriate way to select improvement areas in this domain?

The College welcomes the focus on improving the premature mortality of patients with serious mental illness (for example contained in 3.14: "Some groups of people, for example those with serious mental illness, have significantly worse mortality than the population as a whole [and] it may be desirable to select some improvement areas in where there are significant inequalities in outcomes").

However, we remain concerned that the process of choosing five improvement areas (which will always be somewhat arbitrary) nevertheless risks overlooking the needs of vulnerable groups such as people with severe mental illness (standardised mortality ratios for people with schizophrenia, for example, are 3–4 times higher than the general population, with deaths mainly due to respiratory, circulatory, endocrine and digestive disorders), people with learning disability (who have high rates of preventable physical morbidity and premature mortality) and young people with mental health problems who commit suicide (a significant cause of premature mortality amongst younger people). If suitable outcome indicators for these conditions and populations are not chosen (for example, 'Amenable mortality for people with serious mental illness'), there is a risk that they may not be given the necessary focus that they merit.

10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed?

The College welcomes the acknowledgement in the consultation that 'considering all deaths above particular ages as 'not premature' discriminates against older people who still lead healthy and fulfilling lives'. However, the definition of older people in the consultation seems

somewhat arbitrary, and using it runs the risk of compounding the long-standing age discrimination which exists in health services.

The College would support an outcome measure such as 'healthy life expectancy at age 65' provided there were similar measures for higher risk groups such as those over 75, 80 or 85. It would be important that the measure of health included physical and mental domains.

11. If not, what would be a suitable outcome indicator to address this issue?

The lack of targets for the health of older people has been one factor which has inhibited service development and contributed to age discrimination. The trend to move away from target-setting and age-related, condition-specific mortality/survival statistics may be of value if these are extended up to age 85 at least rather than 65 being more typical. From a population viewpoint it would be extremely useful to know if there was a point at which there was an exaggerated stepwise increase in mortality for any given illness and this in turn would allow national comparisons. The College recognises that, from the standpoint of mental health, difficulty in determining the onset of conditions such as depression or dementia may dilute the usefulness of these statistics but they would still be invaluable to professionals working with older people given the co-morbidity in that age group.

12. Are either of these appropriate areas of focus for mortality in children? Should anything else be considered?

No comment.

13. Are either of these appropriate overarching outcomes indicators for this domain? Are there any other outcome indicators that should be considered?

Both measures proposed are vague and on face value lack immediate validity. The two measures are also measuring quite different areas. The use of validated quality of life measures would be the only sensible way to take forward an overarching indicator.

14. Would indicators such as these be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?

The EQ-5D (EuroQoL-5D) is easily completed and could also be used with the EQ-thermometer as a quick tool to compare quality of outcomes across physical and mental health fields. For those without capacity, a proxy measure should be considered.

Another area to consider is the use of specific patient-defined goals measured on a standardised scale which can then be combined as to how effectively services are meeting the needs and the key priorities patients themselves set. Work has been done to evaluate such measures in mental health in the US and the UK. Further development will be required before they could be used across the NHS as a whole.

In addition, an indicator relating to employment (as per, for example, PSA 16) should be considered.

The College also suggests that a measure be developed which looks at data on the use of out of area treatments for people with mental health problems (e.g. numbers of people placed out of area, length of stay) as

this would be a good indicator/proxy measure of how well the NHS – with regard to this poorly-served patient group – is performing on this domain in regard to managing people with SMI and enabling them to live independently (where possible) and to achieve any other outcomes which they have themselves identified.

15. As well as developing Quality Standards for specific long term conditions, are there any cross-cutting topics relevant to long term conditions that should be considered?

This would be an area where the NHS will need to fund pilot work looking at reliability and feasibility. However, the physical health needs of people with mental health problems, and the mental health needs of people with physical health problems, are both areas which are so overlooked that the College would suggest that two quality standards ('The physical health needs of people with mental health problems' and 'The mental health needs of people with physical health problems') be developed to ensure that these aspects of people's health needs are adequately addressed across the range of long-term conditions. In addition, a quality standard relating to cross-agency working for long-term conditions might be developed.

16. Are these appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?

Notwithstanding our concerns explained below in response to question 17, the first proposed indicator – Emergency hospital admissions for acute conditions usually managed in primary care – would not, as it stands, be appropriate in terms of mental health since the NCHOD data which is listed in the Annex as being the source of this data only concerns physical health conditions (ear/nose/throat infections,

kidney/urinary tract infections, heart failure). In theory, however, it could be made appropriate if data on mental health conditions were also added to this dataset.

Regarding the second indicator – Emergency bed days associated with repeat acute admissions – it is not clear whether the HES data listed in the Annex as being the source for this indicator includes mental health conditions; again, it would not be appropriate as an indicator without such information being incorporated into the data collection.

The College also suggests that ‘Accident and emergency presentations by people who repeatedly self-harm’ would be a suitable indicator for this domain.

17. What overarching outcome indicators could be developed for this domain in the longer term?

There is a danger here of trying to develop a large composite measure that will be to all intents and purposes meaningless. The attempt to bring together recovery from, for example, a sports injury, bacterial pneumonia and an acute episode of psychosis into one overall figure would seem to be of little value.

18. Is this a suitable approach for selecting some improvement areas for this domain? Would another method be more appropriate?

The focus of improvement measures on emergency bed days in mental health is not an appropriate one. Although inpatient care is an important part of mental health services, there is a key focus on caring for people in the community which is where, in the example chosen for depression, the vast majority of patients are treated. In mental health care, a broad

overarching quality of life measure or individual goals measure could be supported by more specific outcome measures for key target areas which could be either patient- or clinician-reported and include measures of symptoms and social functioning.

19. What might suitable outcome indicators be in these areas?

The Royal College of Psychiatrists is developing guidance for outcome measures in psychiatry. See answer to question 33.

20. Do you agree with the proposed interim option for an overarching outcome indicator?

Yes. One overall question that encompasses this area is 'Would you recommend the service to family and friends?' Such a one-item questionnaire should be evaluated for validity alongside the separate areas. The aim will be for simplicity rather than a multitude of questions.

21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator?

The aim should be not only to produce an outcome indicator to be used at a service wide or national level but to develop indicators that can be fed back to clinicians regularly and inform their ongoing Continuing Professional Development. Such surveys could be collated and reviewed during the process of appraisal for revalidation.

22. Do you agree with the proposed improvement areas and the reasons for choosing those areas?

The College believes that older people should be specifically included here. Although primary and community services, acute care and mental health services cover all ages, the specific inclusion of children and young people suggests that an 'all age' approach is not being taken. Older people with mental illness often become overlooked as a strategic group because their presence is implied in other areas.

People with dementia are a rarely researched group with regard to their views on services or on quality of life yet they have exposure to a wider range of health care and social care services than is typical in younger adults.

It seems inappropriate to only measure the experience of end of life care as a proxy measure obtained from the views of carers (as per figure 9: 'e.g. bereaved relative survey'). Although in some cases the terminal condition or phase of the illness may be brief, in others, e.g. dementia, it may well be very prolonged. Patient views should be included in this category.

In relation to mental health services as a suggested improvement area, it would be very useful for providers and clinical teams if patient experience were measured not only in relation to settings (inpatient/community) but also – in respect to community mental health services – the *type* of team (e.g. functional/specialist team (crisis resolution/assertive outreach/early intervention in psychosis) and community mental health team).

23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?

The College recommends that a focus of research be whether or not a single questionnaire can be used to cover all services since, if this were possible, it would have the advantage of allowing comparisons of satisfaction across services. The likelihood is that there will be core areas common to all with perhaps one or two areas that need to be specific. Again, there must be a caution against a multiplicity of questions.

A specific focus will need to be developing standards to measure the experience of those who lack capacity.

24. Do you agree with the proposed future approach for this domain?

The future approach will depend on how useful simple, routinely collected measures have been in driving up standards. There needs to be a period of time to allow measures to bed in and be able to effect change before more complex systems are introduced.

One area where patient experience should be measured is for long-term conditions which involve patients in transitions between different age-based services (e.g. from child and adolescent mental health services to adult mental health services, and from adult mental health services to older people's mental health services).

The College suggests that 'people with dementia' should be added to the examples given under 'long term conditions which cut across conventional organisational boundaries' (3.54).

25. Do you agree with the proposed overarching outcome indicator?

Whether the number of similar incidents should be decreasing is not as apparent as would be expected. It may be that there is a re-occurrence of similar incidents or near misses but these are being picked up much earlier and are therefore a cause of less significant harm. The danger of focusing on the number of any incidents is that of providing encouragement for people not to report an incident - which would be against the open culture of reporting. Furthermore, it should be borne in mind that an effective patient safety culture does not preclude the taking of risks to promote independence; it would be regrettable if work in this area resulted in a more institutionally risk-averse culture.

With regard to Never Events (3.63), the College suggests that there should be greater clinician involvement in identifying Never Events. For example, having the escape of a transferred prisoner from medium security as a Never Event introduces the perverse incentive not to admit such patients (contrary to the drive to speed up prison transfers) or to admit them under different parts of the Mental Health Act to avoid the financial penalty of the Never Event.

26. Do you agree with the proposed improvement areas and the reasons for choosing those areas?

Other vulnerable groups include mental health inpatients. It would be helpful to have a focus on safety in mental health inpatient settings.

27. What action needs to be taken to ensure that no one is disadvantaged by the proposals and how do you think they can promote equality of opportunity and outcomes for all patients and, where appropriate, NHS staff?

Adequate attention needs to be paid to the lack of available national data for key areas where there is already concern of poor care and poor outcomes. Vulnerable groups, particularly those without capacity, should be adequately represented in these outcome measures.

If the Criminal Justice System is not incorporated as a partner agency, there is a danger that these outcome measures will not apply to people once they are prisoners, adding further to their disadvantage.

28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?

It will be important that the relative merits, in terms of sustainability, of paper-based and computer-based data collection processes are estimated in advance of any implementation, and assessed once the Outcomes Framework is introduced.

29. Is the approach to accessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?

There is a key issue about ensuring that the collection and monitoring of outcomes are cost-effective and proportionate to the benefit obtained. This needs to be an ongoing focus within the department.

30. How can the NHS Outcomes Framework best support the NHS to deliver the best value for money?

The Outcomes Framework will be a crucial part of ensuring value for money but will only work alongside ensuring that appropriate pathways of care (delivering interventions defined by NICE) occur together with a focus on productivity. The Outcomes Framework is only a part of what is required for a cost-effective service.

31. Is there any other issues you feel have been missed on which you would like to express a view?

The College suggests that a key issue with outcome measurement is implementation: getting enough patients to provide feedback, fine-tuning the use of measures (such as HoNOS) by clinicians, support for clinicians so that they do not feel burdened with paperwork after seeing patients, sufficient IT support so that feedback reports can be useful for individual clinicians in their everyday work and for organisational clinical governance. Adequate planning and resources to ensure that an implementation strategy is in place will be of the utmost importance in any serious attempt to address outcome measurement.

32. What are the strengths and weaknesses of any of the potential outcome indicators listed below with which you are familiar?

For domain 3, emergency admissions are often precipitated by an incident, although the underlying cause of dementia is often a secondary diagnosis. It would be helpful to examine the presence of dementia as a primary or secondary diagnosis in the consideration of 'emergency admissions for conditions usually managed in Primary Care'.

33. Are other practical and valid outcome indicators available which would better support the five domains?

Yes. The following paragraphs are a summary of a paper 'Recommended outcome measures for use in adult psychiatry' which the College is in the process of finalising. The full document will be published in the autumn, and will be available from the College's Policy Unit (email: rmeier@rcpsych.ac.uk)

Outcomes in mental health, as with other chronic conditions, must reflect the quality of treatment provided and care received and not only the measurement of symptoms (which may be resistant to change).

To have a comprehensive picture of the quality and effectiveness of care requires information across three domains:

Effectiveness of treatment, in terms of:

- The achievement of patient identified goals (in keeping with the recovery model).
- The reduction of symptoms of mental illness.
- The achievement of desired social outcomes and quality of life.

The aim should be that:

- Fewer people will develop mental ill health, through a combination of public mental health measures
- More people will recover from acute mental illness more rapidly, through a combination of early recognition and effective evidence-based treatments and interventions
- More people will make meaningful self-defined recovery from serious mental illness, through a combination of effective evidence-based treatments and interventions across health and social care.

- Fewer people with serious mental illness will die prematurely through physical conditions and suicide through a number of evidence-based interventions such as access to smoking cessation programmes, and a targeted suicide prevention approach.

Patient safety

- The aim should be to ensure that fewer people of all ages and backgrounds will suffer avoidable harm, through being treated and cared for in a safe environment and protected from avoidable harm e.g. suicide.

Patient and carer experience of care provided

- The aim should be that more people of all ages and backgrounds will have a positive experience of care, through better processes for delivering personalised care.
- Outcomes cannot be completely separated from standards for the process of care. For some services and disorders, standards of service provision and treatment have already been identified, e.g. NICE, accreditation schemes and quality networks. They have associated audit tools to demonstrate compliance with recommended treatment and service guidelines. Many of these measures of the process of care are well established and will need to be maintained until robust and reliable outcome measures are evaluated and bedded into the system.

Effectiveness outcomes

There are a range of outcomes that can be considered within the effectiveness domain:

1. Patient-identified goals
2. HoNOS: The HoNOS and HoNOS 65+ are clinician-rated scales which measure outcome in 12 domains on a 5 point scale (0-4). The domains cover both symptoms and social functioning. The scale can be reported as a total

(although this combines several disparate factors) or by individual area looking at outcome in each of the twelve domains. HoNOS has several advantages:

- It is already part of the minimum mental health data set and is therefore collected throughout the NHS.
- It is simple to use and most NHS staff have been trained in its use.
- It covers both clinical and social outcomes.

3. Condition Specific Scales: There are many condition-specific symptom scales relating to specific areas of practice. There is currently no agreement as to which should be used.

4. Quality of Life Measures: Two simple quality of life measures are the SF12 (short-form survey 12) and the EQ-5D (EuroQol 5d). The College also suggests adding, for quality of life of people with long-term conditions, a measure assessing the proportion of people with dementia on a dementia register who are living in non-residential care or, if this data is unavailable, the prescription of anti-psychotics for people with dementia.

5. Social Outcomes: these include

- Access to employment
- Participation in volunteering
- Engagement in community activities
- Reduction in personal debt
- More patients receiving personalised care

When Department Objectives come into force to replace PSA targets in 2011, data should be collected which includes categories of supported accommodation (to be able to show move-on for those with longer term conditions as a sign of recovery) and participation in training, further education and volunteering.

The Recovery Star has been developed in the third sector as a way to engage patient and professional in the identification of goals across a range of social

areas. It has not yet been validated as an outcome tool and at this stage cannot therefore be recommended for this purpose.

6. *Physical Health Measures*: Given the impact of physical morbidity and mortality amongst those with mental illness, and the lack of engagement of some with severe mental illness with primary care services, physical health indices should be included in outcome measures for mental health services.

Patient safety outcomes

One measure of patient safety is benchmarking the reporting of adverse incident data as done by the NPSA (see: www.npsa.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=9260)

Specific safety measures include:

Community Measures

- Suicides and self-harming incidents
- Harm caused to others by mentally ill patients

Inpatient Measures

Outcome measures for patient safety could include:

- Violent incidents on inpatient wards: patient-to-patient, patient-to-staff.
- Suicide and self-harming episodes.
- Falls.
- Medication errors resulting in significant harm.
- Absconding of detained patients from inpatient units.

Outcome measures for patient and carer experience

The service user experience picks up another focus of care. The CQC's *Mental health acute inpatient service users survey 2009*, for example, explores a number of facets of service user experience.

There is need to have data collected at team level so that action plans can address any identified shortfalls in the experience of care. A common tool

would facilitate benchmarking at team level and complement the CQC data on provider organisations.

Other Outcomes

Staff and GP views provide another perspective on care provided by a given service and, again, a core standardised survey should be used wherever possible with additional questions added to address specific local issues.

Service quality and performance is also measured by accreditation programmes such as the AIMS programmes for in-patient units. The QuIRC – Quality Indicator for Rehabilitative Care – is an internationally tested, web based self-assessment tool for rehabilitation wards/community units, which is completed by the unit manager. It has been incorporated into AIMS-Rehab.

Process of Care

A pathway of care setting out the assessments and interventions that service users and their carers should expect for a given cluster of symptoms.

Productivity

Quality and productivity are inter-related. Detailed measures regarding *community teams* (e.g. no. of patients seen as new to them may; cluster score; length of stay), *inpatient services* (e.g. no. of admissions, length of stay and readmission rate) and *the use of out of area placements* (e.g. information as to who is in an out of area placement and for what reason) will be of value in determining capacity and productivity to ensure that services are both of high quality and are cost effective.

34. How might we estimate and attribute the relative contributions of the NHS, public health and social care to these potential outcome indicators?

No comment

35. Are these appropriate principles on which to select outcome indicators? Should any other principles be considered?

The College supports the key principles set out in paragraph 2.6.

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