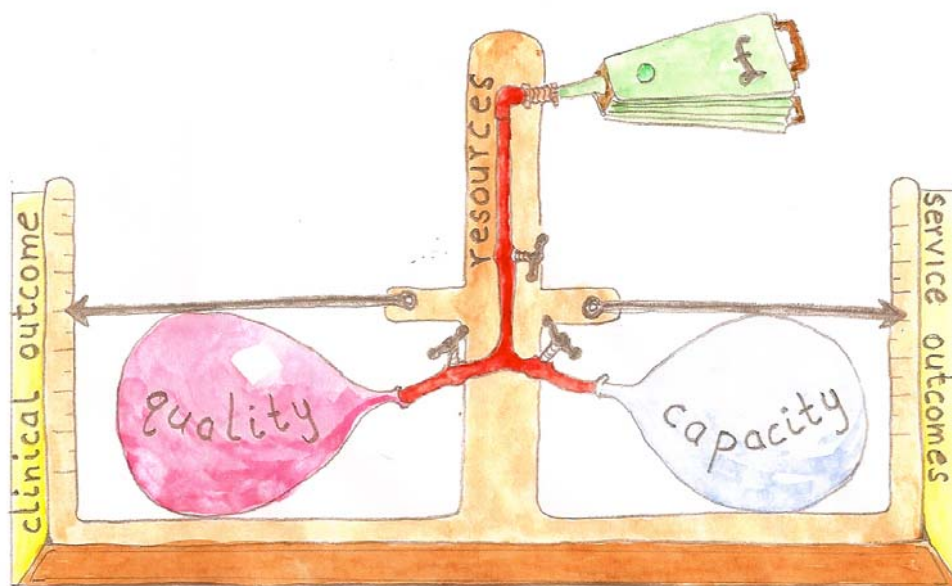


## Information-based Funding, Quality and Outcomes for Mental Health.



### Statement of Principles

## **Foreword:**

The distribution of funding and the maintenance of high quality services are priorities for all mental health services and for psychiatrists, wherever they practice.

The College's initiative on 'Information-based Funding, Quality and Outcomes' is beginning at a time when both the quality assurance of mental health services and their funding mechanisms are under review throughout Europe. Lord Darzi's Next Stage Review of the NHS in England promises to put clinicians at the forefront of NHS quality development, along with world class commissioning and Payment by Results for mental health services. In Scotland the plan is to use balanced scorecards to bring quality measures into the wider management and resourcing processes. Although the organisation of health services is diverging, the broad objectives of such policies are similar in all four of the UK legislatures, and all of them can only be achieved through multiple projects, nationally and locally driven.

Our Fair Deal campaign, in concert with those objectives, aims to empower all of the stakeholders so as to achieve adequate and effective resourcing to improve outcomes as judged by service users themselves.

So how will all of the required implementation projects come together against the backdrop of what many feel to be uncertain progress in key components such as routine outcomes measures, computerised electronic records and population needs estimates? There are few shortcuts and no simple answers, but there does seem to be a better consensus now as to the direction of travel, there are general principles that apply across specialties, and an increasing body of international expertise and research findings.

The first stage of the IFQO initiative has been to produce a Statement of Principles, as an overview to guide further work. Associated with it is a series of 'Questions and Answers' with links to source material and project websites. Intended to be regularly updated, these electronic resources will be publically available on the College website. Progress reports from the relevant projects, new principles and new questions will be added as the work develops.

The initiative will include College proposals for solutions to the problems posed by implementation in each country. The College will collaborate whenever possible with the responsible agencies, offering the expertise of the profession.

This is subject matter that has often been under-represented both in the psychiatric training curriculum and continuing education; yet it is as important and intellectually challenging as any of the traditional disciplines. It will affect all psychiatrists and merits their appropriate attention.

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## **Introduction:**

The College shares the concern that any new administrative mechanisms proposed for each country should work efficiently and effectively. New mechanisms are needed to support the development of ideas and technology and preserve established good practice. In order to do so they must use the right information, and there are certain principles that should govern its use.

As people follow their journey through mental health services, data items are sequentially recorded in various parts of electronic health systems, linked by their 'patient identifier' code. The data must be systematised, or 'modelled' in various ways to support the patient's care through the service. Data from many patients must also be combined, and viewed alongside information on facilities, staffing, finances, etc. to run the service. It can be used to commission and monitor services and inform the public. Together with research data it contributes to the knowledge base, which in turn guides the processes of service delivery. All of these separable processes are interdependent in some way. Determining what data should be collected, how it should be linked, and how it should be used is not as simple as it might at first seem.

Psychiatrists recognise the inherent difficulty in creating information systems which are simple and safe when the services that they model have such a variety of inter-dependent parts. But we believe that there is a lot that could be improved. Too often both management and clinical processes are limited by the availability of reliable information.

In particular the College promotes the principle that the distribution of funds to mental healthcare providers should be inseparably linked to measures of quality and outcome as well as to needs and to levels of appropriate care activity. The information used should be made available to the public, and the processes must be transparent.

Commissioners, managers of provider organisations, and clinicians all need access to information that can carry meaning across service boundaries. Good communications are needed between agencies serving different groups of people, between geographical areas, and between those whose primary responsibility is financial and those whose concern is for care quality. To facilitate the use of information across such boundaries the same definitions of terms and common formats must be used, but there is a need to carefully balance standardisation and local flexibility. The information culture must be empowered to adapt and change over time.

Service users and carers also need to be well informed, particularly if they are to benefit from government plans for greater choice.

The main principles that we have identified are listed briefly below, and then expanded in the associated set of common questions and answers, so that readers can select the topics that interest them most. Related questions and links for further information are listed after each question and in a bibliography. The website will include a list of relevant projects in each jurisdiction with project updates and contacts. Contributions, comments and discussion are welcome.

## **Summary of Principles:**

1. Fair resources for mental health. A national funding mechanism should provide the means to maintain the overall resourcing of mental health services at a fair level in relation to other care sectors such as services for physical illness. Funding strategy in each area should be based upon information on the prevalence and severity of problems in the population, the costs of interventions, and the potential gain in mental wellbeing. It should not be based upon repetition of annual levels of provision without systematic adjustment for changing and unmet population needs and the resulting burden upon carers and non-statutory services.
2. Integration of quality and funding mechanisms. Funding mechanisms and contracts for mental health services should be inseparably linked with measures of quality and outcome as well as levels of activity and need. If resourcing and efficiency remain unchanged, the capacity of a service can only be increased at the expense of quality, including patient safety and staff wellbeing. There should be a direct management link between each of the 'four 'e's': experience (of service users, including their safety and dignity), efficacy (evidence based interventions), effectiveness (what the impact of our efforts is in real life) and efficiency (how much of the above we get right for x amount of money).
3. Use of both process and outcome measures. Clinical outcome measures should be used alongside 'process' measures (the extent to which various good practices are used by a clinical team). Outcomes and process measures are not alternative approaches to quality assurance, but complementary. Compliance with a set number of policy criteria does not guarantee a good outcome for the service user, whilst a good outcome may sometimes be achieved despite bad service if alternative care is available.
4. Equity of access and wellbeing. Funding mechanisms and measures of quality and outcome should enhance the ability of mental health services to provide true equity of access for service users - across geographical boundaries, between socio-economic, ethnic and sub-cultural groups, between different age groups and sexes, and between people with different types of mental health problems. They should be used positively as a tool to promote social inclusion and choice.
5. Availability of financial information. The costs of care – of the direct provision of different interventions within various settings, and the associated costs - should be computed. They should be available to the public, to service staff and to commissioners. It should be possible to resolve 'bottom-up' costing against top-down budgets. Transparency of financial information will lead to improved efficiency and less discrimination.
6. Integration of information. Information services and electronic systems should be configured so that it is possible to bring together the data relating to each stage of every service user's care journey. There should be a means for integrating information within and between provider organisations, between health and social care, and between services for different age groups. System specifications should include business models for long term as well as acute conditions.

7. Clinical leadership, user's outcomes. Clinicians should be central to the processes of defining what high quality care is, and developing the means for quantifying the outcomes of specific interventions. Their understanding of the way in which their services work and interact with their wider environment is essential to the improvement agenda, and often extends far beyond their contractual role. However, service users and their carers should be the main stakeholders in the partnership when it comes to setting overall objectives and identifying the desirable outcomes for the service as a whole.
8. Provision for the information culture. Clinicians should be able to record and analyse their own activity, quality and outcomes measures, and those of the teams within which they work, and compare their data with quality standards and data from similar units (benchmarking). For them to do so there must be adequate training and support, provision of information technology that is fit for purpose, and specific time allocation within their job plans. Fairness in funding should extend to investment in all aspects of information management that is comparable with other sectors of healthcare.
9. Efficiency of data collection. Wherever possible, management information should be drawn from existing clinical information. The use of data should be monitored: if data use cannot be demonstrated, it should no longer be collected.
10. Balance between standardisation and local flexibility. The College welcomes recent moves towards a mix of locally and nationally-determined quality measures. To make that work, we need structures in each country of nationally defined or approved clinical terms, measures and document formats from which to choose, if local data are to be communicable and more widely comparable for benchmarking.
11. Mental wellbeing. The standard against which the overall quality of an area mental health strategy should be judged is the mental wellbeing of the whole population. Mental wellbeing is more than the absence of mental illness. Therefore the scope of a mental health strategy should include more than a treatment service; it will require adjustment of many local policies even beyond health and social care, and it follows that its outcome goals should be as broad.
12. Comprehensive incentives. Targets and performance indicators should be used sparingly and selected carefully so as to minimise their potential for introducing perverse incentives and unintended consequences. Above all, incentives should be balanced across the whole span of service provision. The temptation to introduce specific incentives to meet narrow or transient political objectives must be resisted. Because resources are finite and relatively fixed, the identification of targets or indicators only for some conditions or service types inevitably leads to deficits in other services.
13. Interventions recording. Interpretations of outcome measures must take into account all of the care interventions that have been carried out throughout the episode in question.

A national interventions classification or list must therefore be introduced as an integral part of each national data model.

14. Safety is paramount. The safety and confidentiality of mental health records are of utmost importance and security requires active monitoring in every setting. The safety of the service user, professional and organisation must all be ensured.

There is more detail, with links to reference sources in the associated pages ([IFQO Questions and Answers](#)):

- How can commissioning decisions be based upon quality and outcomes measures as well as levels of activity?
- Is it possible to draw management information from clinical records?
- What are the criteria for judging a MH funding mechanism?
- What should each psychiatrist be given to enable them to assess their own quality of service?
- Why are quality and outcomes issues important in mental healthcare in particular?
- How safe and confidential is clinical information in the local and national systems?
- How can we measure quantities of mental healthcare in the health market so that they make clinical sense?
- What is the Payment by Results Project?
- How can the right level of resourcing be proven for an area?
- What outcomes, whose outcomes?
- What are the differences between quality-based commissioning of mental health services and acute services?
- What are the dangers of a tariff-based system of funding for mental health services, and how could they be avoided?
- How can we ensure that mental health gets a fair deal compared to other sectors?
- How can we strike a balance between national standardisation and local choice?
- How should the costing of mental healthcare be improved?
- How should we choose the best mental health outcomes measure?
- Do we need a classification or list of mental health interventions?

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### Author's note:

I am very grateful to the above for their many useful additions and corrections. I cannot be certain that the views expressed are necessarily shared by all contributors. I hope that my English pre-occupations and terminology in the early versions will be balanced by additional material from the other countries as it becomes available. The document will remain open for improvement for as long as the initiative continues (12-18 months).

If you have a question or a contribution that you would like to be added please contact [martin.elphick@awp.nhs.uk](mailto:martin.elphick@awp.nhs.uk) or for further information please see the IFQO website: <http://www.rcpsych.ac.uk/members/currentissues/ifqo.aspx>

ME 12/02/09