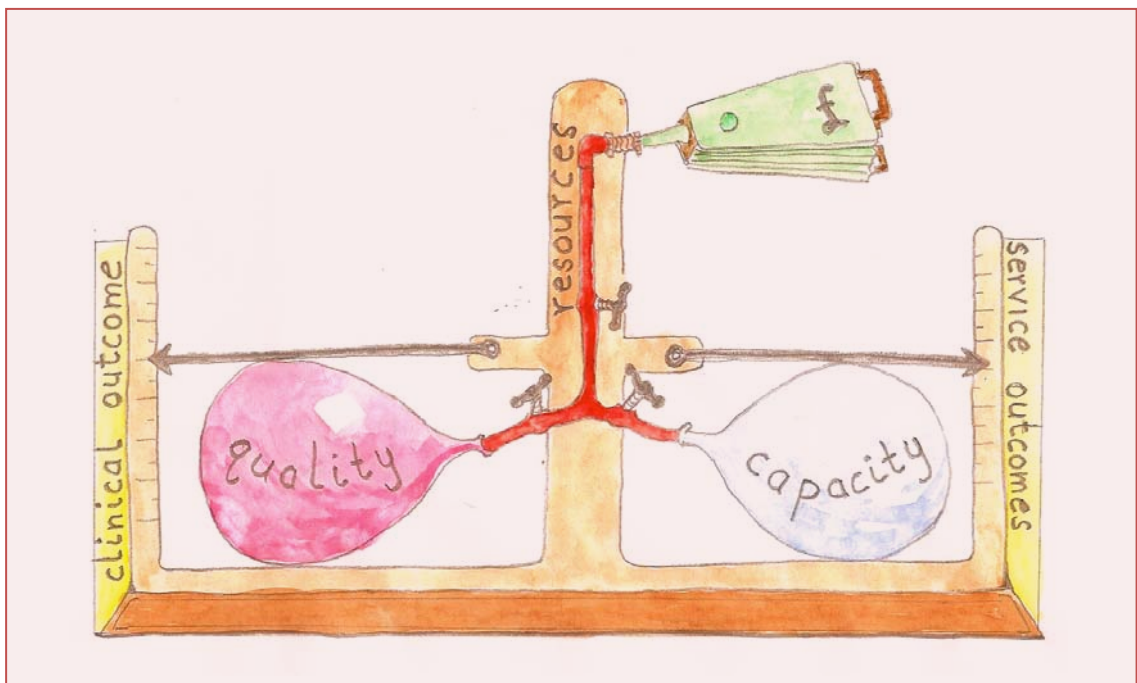


Information-based Funding, Quality and Outcomes For Mental Health

February 2009



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.

Professor Susan Bailey
Registrar

Dr Martin Elphick
Specialist Adviser

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.

Questions and Answers (click to navigate)

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

How can commissioner's decisions be based upon quality and outcomes measures as well as levels of activity?

At present there is limited information for commissioning¹.

The mental wellbeing of the whole population is the most valid criterion of success (see for instance '*A New Vision for Mental Health*'), but it is ambitious in terms of information collection and use. It cannot be inferred from statistics collected within provider organisations. The results of whole population surveys and needs estimations should be used where possible to determine local prevention and promotion strategy as well as the commissioning of therapeutic and recovery services. Ideally that implies the need for joint commissioning by responsible agencies and a broader mental health strategy than is currently employed.

Funding decisions on statutory care services may be linked through direct or indirect mechanisms to quality measures:

Direct: Some proposals have been made for 'automatic' systems in which a percentage of the potential funding for each service is held back by commissioners and selectively released to reward those providers meeting targets for a specified range of quality measures (NHSNW, 2008). There appears to be little experience of that technique globally outside the acute sector. 'Best practice tariffs' are promised in England by Lord Darzi's review (DoH, 2008) but it is not certain yet how those might work for mental health. As is the case for performance targets in general, the main dangers arise from placing undue emphasis upon some criteria to the detriment of other aspects of the service; or from removing supportive funding from providers who are already struggling with a local obstacle.

The balanced scorecard approach to be used in the Scottish benchmarking project includes a number of mandatory performance indicators as well as some for local selection (Scottish Government, 2008).

Indirect: Commissioners might of course take into consideration any number of quality measures when they use their discretion to decide upon one organisation or another to provide a service. And they can subsequently agree with that provider to use any range of quality measures for subsequent monitoring. It is also intended in the policies for England that a similar principle of devolved choice should enable practice commissioners and individual patients to make choices between providers, based upon freely available information (DH, 2008). For these mechanisms to be effective, information on a range of quality measures needs to be very easily accessible, and easy to interpret. That is not the case presently. There is a risk that subgroups of the

¹ The split between purchasers and providers is greatest in England. Terminology also varies between countries. The (English) author apologises for favouring the familiar in this first version and would welcome constructive suggestions as to how to make the document more universally applicable.

population with less access to information, or less ability to make complex choices, will be disadvantaged.

Local decisions as to *which* quality and outcome measures will be used should encourage local issues to be addressed, although there may be a temptation to choose easily available, cheaper methods. On the other hand, the argument in favour of standard measures is that each commissioning body should be able to compare quality between rival providers; and providers will frequently be working across commissioning boundaries – they will not wish to provide different measures for each commissioner. National minimum sets of quality and outcome measures therefore seem to be required, with options for local additions (DH, 2008). An authoritative source from which quality measures can be selected for different purposes seems to be required, together with the means to collect the data at a local level.

CSIP (the Care Services Improvement Partnership) is currently producing a compendium of mental health outcome measures covering a range of settings and intended purposes (CSIP 2008).

The College Research and Training Unit is the leading national authority on quality assessment of MH services in the UK. The CRTU website has details of each of its projects and programmes including that of the CCQI (College Centre for Quality Improvement).

There has been a long history of difficulties in sustaining the collection of clinical outcomes data. It is generally agreed that there are statistically reliable and valid measures of different types, but clinicians who have to make and record the assessments often remain unmotivated. That could be improved by providing them with regular access to the analysis of their own results, and the means to change their service model accordingly.

Commissioners should insist upon the presentation of quality and outcomes information from providers, separately by team, intervention type, care pathway, problem or client group, etc.

National bodies should agree a national set of common quality measures as well as a validated additional set for optional local use.

Related questions:

- **How can the right level of resourcing be proven for an area?**
- **Why are quality and outcomes issues important in mental healthcare in particular?**
- **What outcomes, whose outcomes?**

- **What are the dangers of a tariff-based system of funding for mental health services, and how could they be avoided?**
- **How should the costing of mental healthcare be improved?**
- **How should we choose the best mental health outcome measure?**
- **Do we need a classification or list of mental health interventions?**

Sources:

CSIP Routine Outcome Measures Website

CSIP Commissioning toolkits

Dept of Health (2008) "High Quality Care for All: NHS Next Stage Review Final Report."

E-journal article on CQUIN (Commissioning for Higher Quality and Innovation)

Jacques J (2008) Payment by Results and Mental Health Services. *Psychiatric Bulletin*, 32 (10), 361-363

NHSNW Advancing Quality Website (2008)

Public Finance (2008) E-Journal article on funding and quality

Royal College of Psychiatrists - College Centre for Quality Improvement

Scottish Government (2008) Mental Health Project Final Report: National Benchmarking Project Report 2

The Future Vision Coalition (2008) - A new vision for mental health

Is it possible to draw management information from clinical records?

This is a cherished goal of health informatics. Many types of routine management data could potentially be collected as a by-product of clinical processes like appointment booking and discharge, but are often set up so that data has to be entered more than once in different software applications.

Attempts to routinely aggregate clinical data are confounded by at least three factors:

Firstly, the software for information systems incorporates a generic business model for health services that works (more or less) for all of the providers who purchase that system. It will usually be modular in structure, each module linked to a store of patient identification data. But the clinical processes of each team will not immediately match the generic model without some modifications or addition of a new module, which is costly and involves a great deal of clinical input.

Secondly, paper-based clinical records are rarely standardised enough to ensure that the terms and data items used have a consistent meaning across documents, individual records, teams and units. That does not matter with a paper system which relies upon the reader to extract common meanings from different formats. But to make maximum use of an IT system, a standardised data definition of some sort must be adhered to. Also, each instance of the use of those defined terms often has to be within a standard context (such as a labelled field in a formatted document like a CPA plan or discharge summary). Only then can an automated search be made across records to yield data that can be aggregated for management use. The term will then be assigned a code by the computer. The standard nomenclature of coded health-related terms used in this country is SNOMED. Many terms are part of a classification or hierarchy, which can be reflected in a standard code which will place each instance of its use in its correct position in a database. For instance, if an automated search is carried out in a set of records for the presence of the term 'depression' then the codes must be different for depression of mood (part of the affective disorders family of terms), depression of a skull fracture, depression in the family history, and depression of the economy.

The third factor is that the most formalised clinical document generally available in records is usually the Care Plan (or a variant like a CPA plan), which records *intentions*. By contrast, *retrospective* information about what actually took place is more often useful for management.

Although it is certainly most efficient to draw management data from existing patient-related information there are naturally also times when clinicians should collect 'management' information which only indirectly benefits clinical care. Audit information is an obvious example.

The collection and use of routine data takes time. Implementation plans for new information systems should include details as to how that time will be afforded within the clinician's weekly work schedule. There may need to be a formal adjustment to job plans. There should always be a justification in terms of the net gain to the mental health of the population served: the information system must improve effectiveness or efficiency or it should not be introduced.

Any outcome and process measures need to be short and rapidly completable so that they are compatible with the 60 minute new patient appointments and 15 to 30 minute review appointments used by many psychiatrists; the longer the outcome and process measures take to complete, and the more often they need to be done, the more patient care and staff wellbeing will suffer. It has to be considered that time spent by clinicians on measuring processes and outcomes subtracts directly from their clinical diagnostic and therapeutic work with patients.

Clinicians must be involved in developing and implementing integrated systems, even when the end use of information is by 'managers'. Multiple usage of data should be an explicit quality criterion for systems developers. But many systems can be adapted by local IT managers to collect items of local choice. When new forms and documents are designed, standardised, defined terms should be used whenever possible as they are more likely to be useful at a later date and for multiple purposes.

Related questions:

- **How can we strike a balance between national standardisation and local choice?**

Sources:

Academy of Medical Royal Colleges (2008) A clinician's guide to record structures: Part 1. Why standardise the structure and content of medical records?

Academy of Medical Royal Colleges (2008) A clinician's guide to record structures: Part 2. Standards for the structure and content of medical records when patients are admitted to hospital.

NHS Connecting for Health-Website with information on standard international terms

What are the criteria for judging a MH funding mechanism?

Three general principles were proposed in the College's response in 2007 to the Department of Health (England) consultation paper on Payment by Results.

1. The national funding mechanism as a whole should provide the means to maintain the overall resourcing of mental health services at a fair level in relation to other care sectors. Funding strategy should be related to measures of disability and the prevalence of problems in the population. It should not be based upon repetition of annual levels of provision within care services, which take no account of changing and unmet population needs and the resulting burden upon carers and non-statutory services.
2. The funding mechanism for mental health services should be fully integrated with other information-based commissioning and governance approaches so as to provide a means for maintaining or improving quality.
3. The funding mechanism should enhance the ability of mental health services to provide equity of access for service users - across geographical boundaries, between socio-economic and sub-cultural groups, and between people with different types of mental health problems.

Related questions:

- **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 should the costing of mental healthcare be improved?**
- **How can the right level of resourcing be proven for an area?**
- **How can we ensure that mental health gets a fair deal compared to other sectors?**
- **What are the dangers of a tariff-based system of funding for mental health services, and how could they be avoided?**

Sources:

Department of Health (PBR team) (2008) Developing a Payment by Results tariff for mental health (includes factsheets and updates)

Dept of Health (2008) " High Quality Care for All: NHS Next Stage Review Final Report."

Jacques J (2008) Payment by Results and Mental Health Services. *Psychiatric Bulletin*, 32 (10), 361-363

Royal College of Psychiatrists - Fair Deal for Mental Health Campaign

The Future Vision Coalition (2008) A New Vision for Mental Health

WHO (2005) European Observatory on Health Systems and Policies. Policy Brief: Mental Health iii. Funding Mental Health Services in Europe. (Authors McDaid D, Knapp M, Curran C).

What should each psychiatrist be given to enable them to assess their own quality of service?

All clinicians should assess their own performance both as individuals and as members of teams, but we need support, time, and the right tools to do so. The number of policies requiring such information has increased faster than the provision of the means for supply, and this is an area for obvious efficiencies in using the same data for different purposes like team evaluation, audits, validation and licensing, appraisal, applications for performance-related awards such as CEAs, etc. Often individual data can be aggregated to provide organisational indicators.

Implementation of information systems should include specific plans as to how that time will be afforded within the clinician's work schedule each week. There may need to be a formal adjustment to job plans. There should always be a justification in terms of the net gain to the mental health of the population served: any information system must improve efficiency or it should not be introduced.

Software to support the concept of the 'Clinical Dashboard' - a set of outcome measures to enable each clinician and team to continuously monitor their performance – is being developed by Connecting for Health in England in collaboration with the College. A pilot project for mental health as well as acute conditions will be in progress in late 2008 and 2009.

National MH bodies (DH, CSIP, IC and professional bodies including the College) should agree and promote a limited number of suitable measures; and then work with CFH to develop the dashboard and other tools to assist quality work at the level of individual clinicians and small teams.

Related questions:

- **Is it possible to draw management information from clinical records?**
- **What outcomes, whose outcomes?**
- **How should we choose the best mental health outcome measure?**
- **Do we need a classification or list of mental health interventions?**

Sources:

[CSIP Routine Outcome Measures Website](#)

[Royal College of Psychiatrists-Assessment for Consultant Psychiatrists-360 degree appraisal](#)

[Royal College of Psychiatrists-College Centre for Quality Improvement](#)

Why are quality and outcomes issues important in mental healthcare in particular?

There appear to be no natural ‘types’ of mental health problems that would enable predetermined amounts of resource to be allocated for each. Just as the severity and complexity of each person’s mental health problems is determined by an interplay of factors, so is the type of management required and the difficulty encountered in resolving them. This means that there is not much predictability in how much improvement will result from a certain level of financial input.

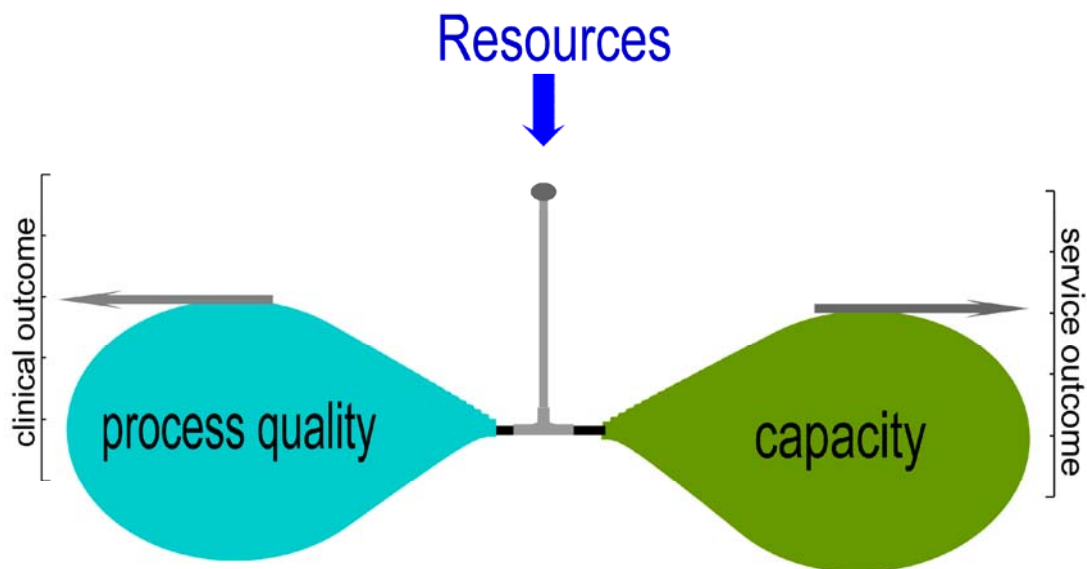
This contrasts with some acute physical conditions, which require a set type of intervention. The treatment (an operation, for instance) is either carried out or not, and if there are no complications it is judged a success. There is a simple mathematical relationship between a finite number of people needing the intervention, the number of interventions carried out, and the results. Although there will be some interaction between costs and quality there is a relatively narrow range of possible prices.

Returning to mental healthcare, a poorly resourced service will often share the care it can afford between all of the service users seen by each team. It may be struggling with low staffing numbers, high complexity for socio-demographic or economic reasons, or high travel times. Such teams can have large caseloads of people for whom they are doing very little good. If no more than activity measures are used to assess the performance of such a team then it will have an appearance of effectiveness – a lot of contacts, and a high caseload. It may even be adopting all of the guidelines, after a fashion. But the net gain to the service users will be very little. The way that quality and capacity interact with resourcing is shown in the illustration.

To avoid the danger of improving one aspect of quality at the expense of others, additional measures are needed at each stage of the care journey:

- Severity scores can be used to monitor entry criteria to the service.
- Process measures ensure that approved practice is used
- Outcome measures test whether the processes have worked.

Each type of measure will do some good; all three would be ideal. The same measures can be used within the team to adjust practice, by Trust managers to compare teams, and by commissioners to make resourcing decisions.



'Balloon technology' - The dynamic relationships between the key variables.

Increased resources can inflate capacity, as measured by service outcomes, and/or improve process quality ('effectiveness'), with resulting gains in clinical outcome. But if resources and the efficiency of their use are unchanged then one balloon can only be inflated by squeezing the other. Efficiency (comparable to pressure in the balloons) works throughout the system to enhance the overall effect of resources.

Related questions:

- How can we measure quantities of mental healthcare in the health market so that they make clinical sense?
- How can commissioner's decisions be based upon quality and outcomes measures as well as levels of activity?
- What are the differences between commissioning Mental Health services and Acute services?
- What should each psychiatrist be given to enable them to assess their own quality of service?
- How can the right level of resourcing be proven for an area?
- What outcomes, whose outcomes?

Sources:

CSIP Routine Outcome Measures Website

CSIP Commissioning toolkits

E-Journal articles on funding and quality, including CQUIN

Public finance

Scottish Government (2008) Mental Health Project Final Report: National Benchmarking Project Report 2

How safe and confidential is clinical information in the local and national systems?

The possibility that sensitive information might fall into the wrong hands has probably been the commonest concern about computerised records expressed by psychiatrists.

There are two scenarios commonly envisaged – access to a single targeted record for malicious or improper purposes, and access to databases comprising many different records.

A comparison with paper records is sometimes made but it is very hard to conclude which is safer overall. Paper records are often kept in insecure offices and can be read without leaving any trace, copied, destroyed or removed. By contrast electronic records are password-protected and health information systems have security devices to prevent access by ‘hackers’, but each and every record can be accessed through computers in any one of many sites at all hours.

Both confidentiality and security are complex issues, some of which have been covered in a College Report (CR133) together with guidance on information sharing and disclosure.

Once it has been decided what should legitimately be disclosed to whom, and under which circumstances, protective measures include passwords, role-based access, encryption, operating system security, firewalls, the partition of records to include highly restricted ‘envelopes’, anonymisation, and audit paths which permanently record who has opened each record, and when.

Recent high profile incidents in which large confidential databases have been mislaid or stolen highlight the need to remember physical security, especially when using mobile devices.

There has also been a great deal of debate about whether national electronic records in particular should be ‘opt in’ (service users having to positively agree to participate) or ‘opt out’ (the assumption that records will be included unless there is an objection). It is worth pointing out that those decisions do not necessarily need to be made by the individual service user. A whole unit dealing with particularly sensitive information can withhold all of its records, or everything in a specific document format, or use an ‘opt in’ protocol even though it is part of a bigger organisation working on the ‘opt out’ principle.

The College is committed to the principle that the safety and confidentiality of mental health records are of utmost importance and require detailed attention in each separate context.

Sources:

Royal College of Psychiatrists CR133, Good Psychiatric Practice: confidentiality and information sharing

NHS Connecting for Health (2008) Security and Access

How can we measure quantities of mental healthcare in the health market so that they make clinical sense?

Historically, mental healthcare has been purchased in 'block contracts' by state funding, annual budgets being set for each geographically-defined area by making adjustments to the previous year's total. It has been mainly up to providers themselves to split their finances further between different units and teams, balancing governmental directives and strategies against local priorities.

Many countries have now begun to try to match resources more directly to specific measured local health needs, particularly in the acute sector. The intention is that where the demand for more activity has been met, the money will follow. Either the number of cases treated for each type of condition is counted, or each procedure is counted. The groupings of conditions or of procedures are selected so that all of the cases will be both clinically similar and cost more or less the same. These groupings are sometimes called 'costing currencies' or casemix groupings. In England the current set is called Healthcare Related Groupings, HRGs. A tariff, a fixed price, can be set for each grouping.

Any Mental Health costing currency must be:

- Clinically meaningful
- Have a manageable number of groups
- Be produced from readily available or attainable data
- Have comparability in (actual, not planned) resource use

Note that such systems only provide an immediate mechanism for *distributing* a health budget. If the total budget has already been set, they just redistribute funds from one area of care to another. Hopefully, the figures from a previous year can be used to contribute to the decision process of resetting next year's allocation, but even the weight of that evidence will not automatically swing the political balance.

Tariffs therefore shift financial risk (responsibility for meeting resource constraints) from providers to commissioners. They can be seen, if they work properly, as part of a move to better commissioning.

Also, the unbundling of block budgets necessarily increases transparency regarding the cost of individual services and also variations in cost both between and within providers. That should tend to improve efficiency.

And the whole system improves the incentive to implement better information systems.

However, one of the assumptions that is sometimes made about such systems is that the need of a population for care of a specific type can be measured by the number of

cases that present themselves or are referred to the providers. But we know that is not the case so far as mental health needs are concerned, because many people with MH problems do not seek help or get referred to secondary services. And the poorer resourced services may have the lowest referral rates because expectations have become so low. Therefore, if a system is used in which finances reward activity ('met need'), there must be some independent additional means for measuring the unmet need as well. Otherwise a population whose expectations are low or whose services are difficult to access, or a cultural sub-population which is reluctant to seek help, will not get adequate funding.

Costing currencies in the acute sector have worked best in conditions that require discrete procedures that are time-limited. In chronic conditions, both in the 'acute' sector and in mental and community healthcare, it is much harder to define a start and end point for the costing and remuneration process. If long term care is simply costed by the month or quarter, there is too much variability between individual cases *within* each group to allow distinctions to be made *between* client groups and so the system represents little improvement upon block contracts.

A further problem results from the poor correlation in our sector between the 'condition' (whether it is classified using a medical diagnosis, a psychosocial formulation, a functional measure, or all of them combined), and the amount of care that the person requires or eventually gets. That makes the goal of tariff-based funding of condition-based groupings unattainable. Instead, recent projects (including the Payment by Results programme for MH in England) have attempted to identify broad groupings of clinical interventions, or care packages, which have both clinical meaning and similar resourcing implications. Detailed costing methodology has not yet been applied to the proposed groupings, and it is by no means certain that the care packages could support the use of a nationally-set tariff. Some way of assessing the whole population need would still be required. Nonetheless, a valid means of classifying mental healthcare activity would enable comparison between areas and between providers to begin.

Related questions:

- **What are the dangers of a tariff-based system of funding for mental health services, and how could they be avoided?**
- **How can the right level of resourcing be proven for an area?**
- **What is the Payment by Results Project?**
- **How can we ensure that mental health gets a fair deal compared to other sectors?**
- **How should the costing of mental healthcare be improved?**

Sources:

Andrews G, Issakadis C, Sanderson K, Corry J, Lapsley H (2004) Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders. *The British Journal of Psychiatry* 184, 526-533.

[E-journal article on quality and funding](#)

Elphick, M (2007) *Information-based management: a two-stage proposal for improving funding mechanisms and clinical governance in mental health*. *Psychiatric Bulletin* 31<- ,44-48.

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Parsonage, M. (2004) Payment by Results: what does it mean for mental health? *Primary Care Mental Health*, 2 (3-4), 183-198.

[Scottish Government \(2008\) Mental Health Project Final Report: National Benchmarking Project Report 2](#)

What is the Payment by Results Project?

The following is adapted from the Project Initiation Document for this project in England:

“PbR was first introduced in 2003/04 for elective secondary care procedures. It was always intended that the scope of PbR would increase, with the 2002 consultation document Reforming NHS Funding Flows: Payment by Results highlighting mental health as a priority area for including within PbR. To this end a project was initiated to develop currencies for mental health.

This project split into two separate strands, one led by the Information Centre and another by a group of Mental Health Trusts from Yorkshire and the North East (hereafter referred to as the Care Pathways and Packages Project).

The Information Centre work focused on statistical analysis, whilst the Care Pathways and Packages Project approached the issue from a more clinically driven perspective. Both strands published reports in the Autumn of 2006 and it was decided that consideration of the next steps should take place as part of the consultation Options for the Future of PBR 2008/09 to 2010/11.

This consultation revealed strong support for further work to be carried out on developing a PbR system for Mental Health. Over 100 of the consultation responses mentioned Mental Health as an area needing further work. Mental health was identified as the top priority for expanding the scope of PbR.

The formal response to the consultation has now been published, confirming that mental health is a priority area for future work.

Project Objectives

- To develop national currencies that can be used as the basis for contracting and paying for mental health services in England.*
- To produce a more transparent funding system for mental health services, with clarity as to what care is being provided, how it is paid for and what outcomes are delivered.*
- To ensure that funding reforms support mental health policy objectives.*
- To identify good practice in needs based packages of care.*
- To cost up both good and existing practice.*
- To ensure that an amended mental health minimum data set is fit for the purpose of mental health PbR.*
- To achieve agreement on a standard needs assessment tool.*
- To develop necessary software to allow grouping of service users into clusters.*
- To successfully pilot local approaches to PbR for mental health and extract the nationally applicable learning.*
- To specify the necessary changes to SUS to support the operation of a mental health PbR type system.*

Project Scope

The focus of previous work has been on working age mental health. The project's scope is extending to include:

- *Older people's services.*
- *Forensic and secure services (medium, low, challenging behaviour and community) and other specialist services.*
- *The project will include services in the community that are traditionally described as both primary and secondary care, with the exception of exclusions (e.g. GP services, see below).*
- *Liaison mental health services will also be included within the scope of the project, although it will have its own approach to funding."*

A recent paper by Jacques summarises many of the potential advantages and disadvantages of PBR for mental health services.

Related questions:

- **What are the dangers of a tariff-based system of funding for mental health services, and how could they be avoided?**
- **How can the right level of resourcing be proven for an area?**
- **How can we ensure that mental health gets a fair deal compared to other sectors?**
- **How can we measure quantities of mental healthcare in the health market so that they make clinical sense?**
- **How should the costing of mental healthcare be improved?**
- **How can commissioner's decisions be based upon quality and outcomes measures as well as levels of activity?**
- **What are the differences between commissioning Mental Health services and Acute services?**

Sources:

Department of Health (PBR Team) (2007) Reports of the two strands of PBR project work from 2006

Department of Health (2008) Options for the Future of Payment by Results: 2008/09-2010/11-response to consultation

Department of Health (PBR team) (2008) Developing a Payment by Results tariff for mental health (includes factsheets and updates)

Jacques J (2008) Payment by Results and Mental Health Services. *Psychiatric Bulletin*, 32 (10), 361-363

How can the right level of resourcing be proven for an area?

The established block contracting system bases each area's budget upon that of the previous year, with amendments. Whilst that does nothing to automatically promote equity, good commissioners and senior managers with an understanding of their services have often used their discretion to good effect. Many costs are fixed or semi-fixed anyway, being associated with facilities and long term staffing. So the proportion of each mental health provider's budget that can vary over a short period of time to match population needs is smaller than might be expected.

Furthermore it is not as simple as it might seem to decide what 'equity' should mean. The idea that since 20% of morbidity is psychiatric, therefore 20% of spending should be on mental health services misses the point that different treatment packages have different costs. A condition that can be effectively managed (in terms of gain in wellbeing) more cheaply than another should not be allocated excessive funds to the detriment of people whose equal suffering is more expensive to relieve. And it may also be difficult to decide whether the aim should be to merely match resources to the prevailing need in each area (equity of access), or to go further and take some responsibility for trying to *reduce* the prevalence if it is known to be high – perhaps through some form of positive discrimination? The answer may depend in part upon the extent to which the commissioning authority has responsibility for preventive rather than responsive actions.

Even equity of access encompasses several factors. The capacity of the service is only one of them. Geographical factors may make it hard to get to a facility or to move from one centre to another (both for the patients and staff). Some may feel more welcome than others. It is therefore dangerous to base resourcing upon theoretical calculations of what 'should' be the case, as it is rarely possible to take all factors into account.

What information could be used, and how? Three examples will serve to illustrate some principles, and some practicalities:

1. The most direct 'gold standard' measure, in theory, might seem to be a door-to-door local mental health survey, carried out every few years, to quantify the prevalence of each type of mental health problem in each area, age group and subculture. The information gained would be more reliable than any of the alternatives and could be used to plan a broader local mental health and wellbeing strategy that includes prevention and promotion, as well as therapeutic and recovery aspects; and non-health measures such as local social, housing, educational and occupational policy. Such surveys are technically feasible, but fall outside the competency and affordability of most health commissioning bodies. The return would not justify the expense. It is better to assume an approximate range of prevalence for the common anxiety and depressive disorders, and use other methods for the rarer, severe and enduring conditions: most people with

those conditions are known to services, even though they may not have stayed in touch.

National mental health population surveys cannot reliably be used to provide arithmetical estimates of local prevalence.

Professor Gyles Glover, Durham University:

*Surveys of the size of the Health Service England or the National Psychiatric Morbidity Surveys unfortunately cannot provide measurements of the prevalence of the types of illness treated in specialist care at a PCT level, the best they can do is provide regional estimates and data for synthetic estimates at low level. Roughly 2% of the population uses specialist mental health care. To identify a hundred likely users (a reasonable sized sample, given the wide range of types of service user for whom planning is needed) in each PCT would therefore require a sample of $100 * 50 * 152 = 760,000!$ Even then, the technical problems of such a survey would be formidable, since the methods currently used for the NPMS (writing to a random sample of addresses picked from the post office directory, approaching those not specifically declining, and interviewing one or more chosen by Kish grid methods) clearly omit consideration of people not living in ordinary households or declining to be interviewed - presumably a fair proportion of people with schizophrenia.*

However even if this were done satisfactorily, there is still not yet academic consensus about the relationship between research based prevalence figures, expressed demand and actual needs for care. (see for example the first section of David Melzer's book 'Social Inequalities and the Distribution of Common Mental Disorders').

2. The 'default' approach to population needs estimates is to use retrospective data on service utilisation ('they saw 1,430 cases last year so we will plan for 1,430 this year'). A practical improvement upon that basic system is to collect clinical data on the severity of new cases (or a representative sample) and use the findings the following year to adjust the resourcing of each team. Team caseloads can then be changed accordingly, using the new budget to ensure that there is equity between teams with respect to the threshold for acceptance into care. Severity ratings that are sufficiently reliable for this purpose (eg 'TAG') can be very quickly done (30-60 seconds) - they are used only for retrospective monitoring and not as a clinical decision tool. If this approach is used, the threshold for *discharge* should not change; enhanced resourcing is being used to genuinely increase capacity (see [figure](#) on balloon technology). This technique can help to reduce the unmet needs of a population, but only if people with mental health needs come forward for help and get referred.

Demand can seem to change quickly, but it takes a long time to fully equilibrate. For some conditions, there are limited, finite numbers of sufferers so it is realistic to set a goal that all of them should be in contact with services. For mental health problems with no natural boundary at the less severe end of the scale a severity threshold should be used.

3. There are statistical tools available for making population needs estimates. These make calculations based upon the latest available census data for the area. The established centre for such work in the UK is the North East MH Observatory. The statistical model is worked out by first estimating the correlation between census data and the figures from a large health database. This is an attractive approach to local needs assessment as it is quick for the local commissioning team, but there are limitations.
- The original model must be based upon reliable data – yet current statistics are of low quality and often not complete.
 - Reference census data will be up to eleven years out of date.
 - The census data may not include the presence of ‘hot spots’ of morbidity such as hostels and (some say) universities and military establishments.
 - The model will be based upon service utilisation, so will tend to underestimate population need.
 - Even after consideration of those factors, the results will indicate what service level would be required for *normalisation* with the services providing data for the reference dataset, not the absolute need.

Each of these approaches to area needs estimation has its different merits. They are more complementary than alternative.

Related questions:

- **What are the differences between commissioning Mental Health services and Acute services?**

Sources:

Alonso J et al (2007) Population level of unmet need for mental healthcare in Europe. *The British Journal of Psychiatry* 190:299-306

Andrews G, Issakadis C, Sanderson K, Corry J, Lapsley H (2004) Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders. *The British Journal of Psychiatry* 184, 526-533.

[CSIP Commissioning toolkits](#)

[TAG: Evaluation of the Threshold Assessment Grid \(TAG\) as a means of improving access from primary care to secondary mental health services.](#)

Fryers T, Jenkins R, Melzer D. (Eds) (2003) *Social Inequalities and the distribution of the Common Mental Disorders*

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The Future Vision Coalition (2008) A New Vision for Mental Health

What outcomes, whose outcomes?

Two types of quality measures are often referred to: 'process' measures, which record whether or not a service or professional carries out a specified type of good practice, and 'outcome' measures, either 'patient related' or 'service' outcomes. Examples of process measures are whether a service audits unexpected untoward incidents, or whether psychiatrists complete electronic CPA forms. These processes are thought to be indicators of a good service, but of course there is no guarantee that the amount of effort or resource that is put into the process is optimal in that context. Since resources are finite, process performance measures and targets can divert resources away from where they are needed.

It is sometimes asserted as a reaction against process targets that it is only the 'end point' - the outcome for the service users – that is a valid performance measure, but it must be accepted that some service users can expect a rapid recovery whilst others have conditions which are more difficult to influence, for intrinsic or extrinsic reasons. We can often neither measure nor control the factors that determine those differences. Therefore whilst a good patient-related outcome is certainly what we aim for most, it is not a reliable indicator of the value of the service provided. That is why process measures are retained, besides their relative ease of collection.

Wilson and Cleary (1995) proposed '*a classification scheme for different measures of health outcome, dividing outcomes into five levels: biological and physiological factors, symptoms, functioning, general health perceptions, and overall quality of life... At each level, there are an increasing number of inputs that cannot be controlled by clinicians or the health care system as it is traditionally defined.*' (see table) That is especially true of mental health outcomes, which are dependant upon so many situational and uncontrolled factors. The classification can be readily extended to non-medical fields such as psycho-social care in which levels could be substituted, graded according to the specificity of the problem and intervention. The observation about the increasing number of inputs points to an apparent dilemma, but one that can be resolved easily enough by following the principles.

The dilemma is that service users themselves are most concerned with their overall quality of life outcomes and their feeling of health. Governmental policy statements, and indeed the College and other professional bodies will strongly support the contention that it is the general mental wellbeing of the population that should be the principle objective of a mental health strategy. But those global outcome measures are the least specific indicators of the efficacy of a specific intervention or service, for the reason that Wilson and Cleary point out. It is the other type of measures, quantifying physiological mechanisms, specific psychosocial problems and symptoms, which can best be used as clinical performance indicators of the efficacy of each intervention.

Biological and Physiological	Symptoms	Functioning	General Health Perceptions	Overall Quality of Life
→		increasing number of treatment-independent variables		→
----- Quality of interventions -----				
----- Quality of care by provider organisation -----				
----- Quality of mental health strategy -----				

Table: The classification of outcomes measures proposed by Wilson and Cleary (top row), their contingency upon factors external to the provision of care (second row), and what they measure (third, fourth and fifth rows).

The conclusion is that different patient-related outcome measures are appropriately used at each level of the health service (alongside a range of process measures, which could be similarly classified). The measures are not alternatives but complementary, and a full range of approved measures should be available in each country even if they cannot be mandated. Using Wilson and Cleary's scheme, the measures to the left must be used to measure the quality of interventions, the measures in the centre should be used to measure the quality of care by a provider organisation (where more than one intervention affects functioning), and the measures to the right will be the best indicator of the local mental health strategy as a whole. It is also worth emphasising that clinicians must be able to see the importance of their own outcome measures within the broader picture, and that those whose concern is primarily with the bigger picture should be able to see the detail from which it is composed.

As the CCQI website says: 'A good measure will be valid, e.g. relevant to a critical aspect of care or critical outcome; reliable, e.g. obtained using multiple sources of information and multiple methods; able to discriminate between high and low performing services; and be derived from a large and representative sample.'

The Care Services Improvement Partnership (England) is currently engaged in an outcomes project which is applying an evidence-based selection and validation process applied to 184 potential instruments for measuring outcome. As the authors say: "It is essential to be clear about the purpose of collecting outcome measures...if the purpose is to audit a particular aspect of a service then the measure selected will need to address the relevant aspects. In other words the content of the measure needs to be appropriate to the purpose for which data is being collected". One of the products of the project will be a compendium of selected outcome measures. It is strongly recommended that those measures are used for preference.

Besides the distinctions between different types of outcomes measures it is also valuable to consider who reports the outcome. Patient-reported outcome measures (PROMS) are not necessarily designed or chosen by the service user, but they provide

the user's view of what has happened rather than the clinician's. The nationally-approved guidelines may have been followed, the clinician may have done a good job and achieved their interpretation of the care plan, but the client may not see it the same way.

Related questions:

- **How can commissioning decisions be based upon quality and outcomes measures as well as levels of activity?**
- **Why are quality and outcomes issues important in mental healthcare in particular?**
- **How should we choose the best mental health outcome measure?**

Sources:

CSIP Routine Outcome Measures Website

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NHSNW Advancing Quality Website

Royal College of Psychiatrists-College Centre for quality improvement

Scottish Government (2008) Mental Health Project Final report: National Benchmarking Project Report 2

The Future Vision Coalition (2008) A New Vision for Mental Health

Wilson IB and Cleary PD (1995) Linking clinical variables with health-related quality of life. A conceptual model of patient outcomes. *JAMA*

What are the differences between quality-based commissioning of mental health services and acute services?

Mental healthcare is in some significant ways dissimilar to 'acute' (physical health) services, and that may be one reason why MH has tended not to be included in mainstream funding mechanisms in the past. Having said that, there is very little that is not shared with some branch of acute care or other, particularly where chronic conditions are concerned. It may be useful to identify some of the differences for those who are not familiar with both sectors:

- It is sometimes forgotten that whilst 'psychiatry' is a professional medical specialty akin to the other specialties, 'mental health' is administratively distinct (in most areas) from acute services. Psychiatrists tend to have a different role with respect to the other professions.
- It is generally harder to establish simple guidelines or definitions for which service users should receive specific forms of treatment or care ('interventions'), so there can be differences between models of care, and differences in expectations between, various areas of the country.
- There is a 'pyramid of need' with no obvious dividing line between those who should or should not receive care for many MH conditions. Current activity levels within secondary MH services may therefore reflect supply more than demand or need. Reliable, valid methods for rapid assessment of case severity are available for monitoring thresholds for acceptance into services.
- The outcome for each service user depends upon many external factors besides the choice and efficacy of the intervention itself. Good quality input and care processes do not always result in proportionately good patient-defined final outcome measures. Prevailing difficulties in the wider environment must therefore be accounted for before making adjustments based upon aggregate outcome measures.
- Patient-reported outcome measures (PROMs) are available and useful in many mental health settings. They can be distinguished from patient-*defined* measures for which each service user determines their own goals. There is an obvious need for caution in setting individual treatment goals with patients whose mental health problems affect their view of a desirable outcome (compulsory detention, some eating disorders, cognitive impairment, delusional disorders, etc).
- Many MH interventions and a lot of 'support' can potentially be provided by different professions, by volunteers or by independent providers, allowing both formal and informal (intended and unintended) shifts between providers. Care is often shared between the family and other carers and agencies such as the NHS, local authority social care, voluntary or independent providers on an individually-determined basis, with no binding agreement as to what care is provided by whom. A poor quality service may be supported by allied carers, and a good service drained by having to take on burdens caused by poor service provision by its partners.
- There are very strong socio-economic and sub-cultural determinants of the prevalence and complexity of mental health problems of differing sorts. Whilst it is true that many physical conditions also occur more often in economically disadvantaged areas, the complexity of mental health problems and difficulty in achieving a good outcome are also correlated with measures of deprivation. Thus there are not only numerically more cases, but each of those cases requires more funding. There is a tendency for that reason to underestimate population needs for care in the most deprived areas.

- Sophisticated information systems for mental health are available, but implementation has been repeatedly delayed. Systems designed for acute services (often in other countries) do not always provide good support for MH business models without modification.
- There is no standard classification of mental health interventions and procedures and therefore no routinely collected information on what *type* of care is given to service users. Indicators of whether national guidelines and protocols are being followed do not have comparable specificity.
- Because the diagnosis of a service user does not fully describe the scope and complexity of their problems, and no intervention classification has been adopted nationally, there are currently no established data definitions that can be used to form useful condition- or procedure-based casemix/costing currency groupings in the way that Healthcare Related Groups are used in physical health services. However, work is in progress to identify more appropriate ways of bundling care input.

Related questions:

- **How can the right level of resourcing be proven for an area?**
- **How can commissioning decisions be based upon quality and outcomes measures as well as levels of activity?**
- **How can we ensure that mental health gets a fair deal compared to other sectors?**
- **Why are quality and outcomes issues important in mental healthcare in particular?**
- **How can we measure quantities of mental healthcare in the health market so that they make clinical sense?**
- **How should we choose the best mental health outcome measure?**
- **Do we need a classification or list of mental health interventions?**

Sources:

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Elphick, M (2007) *Information-based management: a two-stage proposal for improving funding mechanisms and clinical governance in mental health*. *Psychiatric Bulletin* 31, 44-48.

Scottish Government (2008) *Mental Health Project Final Report: National Benchmarking Project Report 2*

What are the dangers of a tariff-based system of funding for mental health services, and how could they be avoided?

- In a tariff-based system the same payment is made across the country according to levels of completed activity within groupings of episodes. The groupings may be defined either by *condition* descriptors or an *intervention* classification (*N* episodes of *x* type of case, or *y* type of procedure). Every episode of care must obviously have similar expected costs, and such groupings have not yet been identified for MH. The system would require additional controls to ensure that both *thresholds for acceptance* into care, and also the *outcomes* of care, were not adversely affected by the resulting pressure upon provider organisations to increase activity (so called 'perverse incentives'). If those two additional variables are held constant, then the use of a tariff would be safe. In such a system the commissioners are applying leverage to increase *efficiency* – so clinical governance within the provider organisation has to be actively employed. The routine collection and use of threshold severity scores and clinical outcomes measures has been piloted in many units over the last two decades. This has to become more widespread if information-based funding is to be implemented safely.
- Since there is frequently a difference between the care that is planned and the care that is eventually provided, both on an individual basis and by a unit or team, retrospective data are needed for payment. Therefore the activity data used in a tariff system cannot be drawn from care plans (intentions). However the assessment and planning process itself has cost implications (and sometimes a therapeutic value) and would receive no remuneration if only completed care packages were to be counted.
- Basing payments upon aggregated data on individual patients and their care, rather than allocating resource to teams, units or other groups of professionals makes it easier to put measures of quality such as patient-related outcomes into the same database as the budgets. Different 'cuts' of the data can then be made to analyse quality against payment as well as activity against payment, in various patient or service groups. Analysis of the same datasets to monitor equity and discrimination issues between different groups and in various parts of the service is also enabled by using patient- rather than service-level data. A third advantage is that it more easily allows 'statistical outliers' (those with the highest needs), and those with co-morbidities, to be identified. They may represent a need for change both in the local model of care and in resourcing patterns.
- Since tariffs are applied only to secondary services, primary healthcare being funded through its own system, a tariff-based system makes commissioners responsible for how much care takes place at which level. It is not easy to define threshold criteria clinically for most mental healthcare. There is a concern therefore that if financial controls are set using a local or national tariff to keep a lid on spending without reference to local severity monitoring it will leave GPs and MH professionals to resolve capacity problems in an unmanaged way. That will in effect shift responsibility not to commissioners but to clinicians.
- Sophisticated costing models of the proposed clinical groupings must be used to establish the statistical variability of costs within each grouping - both within and between providers. Further understanding of the reasons/drivers for the current variability of resource consumption within groupings then follows. An explicit analysis should be made of the extent to which the variability results from necessary reactions to

local needs, or represents *unwanted* efficiency variation in service models. Clearly, to introduce a fixed tariff system that would restrict local freedom to respond to particular population needs would be counterproductive. Tariffs work by allowing providers to increase their throughput as measured by the *number* of cases or interventions. They do *not* in themselves make allowance for cases or interventions being more complex (and therefore costly) in some areas of the country.

- A tariff system requires a resolution to the differences between data collected by different sectors of health and social care, so that the permeable boundaries between them will not allow business and clinical models of care to be distorted by the introduction of a poorly regulated funding mechanism.

Related questions:

- **How can we measure quantities of mental healthcare in the health market so that they make clinical sense?**
- **What are the criteria for judging a MH funding mechanism?**
- **What is the Payment by Results Project?**
- **How should the costing of mental healthcare be improved?**
- **Do we need a classification or list of mental health interventions?**

Sources:

Andrews G, Issakadis C, Sanderson K, Corry J, Lapsley H (2004) Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders. *The British Journal of Psychiatry* 184, 526-533.

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How can we ensure that mental health gets a fair deal compared to other sectors?

Unintended neglect of the care of people with mental health problems is unfortunately a norm rather than an exception, requiring specific, active policies for its prevention. The founding structures of the NHS seem to have resulted in MH services in Britain being generally successful and well distributed even when compared to those in countries with comparable economies. Moving to a more competitive health market brings a need for a re-examination of the mechanisms that ensure equity.

There are difficult questions on what constitutes a 'fair' level of state resource. Should funding be based upon political pressures, perceived severity and distress, the degree of individual impairment of function, the ability to realise one's potential in life, or upon the economic loss to society of continuing care and loss of earnings? And how much account should be taken of treatability? There is no point in spending money on ineffective treatments or insoluble problems. Without good quality information on these measures, widespread misperceptions about MH problems, their prevalence, consequences, chronicity, and effectiveness of care will tend to have a negative effect upon funding.

Whichever measures are used, in an information-based culture we should be able to provide evidence that compares mental healthcare to physical healthcare. That evidence must also be easily available to the public and to the media.

The implementation of Payment by Results in England provides an example. The tariff system has been introduced into the acute sector, but not into the MH sector. It was apparently not foreseen that the obligation upon commissioners to respond to proven activity levels in physical conditions would result in budgets having to be reduced for mental conditions. This seesaw effect will not be countered until MH services can compete on equal terms. That requires both the availability of information and a mechanism in which it can be used. To provide motivation and drive for commissioners, the information and its use must also be accessible to the public.

Related questions:

- **What are the criteria for judging a MH funding mechanism?**
- **How can we measure quantities of mental healthcare in the health market so that they make clinical sense?**
- **How can the right level of resourcing be proven for an area?**
- **Do we need a classification or list of mental health interventions?**

Sources:

Alonso J et al (2007) Population level of unmet need for mental healthcare in Europe
The British Journal of Psychiatry 190: 299-306.

Andrews G, Issakadis C, Sanderson K, Corry J, Lapsley H (2004) Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders. *The British Journal of Psychiatry* 184, 526-533.

[Audit Commission 'Assure' a series of quarterly national updates from the Audit Commission, providing news of the delivery of the Payment by Results \(PbR\) data](#)

assurance framework. The newsletter outlines future developments, emerging issues and best practice examples from the national clinical coding audits.

CSIP Commissioning toolkits

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World Health Organisation (2005) European Observatory on Health Systems and Policies. Policy Brief: Mental Health iii. Funding Mental Health Services in Europe. (Authors McDaid D, Knapp M, Curran C)

How can we strike a balance between national standardisation and local choice?

Too much standardisation, either of care practices themselves or of the information structures that model them will prevent us from responding to local and individual needs. It has a stultifying, automatic feel that inhibits creativity and adaptation.

At the other extreme, with everyone deciding for themselves, new procedures always have to be learnt. Documents and computer screens with unfamiliar formats are hard to read and forms soon become cluttered with everyone's good ideas and policy objectives, often in different fonts. If competing versions of rating scales, classifications and measures are used, the results can not be compared across time or between units.

A decision as to whether to use a standard or local format should of course be properly considered. Standard formats, terms and measures provide data which can be aggregated and compared, but their other advantage is that they have undergone a systematic development and approval process, so development costs can be minimised and software development may not be necessary. The terms used may already have been incorporated into SNOMED (international coding and classification) and be available with on-line support, look-up tables, drop-down menus, etc.

The table below summarises three tiers of possible national 'standardisation'. There has perhaps been too great a tendency in the past to emphasise mandatory national data collection (Tier 1). Most of everything else has been left for local development (Tier 3), with little accompanying resource for the considerable work involved. So as a next step the use of *standardised* terms, measures and formats at local level but on an *optional* basis (Tier 2) needs more support.

In England, the CSIP compendium of outcomes measures provides a good example of central work that supports local decisions, and there has been work in progress on a set of generic electronic document headings for some time, now supported again by CFH.

In Scotland, the national benchmarking project has identified some measures that will be collected nationally, and some for local optional use.

The College is engaging actively in work to promote such standards, proposing the establishment of an approval process for electronic MH record content.

	Standardisation (level at which definitions made)	Collection	Use
Tier 1	National	Mandatory, national	Central returns, commissioning, centrally-driven quality and outcomes governance, benchmarking, etc.
Tier 2	National	Optional, local	Locally- driven initiatives, developmental work, voluntary benchmarking, clinical governance, etc.
Tier 3	Local	Optional, local	Local projects with no intention to communicate wider.

Related questions:

- Is it possible to draw management information from clinical records?
- How can information systems be simplified?
- Do we need a classification or list of mental health interventions?

Sources:

Academy of Medical Royal Colleges (2008) A clinician's guide to record structures: Part 1. Why standardise the structure and content of medical records?

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CSIP Routine Outcome Measures Website.

NHS Connection for Health - Website with information on standard international terms

Scottish Government (2008) Mental Health Project Final Report: National Benchmarking Project Report 2

How should the costing of mental healthcare be improved?

Money comes into state health and care services 'from the top', with budgets divided up as they pass through successive layers of management. In mental health services most of the money is spent on personnel and facilities, which are relatively fixed costs. A top-down accounting system will tell us how much it costs to run each service line (department, unit, team, etc), in terms of spending on staff of various types, on each of the facilities, heating bills, travel, equipment, drugs, etc. Within each line one could also potentially see, using currently collected data, how many patients have been seen, or how many completed episodes of care there have been within each month, quarter, or year.

For planning purposes, if we know what buildings we need in order to house roughly the right number of staff, budget requirements can fairly easily be computed once additional costs ('on costs') have been added to the raw figures. In practice, such careful estimations rarely need to be made, because services are not often started from scratch.

But the system described above does not tell us anything about the costs of providing care and treatment for *specific* groups of patients with particular needs or conditions. That matters, because most MH teams provide care to a broad mix of cases varying in severity, complexity and condition, and from varying socio-economic and sub-cultural origins. All of those factors are generally assumed to affect the costs of care, and therefore also the quality of service that can be provided on a *per capita* budget. In addition there may be pressures to favour certain types of patients, or to spend clinical time doing interventions that are rewarding or erroneously believed to be effective. And when they are managing their caseloads, staff may be unaware of the wider needs of the population, and of gaps in the local services.

There must be many different ways of ensuring that resources are most effectively allocated at this grass-roots level, but they all require some way of splitting up the caseload into clinically meaningful groups, and quantifying how much time, and therefore money, is allocated to each.

There is therefore a strong argument for developing a direct, information-based system which can take note of how money is allocated, not in terms of *services* but in terms of *service users*, their needs, and how well those needs are being met. Whether that system is then used only to assist service providers with their internal financial planning (the better to budget for fairer, more inclusive services), or to provide a 'costing currency' for a competitive health market, depends at the moment upon national politics.

To provide that sort of information, there is a need for a 'bottom up' MH costing methodology which could ideally be resolved against, and reconciled with, top-down budgets ('*this service, with this budget, provided this amount of this type of care for these service users*'). There is continuing discussion about whether condition-based, activity-based, or intervention costing groups would best serve the purpose, but the answer depends upon what the purpose is. In practice nobody has so far found any single measure or classification of a care dimension that alone will predict costs accurately enough for service management – so it is better to collect a wider range of information. Development of a costing methodology for MH has been given an impetus in England by the intention to introduce Payment by Results by 2010/11. But many of

the principles underlying that work and the lessons learned could be made use of in other countries. We will report on the work as it progresses.

Related questions:

- **How can commissioning decisions be based upon quality and outcomes measures as well as levels of activity?**
- **What are the criteria for judging a MH funding mechanism?**
- **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?**

Sources:

Department of Health (PBR team) (2008) Developing a Payment by Results tariff for mental health (includes factsheets and updates)

How should we choose the best mental health outcome measure?

The Outcomes Compendium (published October 2008) will help you select the right tools for best mental health care practice in your field.

'The compendium provides information on available outcomes measures tools for use in mental health services. It provides an evidence based evaluation of existing measures to support informed choice. It is designed to support clinicians engaged in service delivery and development who wish to gauge clinical effectiveness and recovery in a balanced, culturally appropriate and ethical manner...'

A final list of 69 instruments is now included. These include instruments we scored highly, instruments recommended by the practice group, and instruments proposed by the Royal Colleges of Psychiatry and Nursing and also the British Psychological Society.'

Note:

The compendium is an excellent, authoritative, evidence-based resource. Before you use it to select an instrument, it is worth considering some questions in advance:

- Is it really an *outcome measure* that you need? The term is sometimes used loosely to cover any method of quantifying mental health problems and their consequences. Strictly speaking, an outcome measure provides a numerical estimate of the change that has taken place as a result of some sort of intervention or process. Surveys that measure the prevalence or severity of problems within a population or sample of any size on a single occasion cannot measure an outcome, as the starting point is not known. Neither do repeated measures/metrics/indicators which cannot be related to an intervention or process which plays the major role in affecting the parameters that are measured.
- Which intervention/process/care pathway are you assessing? It is worth specifying clearly the intervention or process for which you are trying to assess the outcome, because that will help you decide how to administer the measure, and how to make use of the results. There is no point in measuring outcomes if the results will not indicate some possible action to improve a specific practice. Beware of situations in which there are a large number of powerful confounding factors (independent variables) that may be influencing the results at the same time as the intervention in question. Can you somehow control for those? Can you persuade anyone who needs to take note of the results that they must take action?
- What should you measure? This may seem the easiest question to answer. But are there other outcomes that are worth measuring at the same time (eg that might eliminate confounding variables)? Think ahead to implementing the results in each eventuality you can envisage. Will there be associated questions on which you should collect data simultaneously? Should you be able to break down your dataset into subgroups, or comparable groups for benchmarking? Should you collect parallel data on resources or costs so that you can put forward a business

case for change? All too often people wish, too late, that they had collected some additional data item that would have proved their point.

- Who should measure it? Clinicians, service users, carers, other professionals? More than one group? Are you dependent upon the good will of those who are to spend 'their' time collecting 'your' data, in which case, why should they?
- What resources do you have to do the measuring? How long can you afford to spend on each measure? What about costs of software? Is the instrument available free of charge²? Would it be satisfactory to use a sample (eg one in ten of the whole group) or a census (eg a single week or month of consecutive cases) or a cross section (eg every open case on a certain day)?

Related Questions:

- **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?**
- **What outcomes, whose outcomes?**
- **How can we strike a balance between national standardisation and local choice?**
- **Do we need a classification or list of mental health interventions?**

Sources:

Slade, M., Thornicroft, G. and Glover, G. (1999) The feasibility of routine outcome measures in mental health. *Social Psychiatry and Psychiatric Epidemiology*, 34, 243-249

The outcomes compendium (download). With many useful references, which are also incorporated in this list: [Go to website](#)

² The National Programme for IT in England is currently seeking licences to provide 'free at the point of use' NHS use for all of the instruments selected by the Outcomes Compendium. Ultimately the aim is that they should all be accessible within or via NPfIT software.

Do we need a classification or list of mental health interventions?

Surprisingly, there is currently no means for systematically collecting information on what methods of treatment or management are used in NHS and Social Care facilities. Such information would provide a valuable insight into the availability of different types of therapeutic effort across teams and service types. In combination with data on problems and needs, levels of activity, and outcomes measures, it would contribute to the evidence base for evaluating what is effective in local practice rather than in general principle.

The two core classifications used in the NHS are of health conditions (the International Classification of Diseases version 10 (ICD-10) and of interventions (or 'procedures' – the OPCS -4). Unfortunately, OPCS contains very few mental health items. The inclusion of new procedures in later versions of OPCS has only been allowed when they are proven to be needed for implementation of the Payment by Results programme. Since PBR is only just being accepted for mental health services in England, and since its development has in turn been inhibited by the lack of an interventions classification, progress on both fronts has been inescapably slow! In any case, inclusion of only those interventions needed for PBR would not necessarily cover the whole range of provision in mental healthcare. In the immediate future, therefore, we cannot look to the OPCS to provide a classification.

There is no international classification of MH interventions, but the development of an Australian MH Intervention Classification (initially for use mainly in inpatient facilities) was presented to the WHO Collaborating Centres for the Family of Classifications in 2006/7. A draft version is available on the website (see below).

An ideal classification should be a comprehensive set of mutually exclusive categories. It is widely assumed to be very difficult, if not impossible, to define such a set for mental health that would cover all settings both in health and social care. The difficulty is due to the range of different types of problem to be addressed, as well as the problem of defining exactly what goes on in any particular interaction. Each type of therapy can often be carried out in various types of setting which can greatly affect its execution and results. For those reasons, it may be better to give up the idea of a classification as defined above and with it the aspiration that everything that happens in a mental health unit could be assigned to a clearly defined category. It follows that it may never be possible to reliably compare the total 'intervention mix' of two similar MH teams, in the way that surgical units can compare the numbers of different procedures on their operating lists using OPCS.

However there is still great value in using a standard list of those interventions that are amenable to definition (the rule being that 'you know whether you have done it or not'). Collecting data in which staff record each time they provide such an intervention (the lumps in the therapeutic soup) may tell us nothing about the valuable input that goes on during the periods of indefinable activity (the liquid). But the proportion and quality of the definable activity can be validly compared to activity of the same type in other distant teams using activity and outcomes measures. In fact, outcomes data are only useful when you know for certain what you are measuring the outcome of.

A draft list of MH interventions was prepared some years ago by Ruth Page of the then NHS Information Authority as part of the MH Information Strategy for England, but it has not been tested or approved.

A seemingly alternative approach to an interventions list or classification is to identify a smaller number of higher level care packages, care clusters or care pathways. These approaches are similar to each other in the respect that service users or their data are allocated to broad composite groupings, generally on the basis of a needs assessment (eg 'crisis care', or 'continuing care of serious and enduring mental illness'). This provides a method for breaking down big heterogeneous caseloads into groupings with good face validity, but whether there is still too much variability remaining within each group to prevent valid comparisons between various service settings has not yet been established. Care packages are currently proposed as the care currency for the Payment by Results programme, though they have not yet been approved by the Information Standards Board and are not intended to be a building-block level classification of indivisible categories of intervention.

Related Questions:

- **What should each psychiatrist be given to enable them to assess their own quality of service?**
- **What is the Payment by Results Project?**
- **What outcomes, whose outcomes?**
- **How can we strike a balance between national standardisation and local choice?**

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CSIP Commissioning toolkits

CSIP Routine Outcome Measures Website

CSIP Outcomes Compendium

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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 can 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 is planned). Please let me know where you think there is room for improvement, or if you wish to contribute. Martin.Elphick@awp.nhs.uk.