

Lessons learned from introducing routine outcome measurement in a UK service

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1330-1415

Areas in which lessons learnt

- the advantages and disadvantages of carrot and stick
- dependency on IT systems and their vagaries
- issues in training
- issues in extraction, analysis (including evolving attempts to show change meaningfully), and feedback to clinical and management teams
- the issue of interventions
- the positive and less positive contributions of academic psychiatrists and psychologists
- the impact of government initiatives on these processes

You have already learnt most of these lessons

Main point of presentation:
To make you aware of how far
you are ahead in the race to
Outcomes Nirvana

Context: South London & Maudsley NHS TRUST
Population of 1.1m, of whom ~14,000 (10.4%) are of retirement age

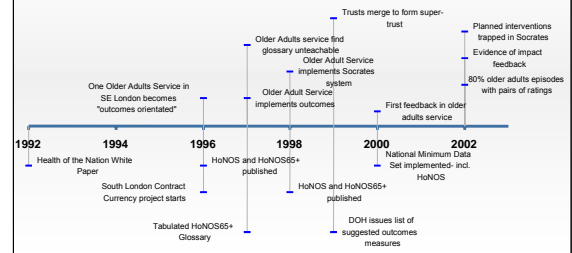


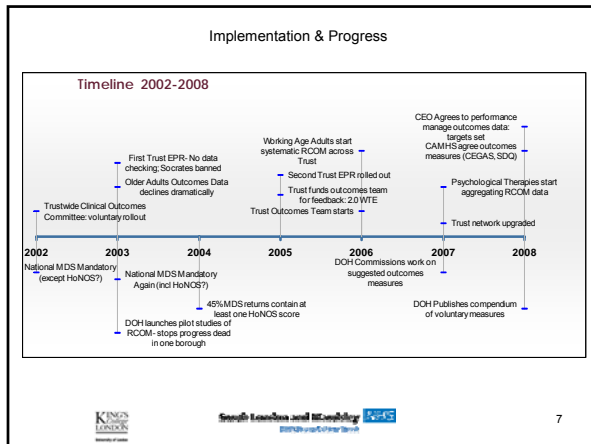
South London & Maudsley NHS Foundation Trust
Local services (excludes national)

- Around 300 distinct teams and services
- 150 based outside 6 main hospital sites
- 30,000 referrals per annum
- 34,000 active cases at any one time
- 4500 clinical staff
- Budget (including national) £337m (≈780m AUS\$)

Implementation & Progress

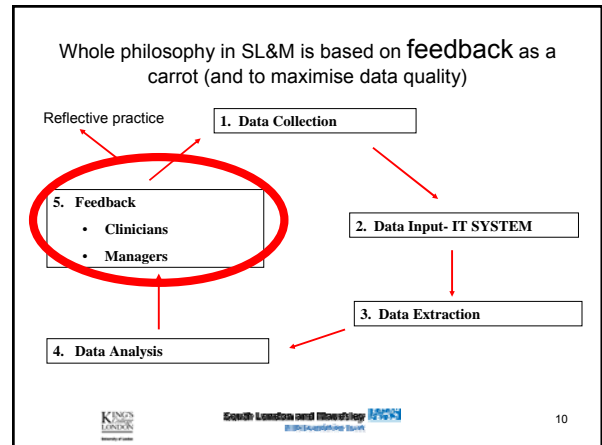
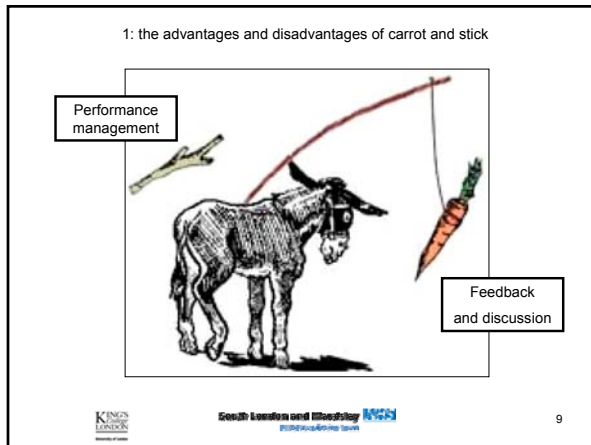
Timeline 1992-2002





Lessons

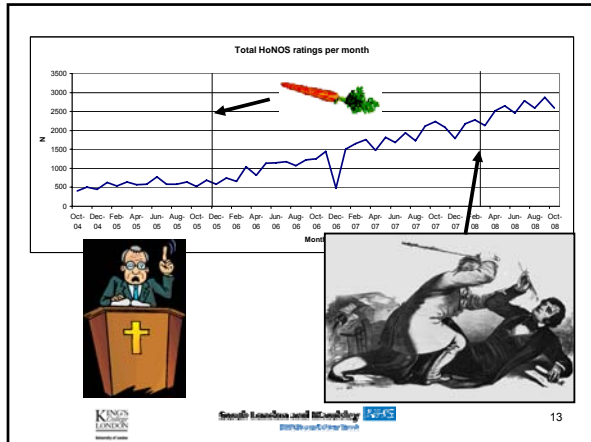
Logos: Kings London, South London and Maudsley NHS Foundation Trust



- ## Stick
- Actual
 - Performance management by CEO and other Trust officers
 - Threatened
 - Local decisions about service cuts will use outcomes measurement
 - Not (yet) outcomes themselves, but their measurement
 - Local health purchasers will increasingly demand outcomes data to justify investment
- Logos: Kings London, South London and Maudsley NHS Foundation Trust

Carrot	Stick
<ul style="list-style-type: none"> • Assumes staff want to get better outcomes • Assumes staff prepared to come to feedback sessions • Assumes resources available for sessions • Assumes information is comprehensible (and palatable) • Assumes staff have power to change practice 	<ul style="list-style-type: none"> • Assumes executives have the will to confront staff who will not participate • Assumes CEO will not go all gooey when his officers complain about how hard everything is • Assumes that there are no other higher priorities for the service <ul style="list-style-type: none"> – Like saving money • Assumes data quality will not be affected by gaming

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1. the advantages and disadvantages of carrot and stick

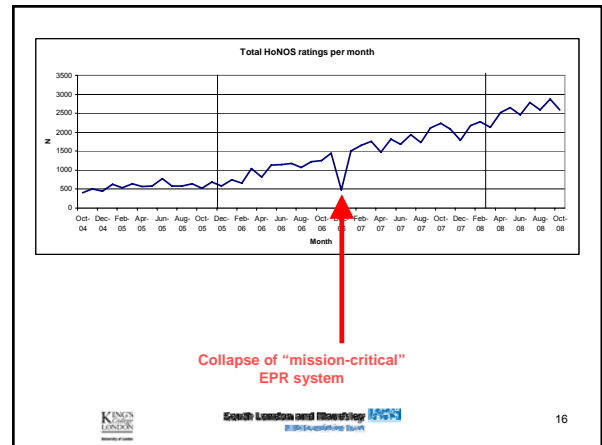
Both are necessary, probably, but stick not noticeably more effective

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2. dependency on IT systems and their vagaries

a) Accept dependency in a zen-like way

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Lessons- b) get involved in design of systems

- IF FEEDBACK IS CRUCIAL, then you must have control over data extraction and analysis
 - The example of British Telecom & Rio
- If you have to drop crucial mandatory fields when bringing in a new system because it is worse than the old one for some other reason (e.g. slow, or simply unfamiliar) then you should wait until the new one is at least as good as the old and keep the mandatory fields in.
- Whatever developers tell you about what will be definitely available in the next version, prepare for disappointment (permanent disappointment)

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2. dependency on IT systems and their vagaries

Probably impossible to mitigate this. Only solution is to be as involved as possible with system changes and wear the opposition (usually external consultants who don't really care) down by dogged persistence over what you need

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3. issues in training

Training (HoNOS, HoNOS65+)

- Massive task in trust of 4500 souls
 - Initial training at inception of programme
 - Induction training of all new staff
 - Refresher training probably a good idea
- Weak aspect of our programme: not funded, ad hoc, left up to local services, mostly no record kept of who has been trained (although this may change)
- Some (weak) evidence that training in HoNOS is not necessary
- Vignette training online not developed in UK but training CDROM available for HoNOS65+

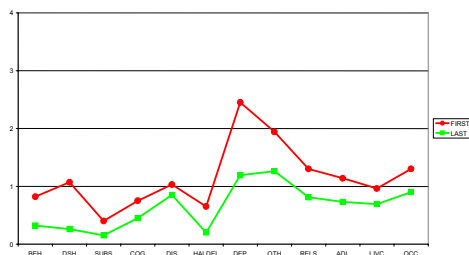
4. issues in extraction, analysis (including evolving attempts to show change meaningfully), and feedback

Extraction & analysis

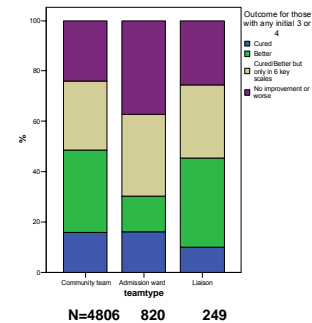
- Needs dedicated information analyst time with wide range programming languages to deal with shifting platforms
- Two strategies with extract
 1. Standard template (EXCEL) tables and graphs showing outcomes by demographic, diagnosis & other variables for each team; fed back by clinician without huge technical data knowledge
 2. Tables suitable for SPSS or other program, then analysed by academic clinicians and fed back with more bespoke graphs to teams and groups of teams by people who analysed the data

Simple change- means

Average HoNOS at start and end episode: 211 SL&M INPATIENTS with Depression diagnosis



Which team type gets most improvement?



Showing change meaningfully

- Topic of Monday meeting: in conclusion:
- Clinicians appear to prefer categorical methods to dimensional ones
- No-one really appreciates HoNOS total scores but they are needed when there are few data
- Clinicians need to be involved in defining categories (not simply by statistical means)
- Categories like “cured” and “improved” tickle clinicians
- Need to be independently validated
 - But very tricky to do

Feedback

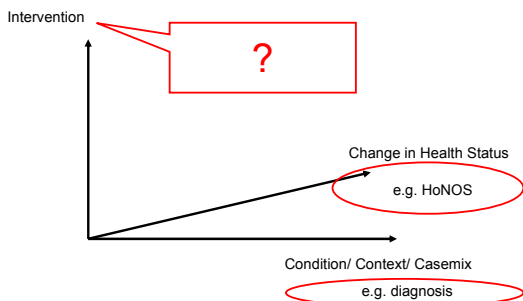
- Passive
 - Making reports available
 - Looked at by a tiny minority (often zero) staff
 - Works little better for managers unless part of performance management process
- Active
 - Sending written reports
 - Better than passive reporting but possible still only read in management emergencies (“we’re going to review your service”)
 - Face-to-face feedback
 - Most fun for outcomes team and for staff/managers
 - Very demanding of resources but possibly the kernel of the programme
 - Only works if staff
 - have actually done some outcomes measurement AND
 - Pitch up (this could be performance managed better in our service)
- Problem
 - We have only a smidgeon of evidence that feedback is related to data quantity and quality
 - We have only one example yet of how outcomes feedback changed practice and outcomes
 - From a time when we had mandatory fields and care plans were systematically entered (2002)
 - This will only become possible again when interventions issue is solved (see later)

From this conference, it is clear that additional approaches are needed:

Using of ratings in clinical practice
Involvement of consumers

5. the issue of interventions

3 dimensions of clinical outcomes (Broadbent, 2001) All necessary: none sufficient



Present system in SL&M

- At each contact staff check boxes categorising the intervention(s) that took place during that contact.

Issues

- Have to scroll down to see the boxes- many don't bother
- Categorisation not comprehensive, but if comprehensive would be very long
- Classification not congenial to everybody (or anybody?: derived from a small clinical team and then "consulted" on)
- Attempt to poll all staff for more valid categories was not v. successful
- Medication is an issue of its own:

Medication

- No electronic prescribing yet in inpatient units in Trust
 - E.g. a bucket of olanzapine is delivered to ward every week, and patients administered this according to prescriptions that are not on electronic system, so cannot tell who got what
- For community patients much prescribing is done by GP
 - Staff reluctant to enter current prescriptions onto EPR system in case it's wrong
 - Anyway the data entry screen for medication needs overhaul
- Upside: we have no reliable data yet on the easiest intervention to trap

6. the positive and less positive contributions of academic psychiatrists and psychologists

Pros and cons of academic input into process

Advantages

- Skills in data analysis, interpretation, statistics and presentation of information
- Understand the partial nature of experimental evidence
- Recognise the huge advantages of big samples
- Bring academic glamour to impressionable staff

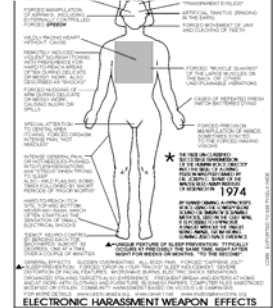
Disadvantages

- Intemperately dismissive of observational data
- Overweening predilection for randomised controlled trials, even for complex interventions
- Contemptuous of clinician ratings- misunderstanding dimensional nature of validity and reliability

From bitter experience, it is best to keep most academic and routine outcomes measurement apart



Government and routine outcomes measurement



Thesis: the UK Government does not want routine clinical outcomes measurement

- Motive: RCOM would severely constrain ability of government to
 - Close down unfashionable services
 - Open fashionable onesAt whim or due to financial problems
- Motive: RCOM would expose the UK pharmaceutical industry to quite unnecessary questions about effectiveness and compromise its ability to provide employment and revenues

Evidence:

- Despite protestations of enthusiasm, UK government has invested almost nothing in development of RCOM measures
 - Refused to continue any substantive funding after 1996
 - My guesstimate is that
 - local NHS trusts are spending about £300,000 pa in total throughout the whole UK on RCOM in MH,
 - Central government just funds pointless and not even very lavish conferences and working groups.

Evidence:

- The UK has made the collection of outcomes data mandatory but has not done anything to Trusts that don't collect it
- The UK government is still prevaricating over
 - What measures should be used
 - When they should be recorded
 - How the data can be used.

Puzzle

Why are the Australian & NZ National and Local Governments so keen?

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