Made to measure?

There is a growing recognition that health services need to be focused on delivering value for their populations. That means making best use of available resources to achieve the best outcomes and experiences for every patient or service user.

To make this a reality, systems need to understand both the outcomes they are achieving and the costs of services provided. However, there are particular challenges in mental health. There are concerns about data quality in general. But there is specifically very little information about what outcomes are being delivered – or even should be delivered – despite significant amounts of data collection. There is no established currency to provide a foundation for conversations. And IT systems are often unable to collect and analyse the required information.

In December, the HFMA Healthcare Costing for Value Institute organised a roundtable to discuss the challenges in measuring value in mental health services. The institute's Mental Health Value Challenge is currently exploring how the use of resources in mental health can be maximised to provide the best possible outcomes for service users. Sponsored by healthcare productivity specialist **Meridian Productivity**, the roundtable brought together clinicians, academics, a service user representative, and IT and finance

Focusing on value requires data and there is no shortage of data in mental health services. But much of it disappears into a black hole. An HFMA roundtable in December discussed the importance of having the right data and reducing the collection burden

professionals to highlight current obstacles and suggest how better progress could be made.

There was a broad consensus that data needed to be overhauled across mental health services. Key messages from the session, chaired by Claire Liddy, managing director of innovation at Alder Hey Children's NHS Foundation Trust, included: collect the right data; collect it for a purpose; use it; feed it back to service users and clinicians; and stop collecting what you don't need.

Rowena Jacobs, professor of health economics at the University of York, underlined the need to improve data quality in general. 'In our research, we've found absolutely enormous variation in activity rates – for example, how many inpatient admissions

or healthcare professional contacts happen within clusters – when we compare across providers,' she said. 'The variation was huge.'

While some of the variation might be warranted – driven by differences in severity and casemix – there was also a lot of 'random noise', which makes it hard to interpret and act upon. This could be reduced by improving the quality of the data and the way it is collected.

'My big agenda is to ensure we only use one data set for commissioning, payment, benchmarking, performance management – for everything – and that should be the mental health services data set (MHSDS),' said Professor Jacobs. Currently, a mental health trust might contract with up to seven clinical commissioning groups plus specialised services, and each commissioner might require data to be reported in a different way. This does not support a consistent or high-quality submission to the MHSDS.

'One way of driving forward improvement in data quality would be if everybody was required to use the MHSDS for contracting, payment and costing – that will drive down a huge amount of that noise,' she added.

'But even with better activity and cost data,

HFMA ROUND TABLE

"My big agenda is to ensure we only use one data set for everything – and that should be the mental health services data set (MHSDS)"

Rowena Jacobs, University of York

there remains a big gap around outcomes. The outcomes that are collected aren't always the outcomes that matter to service users. While the NHS continues to focus on measures such as access times, our research shows that service users are often more interested in being listened to, treated with dignity, their experience of care, and seeing the same healthcare professional at each contact.'

However, Professor Jacobs acknowledged that these outcomes were more difficult to capture in routine data.

Mark Platts, acting director of finance and information at Lincolnshire Partnership NHS Foundation Trust, agreed that consistency was the key to activity reporting and this would be increasingly important as trusts move towards system working, with more collaborative risk and gain share arrangements. 'It may not be helpful bringing seven or eight data sets together because it will just take longer to understand,' he said, agreeing that the MHSDS was a good standard reporting link.

Starting a refrain repeated throughout the roundtable, he questioned the relevance of the current cluster-based currency. 'The relevance of clusters has been questioned over recent years and I'm sure we all struggle at times to see them as relevant or reflective of service users' conditions and core needs,' he said.

At the time of the roundtable, there was an ongoing national consultation proposing to replace clusters with new mental health

resource groups. Mr Platts said this was a positive step in the right direction. But he said moving to a consistent approach for reporting would require some education for leads across systems, including clinical leads, providers and commissioners. 'We all tend to like data in a format we personally understand and are used to, which isn't necessarily the best or most consistent way to reflect the data and outcome,' he said.

Victoria French, deputy finance director at Kent and Medway NHS and Social Care Partnership Trust, raised the issue of language barriers. For example, commissioners liked the fact that you could analyse activity by clusters and had sometimes pushed for outcome measures that enabled them to demonstrate how funds were being used, but did not always provide much help in describing service user progress. The trust was starting to think more in terms of initial interventions (a four-week programme of support), specialised pathways and enduring conditions, she said. This had helped the trust to rethink how it runs services.

'But if we shoehorn that into a cluster, it just doesn't work,' she said. Trying to think about demonstrating value is also difficult as the approach doesn't fit the normal model of how services are described or costed. However, she said that designing the initial interventions approach had helped the trust to proactively introduce a more consistent package of services across its different patches.

Jimmy Quinn, managing director of Meridian Productivity, was also keen to highlight the need to improve the language used in mental health. With very recent experience of relatives receiving mental health services, including as an inpatient, he said the vocabulary used to keep carers informed was far from ideal. 'I was having daily conversations with carers and clinical

leads about my father's progress, and I would get comments such as "he was settled" or "agitated". Or they would tell me he had "eaten his breakfast" or "played dominoes".'

If he asked about the goal for the inpatient stay, he would be told it was to review behaviour for four to eight weeks. 'How do you have any engagement about quality if that is the goal?' There needed to be much more clarity about what the goals of any intervention were before you could measure progress. Once the goal was set and communicated, you could talk about the interventions that would be utilised to reach this goal, how long it might take and start to attach costs to it.
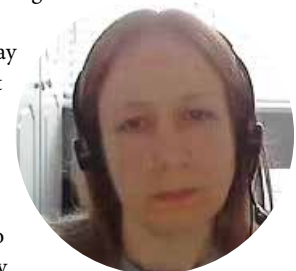
Systems challenge

Collecting data requires IT systems that are capable of meeting requirements. And Ella Worsdale (pictured below), head of information at Pennine Care NHS Foundation Trust, said that clinical systems in mental health presented a significant challenge – especially as many of them had been adapted from acute systems.

She said working together was also a problem as different organisations were at different maturity levels in their use of systems, used data in different ways and all had slightly different pathways.

She also reported clinical disinterest in using clusters. And any local pressure to adopt clusters had diminished within the trust once it became clear that the initially promised move to a cluster-based payment system had been dropped.

However she said improvement work did require data – the challenge was ensuring it was relevant. 'Length of stay is an indicator of what is going on – but it is not the root cause,' she said. 'It is hard to answer whether it is okay for someone to stay in our community mental health teams for 10 years or three years.'

Organisations needed to understand more about individual pathways and to be able to ask 'more intelligent questions' of services to understand what was happening.

This analysis, while important, could not be done without backing it with investment. 'We need the resources to support operational managers to be able to use information,' she said. 'There is so much data out there, but you need time to interrogate and skills to do it.'

The roundtable was able to draw on a number of clinicians to get a frontline perspective on data collection and outcome measures. Echoing earlier comments, Jane Carlile, consultant psychiatrist at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and outcomes lead for the Royal College of Psychiatrists and the college's specialist adviser for payment, agreed that all parts of the NHS needed to use the same data. 'But the level of granularity and level of focus might be different depending on who is viewing the data – for example, frontline practitioners or commissioners.'

She added her voice to those opposed to clustering. 'The aspiration of clusters was good, the implementation, perhaps, less so. But clusters are not useful to frontline clinicians,' she said. She suggested that data collected should not look solely at mental health-related information. She pointed to the requirement on all publicly funded addiction services to report on a broad range of outcomes.

These included: levels of substance abuse; physical and mental health; social, housing, education and employment; criminal activity; and quality of life. 'This could give a much more holistic quality of somebody's functioning and quality of life and provide a much more rounded picture,' Dr Carlile added.

Ian Davidson, national clinical lead of crisis and acute mental health for the Getting It Right First Time (GIRFT) programme, was categorical in his assessment of the need to move on from clusters. 'It's not only not clinically useful,' he said. 'It's not economically useful, because it fails to capture most of the drivers of healthcare need and healthcare demand. So it has failed at all levels since inception and it has actually held us back because it does not promote the use of Honos (Health of the Nation Outcome Scales) as a clinician-rated outcome measure (Crom),' Dr Davidson continued.

He said a Crom did not address all the necessary outcome information, which also needed to draw on patient-reported outcomes (such as the Dialog measure being used in several trusts) and experience measures. But

HFMA ROUND TABLE

"In the UK, in contrast to many other European countries, we expect our payment system to achieve a much larger number of objectives"
Jane Carlile, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Honos, which is already recorded within the electronic patient record, arguably represents the simplest outcome measure to collect.

Worse than this, said Mr Davidson, the Honos outcome scales had themselves become tarnished as a cluster measure.

Work for the GIRFT programme had revealed that a lot of single Honos assessments were undertaken. 'But to get an outcome, you need to do a before and after Honos,' he said. Even in the few cases where a second assessment was undertaken, it was rarely reported back to teams or to their board.

The lack of an incentive to get the data right – as created by the payment system over the last decade for acute hospitals – meant coding had fallen behind in mental health, which undermines the push for quality data.

'In block contracts there is no incentive (to code better),' said Mr Davidson. Poor quality data attracted the same payment as good quality in mental health, and this helped to contribute to a chaotic situation for many aspects of mental health data. 'We collect far too much, very little of which is used clinically, managerially or in any other way.'

GIRFT focus

The GIRFT programme has been looking at variation, recognising that this covers warranted, unwarranted and unexplained differences. Mr Davidson supports calls for the MHSDS to become the key data source for national comparisons. But the poor quality of data led the GIRFT programme to use multiple sources. For example, he said, data from the NHS Benchmarking Network benefited from being fed back to clinicians, providing opportunities to correct errors. This rarely happened with the MHSDS.

Dr Davidson agreed with Mr Quinn that there should be a clear purpose for any change of intensity and input in care provided to service users. 'If you were going into a ward, it should be very clear why are you being admitted, the purpose of this admission, what should be expected to happen to achieve this purpose and the expected length of stay to achieve this,' he said. 'And once that purpose is achieved, it should be easy to move out of the service. That is rudimentary. The position is improving – it was virtually non-existent five

years ago – but from a very low base.'

Ananta Dave, medical director at Lincolnshire Partnership NHS Foundation Trust, identified another aspect of data collection that should be improved. 'When you are collecting information, service users and carers need to know what is being collected, why it is being collected and how they can contribute to it,' she said. 'And we need to feed back to clinicians what difference their data has made.' Without this, organisations were unlikely to get clinical buy-in to the collection of the data – or compliance would tail off.

Dr Dave cited the incomplete submissions for the MHSDS. The collection of ethnicity data was poor and inconsistent across the country and within systems, yet this was vital information, especially as mental health moved to a population-based public health focus.

'The data we collect not only has to help improve care for the individual, but it needs to make a difference to the inequalities in communities,' said Dr Dave. Demographics and population needs had to increasingly be triangulated with outcomes and activity. 'As we come together in systems, we need to develop a joint understanding of what we need to collect. We need to reframe our language around what matters to patients. And we need to hold each other to account,' she said.

If the service is to adopt a set of consistent outcome measures, they need to be ones that matter to service users. Capturing this can be challenging. But clinical psychologist Rumina Taylor, value-based healthcare mind and body lead for academic health science centre King's Health Partners, highlighted work in Australia that attempted to address this. GPs there had changed the traditional language they used to discuss outcomes with service users and asked them instead to 'tell me about your best day'. 'This was a great way of finding out what really mattered to them,' she said.

"We collect far too much data, very little of which is used clinically, managerially or in any other way"
Ian Davidson, GIRFT

'If we can get agreement around what we are measuring,' she added, 'that can be shared by services within a trust and between trusts.'

And if measures are more meaningful, there will be more chance of them being collected. But Dr Taylor warned against overburdening staff and service users with the amount of outcome measures they are asked to complete, but only collecting what is needed.

Data collection time

The amount of time spent on collection activities was picked up by several participants. Mr Quinn said Meridian had worked with one mental health trust for six months to help it improve productivity. It was decided the key measure was direct facing time spent with service users. It introduced a daily review process within the trust's teams to help them focus on the issue.

The ability to plan and correct the balance from day to day led to big improvements. In a subsequent audit, two teams were found to have stopped the daily review process and direct facing time had halved to just 22%.

'Just over a fifth of their working hours were spent dealing with service users – that is shocking,' said Mr Quinn. Management should have the courage to manage based on some of the data they had, he said. The organisation didn't need to collect extra data to manage this; it just needed to keep its focus on the issue.

Dr Davidson said data collection would add to the amount of time spent away from service users. Work for GIRFT has shown that in half of trusts it could take a clinician one to two hours to input an assessment into systems – the assessment itself only took an hour. Data burden was a major issue, he said. The key was to stop collecting data that added no value, or simply wasn't used, and collect the right data.

Service user consultant Jennifer Bostock represented service users and carers in the discussion. She raised concerns that there was an obsession with quantifying everything, but not why it was being done. She likened some data collection to a 'tick-box exercise' and said not all variation was a bad thing. 'There will be all sorts of valid and legitimate reasons for variation, and we don't necessarily want to make everything the same,' she said. 'I'd be reluctant to collect more data, bring in new measures and place more burden on those collecting and analysing it without a significant reflection on what we are doing it for.

'Use what we've got and start by asking the patient,' Ms Bostock said. 'It is not about

getting a patient-reported outcome validated questionnaire, it's about the purpose of it and uses the data is put to.'

She added her voice to calls to ensure outcome data reflected 'what matters to patients'. And she liked the suggestion of asking service users about their best day as an example of methods of measurement that were meaningful to patients and carers.

Other delegates acknowledged the importance of collecting the right data but stressed that counting activity, costs and outcomes were not just about informing direct care. Professor Jacobs said it was also important to see value from the Treasury's perspective. 'If we can't demonstrate we are delivering value for money, the marginal pound will be spent elsewhere. We've seen historically that mental health loses out. It gets disinvested from too readily, because we can't demonstrate what we are doing. So we need to count, and we need that data and to link activity, outcomes and costs.

Mr Platts said taking the income driving aspect of counting activity out of contracting arrangements made sense. Having the whole system on block contracts this year, including acute trusts, had created room for

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Mark Platts, acting director of finance and information at Lincolnshire Partnership NHS Foundation Trust

more discussion on patient data and health outcomes rather than the financial outcome of a transaction.

But he highlighted the importance of understanding value for money, and the ability to understand the costs of delivering services would also be vital to setting the right levels of remuneration under blended payment proposals. That meant counting, and having a meaningful currency that could be costed, were still important.

Asked what the next steps should be, participants gave a range of answers. 'We need to challenge in every bit of the system,' said Mr Quinn. That means challenging, for example, band 6 community mental health nurses on whether they are spending enough time with

service users. It also means challenging finance leaders on their 'salami slicing' approach to efficiency savings. 'I think we are afraid to ask the questions and, since Covid, we have become more afraid to challenge each other.'

Dr Carlile hoped professionals had been vocal in the currency consultation, which closed shortly after the roundtable. 'With my Royal College hat on, I've been one of the stakeholders involved in developing [the proposed approach]. And I am concerned we don't just repeat the errors that we've already made.' She was worried that the system – based around five broad groups and three levels of severity – could still be a burden. And there was still no link to physical health.

There was a danger of trying to do 'all things for all people', added Dr Carlile – meeting the needs of clinicians, while also providing a unit of care that could have costs attached to it.

'In the UK, in contrast to many other European countries, we expect our payment system to achieve a much larger number of objectives,' she said. 'We need to be clear about the main aims of the payment approach and what we are aiming to incentivise.'

Ms Worsdale said the service needed to tackle the data burden issue. 'My team spends a big percentage of its time feeding different people with different versions of the same thing. NHS England and NHS Improvement, the Care Quality Commission, NHS Digital, commissioners – everyone wants it a slightly different way. That is not why I came into this job. I want my team to spend time using data to add value and working with clinicians to use the data we are already collecting. We don't use enough of what we've got.'

Dr Taylor said: 'I would really value someone coming to my team every month, sharing my outcomes with me and showing the feedback on the data I've been collecting. If it was fed back in a thoughtful and clinically meaningful way, it would be motivating.'

With broad agreement on the value of collecting data on outcomes, activity and costs, the real challenge becomes collecting the right data – building on existing projects to improve data capture and usage. The consensus was to explain why data is being collected and feed it back to clinicians and service users. Stop the collection of information that isn't used so that any burden is justified and seen to be relevant. And create time to analyse and understand the information to hone the delivery of better services and demonstrate value. ○

• *For more on the Healthcare Costing for Value Institute, email richard.sawyer@hfma.org.uk*