Improving the efficiency of mental health services: an outcome orientated model

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Publication type: Proposed quality and productivity example

Sharing QIPP practice: What are 'Proposed Quality and Productivity' examples?

QIPP Evidence provides users with practical case studies that address the quality and productivity challenge in health and social care. All examples submitted are evaluated by NICE. This evaluation is based on the degree to which the initiative meets the QIPP criteria of savings, quality, evidence and implementability.

Proposed quality and productivity examples are those predominantly local case studies that meet most of the criteria but lack evidence of impact following implementation. This may be because they are at an early stage of implementation and further evidence is forthcoming. These proposed examples may be of interest, prior to the addition of further information which will be sought within a year period from the point of publication. A summary of findings is provided below along with comments and recommendations about how this case study may be developed.

Overview

This case study is about improving patient satisfaction and experience and reducing did not attends (DNAs), average length of treatment, and dropout rates for patients attending outpatient child and adolescent mental health services (CAMHS). The service uses a formal rating scale, which allows clinicians to assess practice and improve outcomes.

NICE comment

This case study has assumed, rather than actual, savings information. The submitter estimates savings of £300,000 per annum for the outpatients CAMHS service in Lincolnshire and estimates substantial savings if the service is replicated across the East Midlands. Information showing how implementation of this case study has actually demonstrated its aims is not yet available as the initiative is not yet fully implemented. Sleaford and Spalding CAMHS team is the only team currently implementing the initiative. From September 2011, the Sleaford and Spalding CAMHS team is leading on training and implementation of the OO-CAMHS initiative for other Lincolnshire Partnership NHS FT (LPFT) CAMHS teams.

Details of initiative

Purpose	To improve therapeutic efficiency, for example through reducing did not attends (DNAs), dropout rates, average length of treatment, and improving patient satisfaction for those attending outpatient Child and Adolescent Mental Health Services (CAMHS).
Description (including scope)	The Outcome Orientated Child and Adolescent Mental Health Service (OO-CAMHS) is the first CAMHS development that is designed to incorporate session-by-session measurements of outcomes evidence into a whole service model that can improve outcomes for all attending, at the same time as maximising efficient use of resources. Patient experience is likely to be improved through monitoring the patient's perspective of progress and if appropriate changing the therapeutic approach. This in turn can lead to patients attending their appointments regularly as they have confidence in the care they will receive. Four 'CORE' guiding principles underpin OO-CAHMS: • Consultation (with other agencies and families to address extra-therapeutic factors such as social context) • Outcome (using session-by-session outcome ratings, with discussions with families and team members if no improvement is found after five sessions) • Relationship (using session-by-session ratings of the alliance) • Ethics of care (building a supportive whole team ethic). The service uses a formal rating scale, which allows clinicians to assess practice and improve outcomes. OO-CAMHS uses two brief scales for young people: • the Outcome Rating Scale (ORS) and • the Session Rating Scale (SRS) and two brief scales for children: • the Child Outcome Rating Scale (CORS) and • the Child Session Rating Scale (CSRS). The scales used in this initiative are part of the American based 'Partners for Change Outcome Management' system. The Outcome Rating Scale (ORS) and Session Rating Scales (SRS) are very brief, feasible measures for tracking patients well-being and the quality of the therapeutic alliance, often taking less than a minute each for patients to complete and for clinicians to score and interpret. The ORS has been shown to be sensitive to change among those receiving mental health services. Numerous studies have documented concurrent, discriminative, criterion-related and predictive validity, test-retest reliability and internal-consistency reliability for the ORS and SRS (Anker et al. 2009; Bringhurst et al. 2006; Campbell and Hemsley 2009; Duncan et

	al. 2003; Duncan et al. 2006; Miller et al. 2003; Reese et al. 2009a, b). The scales are used to measure the patient's perspective of progress (ORS and CORS) and alliance (SRS and CSRS), respectively. Each measure only takes a few minutes to complete and gives a total score out of a maximum of 40. The scores can then be tracked session-by-session to quantify a patient's progress. OO-CAMHS in Sleaford and Spalding currently uses an American-based secure online system called 'MyOutcomes'. This website allows patients to fill in the ORS, CORS, SRS and CSRS online. The scores on the rating scales are then collected and can be analysed for each patient, but also for each clinician (showing average number of sessions, average change in ORS between first session and most recent session, effect size of this change, percentage reaching non-clinical cut off, etc) and for the service as a whole. These data can be used in clinical supervision, appraisal and whole team development. Services wishing to use the OO-CAMHS approach do not need to use 'MyOutcomes'. Paper versions of the ORS, CORS, SRS and CSRS are available free of charge and the scores can be manually entered onto an Excel spreadsheet. OO-CAMHS is working with an international mentor for the project to discuss whether a version/section of 'MyOutcomes' can be developed with the OO-CAMHS team to reflect a British CAMHS client group.
Topic	Mental health.
Other information	A large body of evidence has demonstrated that matching a mental health diagnosis to a specific therapeutic technique or model has a relatively small impact on outcome when compared with factors that influence outcomes across therapeutic modalities, such as social context and therapeutic relationship (Wampold 2001; Duncan et al. 2010), a finding that extends to mental health treatments for young people (Miller et al. 2008). Furthermore regular session-by-session measurement of outcome and therapeutic alliance has been shown to improve outcomes, reduce DNAs and dropout rates, and so save money through improved therapeutic efficiency (Gillaspy and Murphy 2011; Lambert 2010; Lambert and Shimokawa 2011).

Gate 1: Savings anticipated

Amount of savings anticipated	Potential saving for the entire outpatients CAMHS service in Lincolnshire of £300,000 to be made on annual costs is estimated, and if replicated throughout the East Midlands the potential cost savings could be substantial. This equates to a saving of approximately £40,000 per 100,000 population annually, which can be used to increase service capacity.

Type of saving	All potential savings are considered to improve productivity. The savings occur as a result of: • reduced DNAs • reduced average number of sessions needed • fewer stuck cases (cases receiving long-term treatment with little associated change) and • fewer cases needing inpatient treatment. A review of the first few months after implementing OO-CAMHS in the Sleaford and Spalding CAMHS team found 25% better attendance compared with attendance in other Lincolnshire non-OO-CAMHS teams. Over the course of the past 12 months, the OO-CAMHS team has only referred one patient for inpatient treatment compared with an average of 9.6 (range 5 to 20) for other Lincolnshire non-OO-CAMHS teams.
Any costs required to achieve the savings	No costs of change are indicated. However non-recurrent costs such as training individuals to use the outcome measures may be required.
Programme budget	Mental health disorders.
Details supporting Gate 1	No additional information provided.

Gate 2: Quality outcomes anticipated

Impact on care quality	Understanding the evidence base and the relationship between treatment and outcomes in mental health practice, allows practitioners to focus their approaches to understanding when and in what way services can be of benefit. Using the ORS/CORS session-by-session can lead to an improvement in clinical quality as it provides timely feedback on those at high risk of a poor outcome, which can lead to a change in therapeutic approach or a change of clinician.
Impact on patients, people who use services and community safety	The OOCAMHS model can lead to improved patient safety. It allows healthcare professionals to avoid poor outcomes and avoid inappropriate treatment pathways. The ORS and/or CORS are completed by the young person and/or their parent/carer at the beginning of each session. The scores on four dimensions (intrapersonal, family relationships, social functioning and overall) show where there are perceived problems or potential resources. This can be used to highlight where a risk assessment should be carried out and where resources to help manage that risk may be found. For example, a low score on 'intrapersonal' highlights a need to explore possible risk (e.g. suicide risk); while a high score

	on any dimension (e.g. family relationships) can then indicate a potential resource that can assist in managing that risk.
Impact on patients, people who use services,carer, public and community experience	The SRS/CSRS provides ongoing feedback loops from patients to the clinician on the therapeutic alliance, allowing the clinician to make sure that the treatment provided is appropriate, in turn improving the patient's experience.
Supporting evidence	No additional information provided.

Gate 3: Evidence of effectiveness

Evidence base for initiative	The initiative is underpinned by published research evidence. *[See contacts and resources for a comprehensive list of published research evidence].*
Evidence of deliverable from implementation	The initiative is in the early stages of implementation. The Sleaford and Spalding CAMHS team is leading on training and implementation of OO-CAMHS for other LPFT CAMHS teams starting in September 2011.
Supporting evidence for Gate 3	*[No additional information provided].*

Gate 4: Feasability of implementation

Implementation details	Improvements in service review, management and patient engagement can be achieved by implementing the routine use of a session-by-session rating scale in clinical practice. Organisations that do not have access to the 'My Outcomes' system can easily implement this initiative using paper versions of the ORS, CORS, SRS and CSRS and recording their outcomes data in an Excel spreadsheet. However they may need to consider appointing an administrative assistant to input the data. Depending on the size of the CAMHS centre, this could be a considerable task. For example, in a 6-month period the Sleaford and Spalding CAMHS team saw approximately 600 patients, resulting in 1200 completed rating scales. This initiative is not yet fully implemented across the whole of the LPFT. Sleaford and Spalding CAMHS team is the only team currently implementing the initiative. From September 2011, the Sleaford and Spalding CAMHS team provides training and implementation of the OO-CAMHS initiative for other LPFT CAMHS teams.

	OO-CAMHS won an East Midlands Regional Innovation Fund award in November 2010 of £48,000 to audit, develop a training programme and website, and train other community CAMHS teams in Lincolnshire in the use and implementation of this model. This programme of work began in January 2011 and is due to be completed by December 2011. This, together with cooperation with the national CORC project (including a presentation at the next CORC annual forum), will enable more widespread exposure to the project and should encourage uptake from CAMHS teams nationally.
Time taken to implement	Can be achieved quickly: 0–3 months, providing clinician support is received. Organisations new to session-by-session rating scales may take up to 6 months to implement this initiative.
Ease of implementation	Affects one department or team.
Level of support and commitment	The initiative is likely to receive a mixed reception. In order to mitigate this, it is important to maintain a level of respect for the clinician and ensure clinician engagement is maintained. One of the four CORE features of this initiative is ethics of care. This refers to the importance of developing a supportive team ethic, as changes that happen at a team level (rather than the level of individual clinicians) are the drivers of change. An important part of this philosophy involves an active engagement with patients (who provide ongoing feedback on the alliance). Putting patients' strengths, abilities and choices in the centre of the therapeutic process needs clinicians who similarly feel empowered by having their strengths, abilities and therapeutic choices noticed and respected. The OO-CAMHS approach involves building strong relationships with patients, which is mirrored by building strong relationships in the team. The approach relies on engagement of patients via engagement of clinicians. Imposing the approach on unwilling teams with an unsupportive supervisor or manager is unlikely to be successful (and is the reason many new initiatives, such as the current standard CORC outcome measures, have a poor record of uptake). Although a culture change means that initially some incentive and expectation to use the approach may be needed to get clinicians to try it out, the initiative relies not on coercion for uptake but on the clinical advantages it offers. This means that active engagement with supervisors to avoid coercive strategies and to support a positive opt-in is crucial to the project's ultimate success in any team that decides to take up the approach.
Barriers to	The approach demands a culture change in working practices in

implementation	CAMHS teams. In rolling out the initiative across the LPFT it is vital to overcome clinicians' fears about the implications of putting the patient in a more central role in decision-making and having a spreadsheet that includes their own individual outcomes as clinicians (which can then be compared with those of other clinicians).
Risks	The following risks were identified: • information governance • clinician reluctance • implementation across LPFT.
Supporting evidence for Gate 4	Using the outcome data in supervision and the overall whole team outcome data in team meetings can provide positive reinforcement as clinicians and teams can see that they are making a positive difference. It also provides opportunities to highlight areas where clinicians or the whole team require further development or training. For example, a review of stuck cases for a clinician may highlight further training needs for a particular presentation (such as mood disorders) or a particular treatment approach (such as family therapy). This may emerge for a team as a whole too.

Further evidence

Dependencies	The success of the initiative depends on clinicians accepting the process. Maintaining a database of outcome data is fundamental to the success and longevity of the initiative.

Contacts and resources

Contacts and resources	If you require any further information please email: contactus@evidence.nhs.uk and we will forward your enquiry and contact details to the provider of this case study. Please quote QIPP reference 11/0007 in your email. Anker M, Duncan B, Sparks J (2009) Using client feedback to improve couples therapy outcomes: a randomized clinical trial in a naturalistic setting. Journal of Consulting and Clinical Psychology 77: 693–704 Anker, M, Owen, J., Duncan B, Sparks, J. (2010) The alliance in couple therapy: Partner influence, early change, and alliance patterns in a naturalistic sample. Journal of Consulting and Clinical Psychology, 78, 635–645 Bringhurst D, Waston C, Miller S, Duncan B. (2006) The Reliability and Validity of the Outcome Rating Scale: A

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