SECURING THE MAXIMUM RETURN FROM LOCAL IAPT INVESTMENT

USING OUTCOME DATA TO MAXIMISE QUALITY IMPROVEMENTS AND REDUCE SERVICE DELIVERY COSTS

CORE IMS

CORE IMS are leaders in the field of routine outcome measurement. For over a decade we've helped psychological therapy practitioners develop and utilise some of the most valid, reliable and popular measurement tools currently used in NHS clinical practice. We've facilitated the training of a significant proportion of all those involved in routine outcome measurement. We've developed and deployed the first set of key performance indicators and benchmarks for primary care psychological therapies, and we currently support well over 5000 practitioners with bespoke outcome management software. In this article we offer our views on how we believe providers and commissioning consortia can work together to build on the key strengths of the national programme for Improving Access to Psychological Therapies and quickly overcome some of the emerging challenges.

Emerging results from the national programme for Improving Access to Psychological Therapies[1] are beginning to profile the true potential of psychological therapies. These findings are informed by the unprecedented volume of routine outcome measurement data largely gathered from the most important part of clinical practice – the patient. (Fig 1).

On the positive side, we're learning that collecting routine outcome data at every therapy session pays dividends – provided practitioners learn how to make measurement an integrated part of the therapy process and not a simple administrative prelude. Additionally, we're learning that routinely monitoring outcomes session-by-session can make a substantial contribution to patient recovery – provided measurement is ordinal, data quality is optimal, and the value of client feedback is unequivocal.

> *"It is clear that while there has been a high degree of success in rolling IAPT services out across the country, more needs to be done by local commissioners and services to ensure that those services are provided equitably and to similar standards of quality."*
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> *Glover et al, N.E. Public Health Observatory (2010)*

Figure 1.

> *"Patients diagnosed as needing low intensity treatments received an average of two sessions with Improving Access staff, while NICE guidelines recommend at least six. Those judged to need high intensity treatments were only seen on average three times, compared with a minimum of 16 sessions recommended for treating depression or anxiety."*
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> *Simon Lewis, HSJ (18/09/2010)*

Figure 2.

However, we're equally learning that the cost of rendering reports solely to meet top-down national information targets is not enough to secure practitioner engagement in the provision of high quality data. This is because – of themselves – national reports do little to nurture a culture of clinical transparency; empower practitioners to take responsibility for their performance; reduce collective inefficiency, or ultimately secure the delivery of efficacious treatment 'doses' that can help recover patients from common mental health problems. (Fig 2).

In sum, IAPT have laid excellent foundations to *potentialise* optimum recovery through implementing a culture of routine outcome measurement. To *realise* that potential, we believe that the 'signals' of session-by-session measurement should be further embedded into the clinical process; clinical practitioners need to learn how to integrate and 'listen' to the client's session-by-session outcome rating; supervisors need to learn how to use such sessional outcome data to optimise practitioner and (consequential) service effectiveness, and service managers need to learn how to facilitate and reward such a culture of excellence that these collective activities embody.

PRACTITIONERS MUST LEARN TO ACT ON THE SIGNALS FROM PATIENTS' SESSION-BY-SESSION MEASUREMENT TO SECURE THE SIGNIFICANT POTENTIAL THAT SUCH PROCESSES CAN DELIVER

The IAPT mandate to measure the impact of therapy through session-by-session outcome measurement using PHQ9 and

GAD7 is a laudable achievement that many practitioners may feel like dropping under new local commissioning arrangements, and commissioners may be convinced to acquiesce.

But before jumping to do so it may be wise to consider the empirical evidence emerging from a growing body of US research that suggests using feedback from routine measurement can potentially halve deterioration rates to less than 10% and double improvement or recovery rates to almost 45% for the 1 in 4 patients found to demonstrably deteriorate during the course of their psychological therapy experience[3].

Given the contradictory evidence for the relative superiority of specific therapeutic modalities in routine service delivery and considering the emerging body of evidence profiling significant inter-practitioner differences [3,4] – such potential should lead us to stop and consider whether we are using routine measurement in an effective way before disinvesting from its collection. Could it be that the clinical and dialogical use of routine outcome measurement explains the wide range of recovery rates evident across the IAPT sites in the earlier cited review? CORE IMS certainly have both empirical and experiential evidence to suggest this may well be the case, and we've documented case studies to share as best practice in deploying our clinical training resources.

SUPERVISORS AND CASE MANAGERS MUST LEARN HOW TO USE ROUTINE OUTCOMES DATA TO HELP OPTIMISE SERVICE EFFECTIVENESS, EFFICIENCY AND SAFETY THROUGH PRACTITIONERS

Once practitioners are convinced of the immediate dialogical and therapeutic use of session-by-session measurement, naturally they are going to experience a range of patterns in patients' scoring trajectories from the chosen measures. At the most pragmatic level, each patient will profile in one of three empirical categories. These include: (a) those having score trajectories inclined towards improvement or recovery; (b) those having no current meaningful change scores; and (c) those having increasing score trajectories suggesting current or imminent clinical deterioration. Clearly, supervisors or case managers have a significant role to exercise their experience and expertise in helping practitioners decide on appropriate remedial action to ensure service safety and efficiency. This may not only involve advising on stepping-up patients to more specialist support, but perhaps more radically – stepping clients across to colleagues within the same service tier – who have consistently positive recovery or improvement outcomes with similar specific case mix profiles. CORE IMS already deliver sophisticated supervision case alerts in our outcome management software, but it's our current research – assessing a range of case management tools with leading academics – that promises significant insight into truly maximising practitioner recovery profiles through best match case mix allocations.

SERVICE MANAGERS MUST LEARN HOW TO FURTHER DEVELOP SERVICES THAT ENGAGE PATIENTS TO SUCCESSFULLY COMPLETE THEIR THERAPEUTIC JOURNEYS

Unfortunately, independent practice-based evidence published from both IAPT and CORE datasets suggest service managers need considerable support to help deliver services that engage patients in completing their therapeutic treatments, as this sadly remains the exception rather than the norm.

There is growing evidence to suggest that in many services more than half of all patients referred to psychological therapy for common mental health problems do not complete their treatments, and significantly less than half fail to demonstrably recover from their conditions. In this on-going austere economic climate, we would predict that services will experience a paradigm shift (Fig 3) and have to work to targets that have a direct relationship with patient outcomes, rather than the currencies of targets (e.g. waiting times) or simple provision (i.e. patients seen or sessions delivered). In such a climate where annual gross budgets may simply be divided by the annual net numbers of demonstrably recovered or improved patients – the potential metric of *cost per recovered patient* is a composite variable

Figure 3.

that may be hugely influenced by the net numbers that complete treatment relative to the numbers that start. CORE IMS's financial modeling and benchmarks of the costs associated with 'recovered patients' helps managers prepare for such exacting demands. Understanding the relative contribution of service delivery stages, individual practitioner performance, supervision interventions and service culture can improve the quality of the patient experience and create better value for money. Alongside training, software and consultancy support, CORE IMS's unique benchmarks, case studies, and leadership mentoring are all resources we're developing and deploying to ultimately help manage a difference. ■

REFERENCES

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