

CORC's Position on Commissioning for Quality and Innovation (CQUIN) targets concerning outcome measures

3 April 2013

We have been receiving an increasing number of queries asking for advice in terms of setting Commissioning for Quality and Innovation (CQUIN) targets in services for outcome measures and have produced this brief position paper to help guide commissioners and CORC members negotiate successful CQUIN targets.

CORC warmly welcomes commissioners encouraging and supporting services to adopt and use clinical outcome measures and service user feedback tools, and sees CQUIN targets as a potentially good vehicle to facilitate this. However, we strongly advise caution in the targets set in CQUINs so that they are most likely to facilitate the successful adoption of measures, providing the potential to genuinely improve quality in child mental health services and seek to avoid unintended negative consequences which may, at best, lead to no change or, at worst, have a detrimental effect on services provided to children, young people and their families.

Our recommendation is that CQUINs are set in line with services' stage of implementation of outcomes monitoring.

Early or no implementation: CQUINs should encourage training and development of infrastructure to support outcome monitoring. Targets might include:

- a. Percentage of clinical workforce trained in the use and interpretation of routine outcome monitoring scores.
- b. Percentage of clinical workforce trained in providing service user feedback.
- c. Percentage of supervisors trained in supporting use of outcome data in clinical work.
- d. IT systems allow input of self-report data from clients and reporting back to clinicians in real time.
- e. Percentage of accepted cases who have attended at least one session with a first SDQ or other assessment measure.

Some implementation established: CQUINs should encourage routine collection and use in clinical care. Targets include:

- a. Percentages of cases seen where there are at least two matched scores, e.g., assessment and follow-up SDQ or at least two session-by-session measures.
- b. Appropriate use of measures, e.g., service audits of factors moderating outcomes or use of CORC analyses to find areas for possible service transformation. That is analysing and feeding back results to clinicians is incentivized rather than the results of those analyses.

Well established implementation: all supervisors and clinicians are trained in the use of outcomes, good infrastructure for outcomes is available (IT system which graph progress against expected recovery curves and admin support), and complete coverage of cases. Here it might be possible to consider setting CQUINs around outcomes – with extreme caution (see *Possible risks of setting targets on outcome scores* below). Our recommendation would be to use a combination of response rates, service satisfaction, and outcomes scores, rather than just one fixed indication. The use of measures in in-patient settings and with those with complex neurodevelopmental or learning disability needs to provide a comprehensive approach to CQUINs and in this instance to liaise with QNIC.

Targets should be tested by showing that a specified confidence interval (for instance 95%) includes the target. CORC can provide advice on how best to do this. This is important as it takes into consideration that some variation in percentages and scores occurs due to chance and is beyond the control of the service.

All CQUINs should take into account adequate funding to support the target, including but not limited to IT, training and backfill costs, and administrative support.

The SDQ “added-value” score

Some commissioners are saying that the Added Value Score is the indicator they want to use. We would advise against this. As the SDQ website states (<http://www.sdqinfo.org/c5.html>):

“Although initial findings on added value scores are promising, they should not be taken too seriously until accumulating experimental data from around the world tells us more about the formula’s own strengths and difficulties!”

Presently there have been two studies testing the validity of the added-value score, one published in a peer-reviewed journal (Ford et al., 2009) and another was presented at a Royal College of Psychiatrists conference (Rotheray, 2012). Both supported its use for parenting programs. There has yet to be a test for emotional or other problems.

Possible risks of setting targets on outcome scores

There is a general recognition by all in CORC that this potential initiative is a complex undertaking, with limitations and difficulties given our current imperfect knowledge about outcome evaluation when used in this way. Risks include:

- 1) Any target-based approach introduces the possibilities of perverse incentives into the system. Introducing targets may affect what service providers do in negative as well as positive ways e.g., it may encourage one sort of service at the expense of another. For example it may discourage those services who are doing a very important job in relation to consulting with primary care staff but whose outcomes cannot be measured as easily using this approach, or those who set out to prevent difficulties arising in the first place –the outcomes of such vital work would not readily be captured by such an approach.
- 2) Services may not reach the target not because they are providing an inadequate quality of care but because the target set turns out in retrospect to be unrealistic, or the measures are too limited for the purpose. This may lead to services being unfairly demonised or demoralised. In particular, there is a concern that our measures and knowledge are simply not sophisticated enough yet to allow for such an approach and that inappropriate conclusions may be drawn from the data.
- 3) It may make people wary of outcome evaluation generally and actually put people off the endeavour because they feel data is being prematurely used in ways that are designed to undermine service developments.
- 4) There may be pressure to roll out this initiative to other areas before the approach has been properly evaluated and considered in depth.

- 5) By using a single measure approach for the purposes of the target it may undermine CORC’s recommendation on the need for multiple perspectives to evaluate outcomes effectively (CORC, 2010).
- 6) Services which do a better job of collecting follow-up data may paradoxically show worse outcomes. One study of adult mental health services suggests that people who are less likely to complete questionnaires at follow up are also those who have shown less progress (Clark et al., 2009). Equally, services may have lower response rates at follow up because they are collecting follow ups at discharge rather than to a set time scale which is associated with better outcomes in the CORC data set or because services may chase follow up harder in families where the practitioner is clear that outcome was better. Thus making a special effort to capture data from all cases may reduce the average outcome.
- 7) As services become more responsive to service user feedback and redesign and improve their participation and shared decision making, clients may become more honest in their feedback giving constructive criticism or reporting their view more accurately
- 8) Payment by Outcomes is currently only being piloted, without being linked yet to actual financing, for Adult IAPT. It is too early to know what the impact of this approach will be. It has not been tested for other areas of mental health.

Please note that this is our current advice at the time of producing this document, but that we are always reviewing our guidance and approach in light of the latest research and advice.

Document history

Authors	Date	Note
Miranda Wolpert (with advice from others on the CORC Committee ¹)	July 2011	First release
Tamsin Ford, Andy Fugard, Evette Girgis, Duncan Law, Miranda Wolpert, and Ann York (with advice from others on the CORC Committee ²)	16 January 2013	Draft released for comments (to be returned by 1 Feb 2013)
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¹ CORC committee July 2011: Miranda Wolpert, Ashley Wyatt, Evette Girgis, Duncan Law, Tamsin Ford, Ann York, Julie Elliott, and Alison Towndrow

² CORC committee April 2013: Miranda Wolpert, Ashley Wyatt, Evette Girgis, Duncan Law, Tamsin Ford, Ann York, Julie Elliot, Alison Towndrow, Mick Atkinson, Alan Ovenden, and Laurence Slattery

References

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Ford, T., Hutchings, J., Bywater, T., Goodman, A., & Goodman, R. (2009). Strengths and Difficulties Questionnaire Added Value Scores: evaluating effectiveness in child mental health interventions. *The British Journal of Psychiatry*, *194*, 552–558.

Rotheray, S. (2012). SDQ Added Value Score. Where are we now? Presentation at the Faculty of Child and Adolescent Psychiatry Annual Residential Conference, 19–21 September 2012, Manchester. Slides available from <http://www.rcpsych.ac.uk/pdf/Rotheray%20S.pdf>