

Chapter Ten Monitoring and improvement

Answering the 'So what?' question: Monitoring outcomes for users of mental health services

by Bob Waring

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Abstract

This case study explores the introduction of ‘Outcome Management’ in Liverpool. All mental health services were required to demonstrate the beneficial outcomes resulting from the public money they received. Commissioners acted as investors, with providers of services having to demonstrate a return on the investment: all services set outcome-based targets and reported their achievements on a quarterly basis. As a result, services became more outcome focussed, service users became actively engaged and commissioners developed a means to ensure the effective use of public money. The new health and social care White Paper requires ‘smarter commissioning’ and Outcome Management offers a tool to deliver this.

Key Words: mental health; milestones; outcomes; targets.

From ‘How Much?’ to ‘So What?’

In 1999, Liverpool Social Services was commissioning - at a cost in excess of £12m - more than 40 different services for adults with mental health problems, from a range of providers in the independent, voluntary and (internal) statutory sectors. In common with most public sector bodies which commission services, the city council had mechanisms in place to capture activity data regarding each of these services and robust audit mechanisms in relation to their use of public funds. What the city council lacked was any valid means of assessing the impact of these services on the service users. It was to address this deficit that social services commissioned The Innovations Group (a leading consultancy firm working with public sector clients in local and national government and the NHS) to work with its Contracts Unit and other commissioners to develop a methodology which could measure the outcomes of its mental health services. This case study describes the introduction of the ‘Outcome Management’ project to measure the impact of Liverpool’s spend on adult mental health services.

For mental health services in Liverpool the commissioners had set themselves the following ambitious and high level strategic goal:

“To achieve a community which promotes mental health and prevents the social exclusion of mentally ill people, allowing them to exercise choice, maximise their potential and participate in society safely.”

To this end the commissioners determined that all mental health services would be challenged to demonstrate that they were actively contributing to this vision. One goal set by the commissioners during 2000, was to ensure that all mental health services commissioned by the city council should adopt Outcome Management concepts, methods and tools, irrespective of who was providing those services. The purpose was to target, track, verify and report on the specific health

and social gains experienced by service users. Having tested the Outcome Management approach, it was expected that all providers would be able to demonstrate what they had learned and how they intended to improve their services in consequence.

A large number of mental health services were delivered in Liverpool outside of inpatient psychiatric acute services. These included: counselling services; home support; services to link users to education, training or employment; advocacy services; supported accommodation; and residential services. Some services had been established for many years and were working without any clear Service Level Agreements (SLAs). They lacked explicit goals or measurable objectives against which they could assess how they were benefiting service users. They did keep records and could answer the standard questions asked by commissioners and contracts officers: 'How many people use your service?'; 'What hours do you operate?'; 'How many staff do you employ?'; 'Can you account for the money we give you?'. However, they couldn't answer, in any systematic or verifiable way, the simplest and yet the most meaningful question of all: 'So what do you achieve for your service users?'.

The 'so what?' question goes to the heart of commissioning intent because it seeks to understand what difference the investment makes and how it changes things for service users. It requires a shift from an interest in the quantitative (outputs and a 'bean counting' culture) to an interest in the qualitative (understanding that the skills and expertise of the provider are directly related to outcomes for service users). In this sense, a focus on outcomes is empowering for service providers, who know that their funder is interested in what they can achieve rather than having to rely on proxy measures of activity. A culture in which public money is passed to an organisation without requiring feedback about the outcomes of that funding is one which short changes the public purse and service users, whilst showing little respect to those providing the service. Ironically, it is the commissioners who have not sought to put such mechanisms in place, who must shoulder responsibility for much of this.

Outcome Management

In the autumn of 1999 a letter was sent to all funded providers of mental health services in Liverpool. It outlined the new approach that would be required in the reporting of their activities and invited them to attend a seminar at which the methodology would be explained and questions answered. The vast majority of the providers attended the seminar which was co-facilitated by consultants from The Innovations Group and myself as Contracts Manager for mental health (those providers who were not able to attend were visited individually and the process was explained to them). It is fair to say that there was a considerable degree of scepticism and in some instances anxiety regarding the introduction of Outcome Management. The central message from the 'Investors' to the service providers was that this was not a new scheme by the city council to get more out of them, or to performance manage them to death. Instead, it was a way for them to work in partnership with the commissioners and their service users to improve quality. At the seminar the Outcome Management methodology was described and working examples offered.

Although this approach had not been tested in mental health services before, The Innovation Group had introduced it in other public sector services, including drug rehabilitation and work with offenders, and it was possible to draw credible parallels. Providers attending the seminar were given the opportunity to work together in small groups to test out how the methodology might be applied to their services (they were grouped according to the nature of their service, residential, day services, etc). They were invited to reflect on what their current goals for service users were, how these goals were assessed and how this information could be shared with the commissioners.

Key prompts were offered, for example, 'What sort of health or social gains can you help your service users achieve?' and 'How would you and they know these gains had been achieved?'

At the heart of the Outcome Management process was the 'target plan'. The target plan consisted of five sections in which providers described the nature of their service, objectives for improving the lives of service users and how these could be demonstrated. Each provider was given a set of guidance notes to help them produce their target plans. Target plans described the service being provided, and defined service users and performance targets i.e. changes in the behaviour, condition or satisfaction of service users, including verification methods and milestones. Templates for each type of service were provided (e.g. residential, supported accommodation, support at home, day support or employment, advocacy, counselling and training), with specimen milestones to track service users' progress. Services were expected to adhere closely to the templates but could add additional milestones or performance targets if these would better express the impact of their interventions. An outline of a hypothetical mental health service, which was included in the target plan template for home support service schemes at the seminar, is attached at [appendix 1](#).

Providers were given three months to complete their target plans, which were to become operational from April 2000, and offered individual support if required. I visited several providers to speak with staff, and service users, in order to de-mystify the process.

In completing their target plan, providers were asked to project the annual gains at each stage on a quarterly basis and were requested to make quarterly returns which were evaluated by the commissioners against the projections in the target plan. Providers were asked to provide explanations were they could for any significant discrepancies between the figures in the target plan and those in the actual returns.

This was not simply a technical exercise involving the commissioners and the providers – service users were at the heart of the process. Service users were in attendance at the seminars, and groups representing service users across the city were, once it had been explained and de-mystified, very supportive of the initiative. The expectation was that the providers would have an individual target plan for each service user. Where, as an example, a target for a provider was about 'numbers of service users experiencing a mental health gain' this had to translate down to something specific and meaningful for individuals which could be discussed and agreed with each service user. It was this bringing into focus of the needs of service users which was possibly the greatest benefit of Outcome Management.

Support continued to be offered to service providers by telephone, correspondence and through individual visits. Initially, quarterly seminars were held under the title 'Lessons Learned' which enabled both the commissioners and the providers to enhance their understanding of the process.

The Impact of Outcome Management

The move from traditional, often long standing arrangements - whereby financial support in the form of grant aid was passed to service providers in return for an undertaking that they would do 'good things', as evidenced by activity data and annual accounts - to a relationship based on investing for results, was a 'wake-up call' for commissioners, providers and service users alike. For service providers it meant taking a hard look at their services and realising that they needed to be based on individual plans with individual service users, complete with agreed targets and goals. Rather than engagement between service users and providers being considered sufficient in itself, Outcome Management challenged all to ensure that each activity was purposeful.

At first, target setting was largely based on educated guess work, with neither providers nor commissioners knowing if the figures were realistic or deliverable. Providers were assured that the

first year of the new system was an experiment and it would be in the second and subsequent years that they would be able to demonstrate what they had learned and how they could work to improve their services. The key was seen as shifting thinking and expectation on the part of the commissioners as much as the providers. An initially sceptical set of providers and service users became increasingly confident and even excited about the changes as these impacted on services, reinvigorating many, and for others demonstrating just how much they were achieving in a sector in which long-term maintenance and support is often seen as all that can be expected.

Perhaps, inevitably, there was a mix of some providers seeking to be very cautious and give themselves modest and easily deliverable targets/milestones, whilst others (who may have felt the need to evidence high performance) set very ambitious targets. At the seminars and during individual visits, providers were cautioned against each approach. However, as commissioners, we took the view that only they really knew what they were capable of and so largely accepted the targets and milestones providers set. The first year of the initiative (with which this study concerns itself) was seen as a developmental pilot, at the end of which there would be a 'reality check', with commissioners and providers subsequently negotiating appropriate targets on the basis of actual experience of working in this new way. The providers who gave the greatest concern were those few where the quarterly return figures were precisely as had been set out in the Target Plan.

Conclusion

As a consequence of Outcome Management, all service users in contact with services funded by the city council (many of whom were not in contact with statutory services) became involved in their own care planning process. The city council and the commissioners of mental health services gained an in-depth picture of the activities which they were funding and were able to improve delivery against some key performance targets as a result of the information provided. Despite misgivings on the part of service providers, the exercise was not conducted in order to identify candidates for budget cuts and has not been used for such a purpose. Outcome Management continues six years later and has been sustained because it is a valuable tool to drive forward quality, to deepen partnership and to keep all eyes focussed on the most important factor in service delivery, the beneficial impact on service users.

A major benefit of Outcome Management as described here is that it develops a new mindset for commissioners and purchasers of services. They move from being passive 'funders' to active 'investors' seeking a return on public money. In areas where this approach has been adopted it has enabled commissioners to apply Outcome Management principles to their own internal operations and to ask the question 'What does success look like for high performing commissioning units?'. This is a question which becomes even more pertinent in the light of the expectations of sharper commissioning performance in the new White Paper 'Our health, Our Care, Our Say'.

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Biography

Beginning as a social worker in 1975, Bob Waring is now Integration Development Manager with South Sefton PCT. In 1999 he was responsible for mental health contracts in Liverpool city council where he helped introduce 'Outcome Funding'. Most of Bob's career has been in mental health social work, training and, in later years, senior management. He was an elected councillor for over 18 years, most recently as chair of Health Overview and Scrutiny in Sefton where he has lived for most of his life. His present role is to help implement the integration of health and social care. Bob can be contacted by telephone on 0151-478-1203 or by e-mail at bob.waring@pct.southsefton.nhs.uk