

Getting Good Outcomes: Towards Meaningful Data Collection in an Inpatient Service

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“It is impossible to escape the impression that people commonly use false standards of measurement — that they seek power, success and wealth for themselves and admire them in others, and that they underestimate what is of true value in life.”
— Sigmund Freud (1929) *Civilization and Its Discontents*

Background

Changes in NHS funding arrangements over the past decade – the developing “internal market”, “payment by results” and the ‘Improving Access to Psychological Therapies (IAPT)’ investment – have resulted in a requirement for services to quantitatively assess activity and effectiveness within an increasingly managerialist discourse. Although this quantitative framework assumes a scientific approach, it is difficult for services to evaluate their work objectively, because funding for patient care – and indeed salaries – depends upon demonstrating patients’ *progress* towards ‘recovery’.

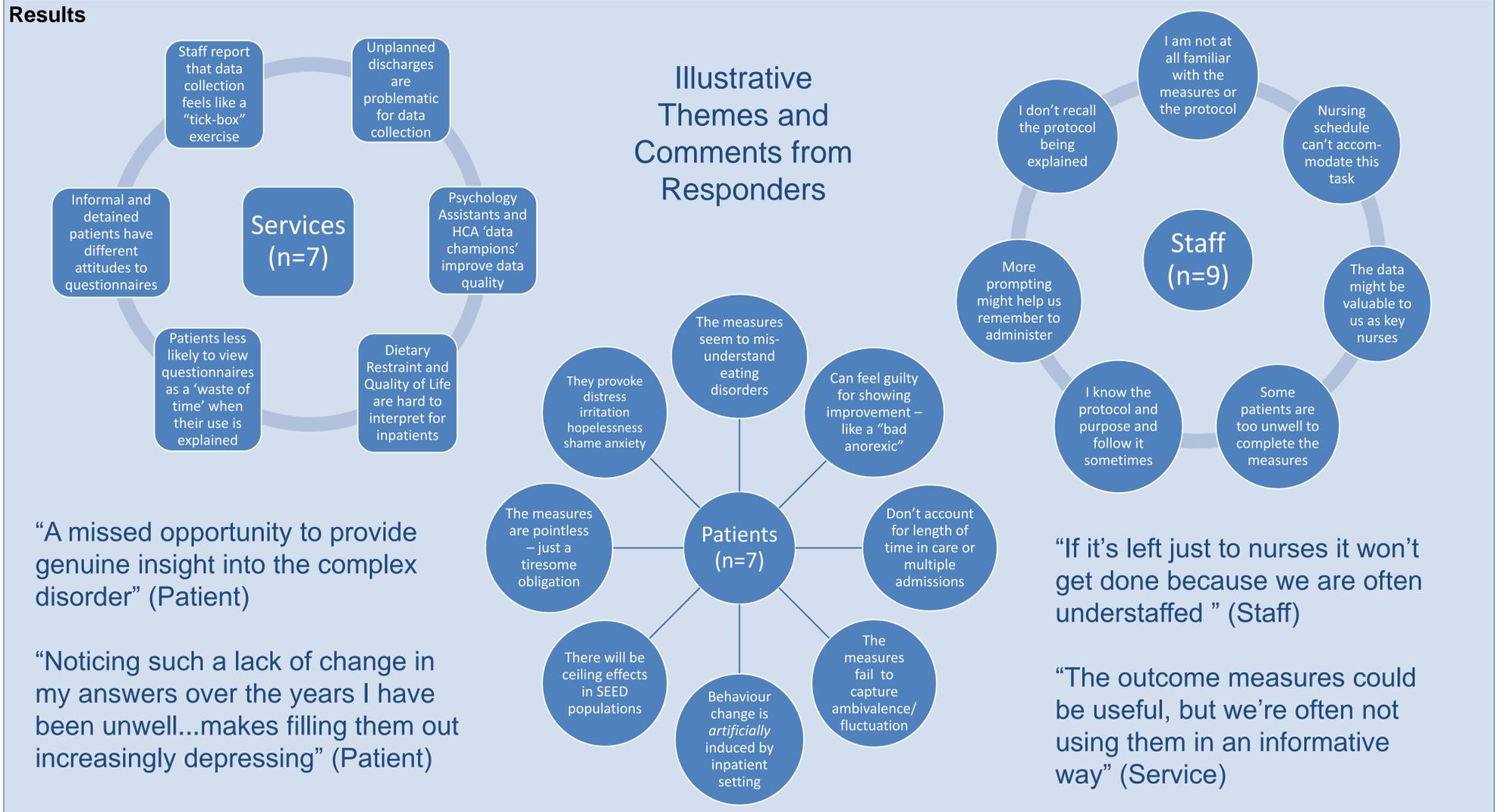
Further, principled objections have been raised over the effect of overzealous measurement in therapeutic settings. Some users of services protest colonisation of the concept of recovery to serve corporate priorities (Turner et al., 2011; “Recovery in the Bin” 2016). They caution against homogenizing the notion of ‘recovery’ and assuming it can be “calibrated” using outcome measures. Others have suggested that measuring patients defends clinicians against the distress of being in touch with the complex realities of suffering, dependence, and vulnerability (Rizq, 2011).

On our inpatient ward, we have noticed signs of dissatisfaction (amongst staff and patients) with the mandated outcome measures: many patients decline to complete the questionnaires, and staff do not consistently offer the measures to patients despite financial penalties for failing to submit complete data sets to commissioners. This is contrasted with much higher uptake for bespoke measures for particular interventions (e.g. Adlam et al., 2015).

Method

- We created opportunities for dialogue with inpatients: clinicians’ concerns with the current data set were raised in staff-patient community meetings; outcome measuring was discussed at the hospital research meeting (attended by patients as experts by experience); a brief written survey was made available to all patients on the ward from January to March 2016.
- We conducted opportunistically sampled semi-structured interviews with RMNs and HCAs tasked with administering outcome measures to patients.
- We contacted other inpatient services to discuss their use of outcome measures, including staff and patient views on implementation and interpretation.

Results



Conclusions

- There are straightforward ways services could improve the patient and staff experience of mandatory outcome measures by helping them understand the purpose and limitations of the questionnaires, and by finding times to critically evaluate the data together in context. This may increase participation.
- With a high proportion of detained patients in inpatient services nowadays, we should not assume self-report measures designed for outpatients are appropriate, and instead seek to alter, adapt, or augment them. For example, Sussex Partnership NHS Foundation Trust has incorporated a cycle of focus groups asking forensic patients about their experience of treatment, which are facilitated by staff from outside the service itself (Aldred et al., 2015).
- Perhaps the ‘outcome’ in outcome measures is a mis-nomer? Do we really mean, ‘output measures’? What are the outputs of an open system that imports raw materials and exports ‘worked on’ products? If we turned our attention to outputs, with a shared notion of what the process felt like, how would we recalibrate our approach? How might we gauge the impact of processes of ‘being with’ rather than practices of ‘doing unto’?

Readings: Adlam, Brunton, Leipold, Plumb (IEDC 2015) ‘Two Unstructured Small Groups using an MBT-ED approach: preliminary findings from a comparative study’. Adlam, Hewitt, Hursey, Lazenby, Plumb (2016) ‘Fine words in theory butter no parsnips in practice: critical approaches to ‘co-production’ on an eating disorders ward’. Aldred et al. (2015) “Not Another Questionnaire” – Creatively Evaluating the Patient Experience in Secure and Forensic Services at Sussex Partnership NHS Foundation Trust in partnership with CAPITAL’. In *Quality Network for Forensic Mental Health Services Cycle 9 (Annual Report – Medium Secure)*. ‘Recovery in the bin’ (2016). *Clinical Psychology Forum* 279; 13-16. March 2016. Rizq (2012) ‘The perversion of care: psychological therapies in a time of IAPT’. *Psychodynamic Practice* 18: 7-24 Turner, Brooker, Lovell (2011) “and they all lived happily ever after”: ‘recovery’ or discovery of the self in personality disorder?”. *Psychodynamic Practice* 17(3): 341-6

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“What is manifold is often frightening because it is not neat and simple. People prefer to forget how many possibilities are open to them.”
— Martin Buber (1923) *I and Thou*