Healthy London Partnership

London Mental Health Transformation Programme

DIALOG operational manual

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1. Acknowledgements

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- Patricia Aveling, Clinical Lead for Mental Health Outcomes, North East London NHS Foundation Trust
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- Andrew Crombie, Consultant Old Age Psychiatrist, CMHT services Camden and Islington NHS Foundation Trust
- Graham Fawcett, Consultant Clinical Psychologist, East London NHS Foundation Trust
- Simon Fewer, Information Systems Programme Manager, East London NHS Foundation Trust
- Martin Greig, Clinical Systems Lead / IMT Champion for Luton and Bedfordshire East London NHS Foundation Trust
- Behgan Jubokowa, Business Analyst, East London NHS Foundation Trust
- Melanie Morris, Electronic Clinical Systems Project Manager, East London NHS Foundation Trust

2. Purpose and Overview

The purpose of this operational manual is to act as a tool to support the London implementation of DIALOG as a patient reported outcome measure (PROM) for **Early intervention programme (EIP) and Care Programme Approach (CPA) services**. There is scope for Mental Health Trusts to extend the use of DIALOG to other mental health services/conditions where agreement has been made within their Trusts. This Manual provides background information on DIALOG, how and when to use it and suggestions for how the data should be analysed. The aim of the Manual is to provide a common level of consistency in how DIALOG is implemented and used across each of the London Mental Health Trust's, whilst still allowing for some local flexibility in the way in which DIALOG is deployed locally. The operational manual is intended to be used alongside a wide range of resources derived to support implementation such as the analytical framework, service user vignette and animation and training presentation. The suite of resources can be found on the HLP website.

It is anticipated that this collection of resources will grow as implementation is embedded within all Trusts

3. Background

- **Why has DIALOG been chosen as a London Patient Reported Outcome Measure (PROM)**

The use of DIALOG as a London PROM was agreed by Healthy London Partnership's London Mental Health Transformation Programme including the Cavendish Square Group (London's Mental Health Trusts Group of Chief Executive Officers, Medical Directors, Nursing Directors and Chief Operating Officers). DIALOG was chosen as London's PROM because:

- The scale has been shown to have **good psychometric properties**.
- It is **simple** to use
- It can be used to evaluate treatment and has the advantage that each item is **meaningful.**
- **Service users** report **satisfaction** in using it
- The information can be used for planning for individual service users and whole services.

In addition the use of DIALOG + has been shown to improve (subjective) quality of life by agenda setting, shared decision making and positive commentary and solution focused approach[1].

4. The use of outcomes in clinical practice

The ability to understand how the care provided to a person with a mental health illness is impacting on their outcomes, is a fundamental part of routine clinical practice. Intuitively clinicians and services will have a sense of this as part of the everyday care they provide.

[1] www.karger.com/Article/Pdf/430991

However, to support clinical practice, improve service user experience and drive quality improvement, outcomes data needs to be collected. Therefore, clinicians should be supported with systems that enables them to use outcome measures with service users, review, discuss, feedback the data and understand the impact of what the data is suggesting not only from a learning and development perspective, but also as part of a continuous service improvement process. Outcomes data provides useful information to ask and explore informed questions about services.

Capturing London DIALOG data will also give a powerful indicator of **service user satisfaction levels**, and where health and social care services need to **focus** for **improvement** as part of a Strategic Transformation Partnership (and then as an Integrated Care System).

Exploring outcomes data may also help to provide a comprehensive picture of **opportunities and challenges** at a provider, commissioner and **STP/ICS level** which is essential to **improving services** for people experiencing mental ill health.

It is important however that outcome data is not used in isolation, context is everything and factors such as age, ethnicity, gender, service type, initial severity, point of assessment, length of stay and diagnosis will all impact on the interpretation of data.

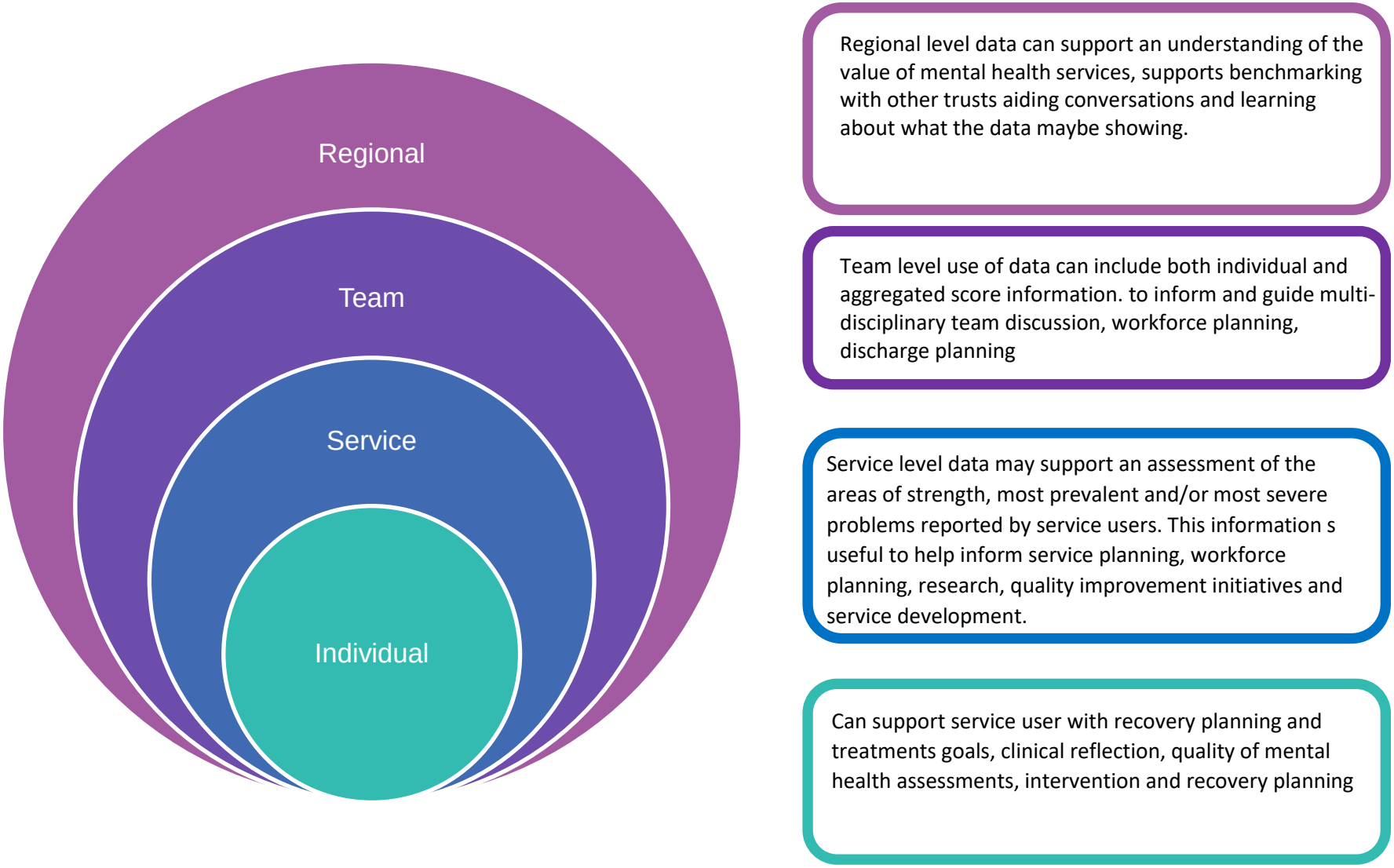


Figure 1 – Opportunities for using outcomes data at different levels. There is value to exploring outcomes at number of different levels depending on the purpose of evaluation.

5. What is DIALOG and DIALOG+

DIALOG is an 11-question survey where by people with a mental health illness are asked to rate their satisfaction and needs for care on 8 life domains and 3 treatment aspects. It is a tool that is completed by the service user and its content helps to highlight areas:

- They'd like further support with, or
- of concern, or
- areas that are going well,

The information may also be used to evaluate or measure the person's recovery journey. The data can be used as part of the patient reported outcome measure.

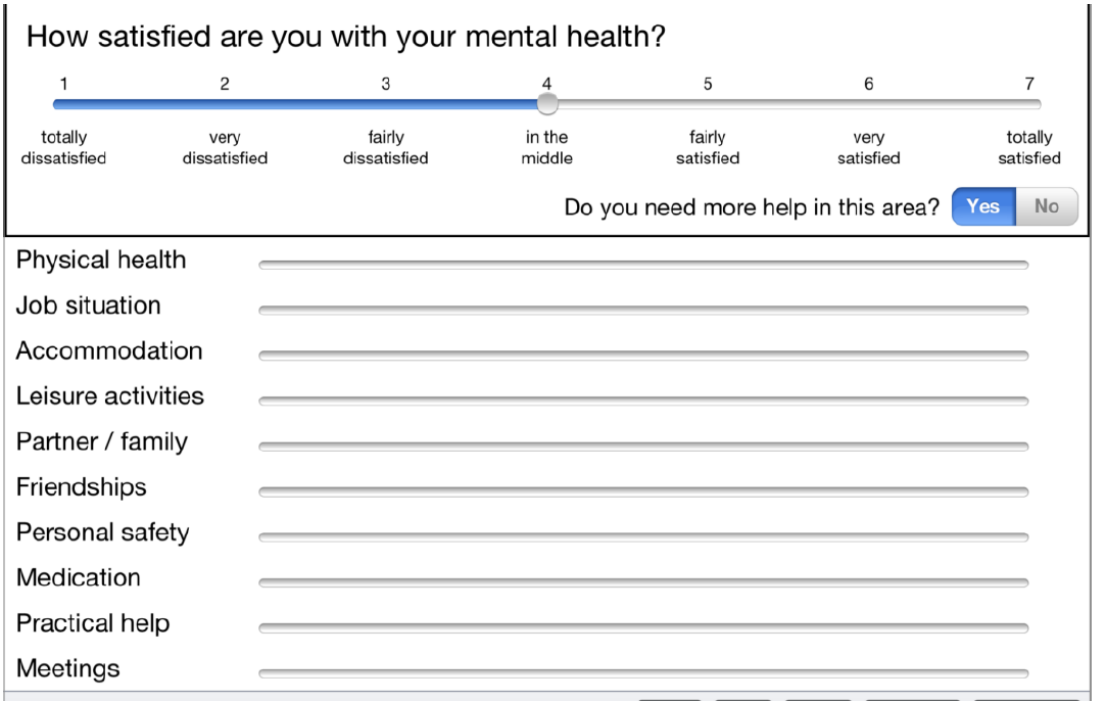


Figure 2: DIALOG scale

DIALOG+ is a specific intervention that uses the DIALOG scale and a 4- step approach based on solution focused therapy. This approach helps to structure and improve the communication between a health professional and a service user and, through that, supports discussions that lead to solutions and helps service users to take an active problem-solving approach to promoting their recovery. The approach involves:

1. 'understanding' - identify scenarios for improvement
2. '**looking forward'** - explore options for actions
3. 'exploring' - finally agree on actions for improving the service user's condition and social situation
4. 'agreeing' - this is meant both to address the specific concerns of the service user as identified in the DIALOG+ assessment and to suggest an approach for dealing with difficulties in general. The decisions are then shown at the beginning of the following meeting in which DIALOG+ is used[2].

[2] https://dialog.elft.nhs.uk/file_download.aspx?id=3306

6. Using the DIALOG scale

The decision whether to use DIALOG vs DIALOG + may vary across the Trusts.

Table 1 Sets out a summary of how DIALOG has been used.

DIALOG intention	Anticipated use
1. DIALOG as the patient reported outcome measure (PROM) and patient reported experience measure (PREM).	• The service user completes DIALOG at key points in their treatment. The service user usually completes DIALOG on their own but staff can assist if required • Staff review the completed DIALOG to understand the service user's perspective • Staff discuss all low scores and any unexpected scores with the service user • Staff discuss any progress / changes identified in the repeat DIALOGs with the service user.
2. DIALOG used to inform care planning ; DIALOG is used to as a PROM and PREM which is used in the care planning discussions. It also asks the person whether or not they want any assistance with the item.	• The service user completes DIALOG at key points in their treatment (referral, review and discharge are the usual points) • The service user can complete the DIALOG on their own or with staff as part of a care planning session • Staff discuss the completed DIALOG with the service user in the care planning session to understand the service user's perspective • Staff discuss all low scores and any unexpected scores with the service user • The written care plan must include the service user's preferences/views identified in the DIALOG • Staff discuss any progress / changes identified in the repeat DIALOGs with the service user
3. DIALOG + is an intervention that uses DIALOG and a solution-based therapy approach to support a structured conversation that help promotes a problem solving approach. In ELFT DIALOG + has been used to redesign their electronic CPA process.	• DIALOG is completed at the start of each appointment during discussions between staff and service user • The current scores are compared with previous scores • Brief Solution Focussed Therapy is used within the session to identify what factors made the service user give the rating they did and what factors would make the rating change • The service user is asked which of the items they want to work on (usually not more than 3 at a time) and what their aims are • Staff contribute their views to the care planning discussions

	• The care plan reflects the service user's priorities identified in the DIALOG and includes elements that are considered clinically important by staff. Differences in opinions are reflected in the care plan. • Staff discuss any progress / changes identified in the repeat DIALOGs with the service user.

There is agreement as part of the London DIALOG implementation steering group that Trusts who opt to use the DIALOG scale should not ask service users to complete the DIALOG without having a discussion about the how the scores matter to service users.

7. DIALOG applicability

- **Children and Young People**

The DIALOG scale has been used in Children and Young People primarily from age 12yrs +. In this context the job situation question has been replaced with school, education or job depending on the age of the respondent. Further research is required for validation in the younger population.

- **Older Adults**

While DIALOG has not been formally researched in an older adults population, this is a challenging facing all available globally-rated patient outcome measures. A small feasibility pilot has been conducted in an older adults CMHT in 2018 and feedback from patients was positive for DIALOG. Some care is required in explaining to both clinicians and patients that items may have different meanings for different patients and that this is an intentional aspect of the design of DIALOG. The "job situation" item may have different meanings for older adults and might encompass voluntary and other unpaid work to a greater extent than in some working age adult populations however patients generally appreciated that clinicians did not assume they had no feelings in this area because of their age. Similarly, the "medication" item common encompassed conversation around the patient's physical health medication but, again, patients felt it was positive that the impact of these medication on the mental and physical health was open for discussion with their primary worker.

8. Analysing DIALOG outcomes data

A DIALOG scale analytical framework has been developed by DIALOG experts within Queen Mary University London. The analytical framework to accompany the DIALOG scale can be found on the Healthy London Partnership website.
The analytical framework covers:

- What does DIALOG measure?
- What is a positive or negative score?
- When should ratings be obtained?
- Evaluating treatment
- Interpretation of scores

A brief overview of the DIALOG analytical framework is provided in Figure 3 below.

Analysing DIALOG data

DIALOG data can be analysed at an individual items level or represented as mean scores

Reflection of scores: 1-3 = explicit dissatisfaction, 4 neutral middle, 5-7 explicit satisfaction

High initial levels of satisfaction scores provide less scope for improvement (so called ceiling effect) whilst very low scores make improvements more likely (so called regression to the mean).
For treatment satisfaction, absolute scores at a given time point more relevant than changes over time, ratings should consistently stay above 4 demonstrating a fair degree of satisfaction

Individual

- Used for an assessment of the personal problems and areas of strength
- Mean scores allows for review of data across every item
- For subjective quality of life scores below 4 require particular attention
- When evaluating treatment, any improvement in subjective quality of life is a meaningful increase
- Patients in long term care – unrealistic to expect consistent and ongoing improvements – personal context important

Service

- Scores of single items of people in a service can be shown as means =average satisfaction scores or as a % of patients who have explicit dissatisfaction/satisfaction
- When considering changes over time global mean scores and single item analysis can be used depending on analysis
- Average subjective quality of life score of ALL patients in a service should not improve yet scores for the same patients should
- A change of overall means scores of >0.125 reflects an average improvement at least one scale point in at least one domain and may be a guide for overall meaningful improvement
- Treatment scores should consistently stay above 4 and % of patients with dissatisfaction kept to a minimum

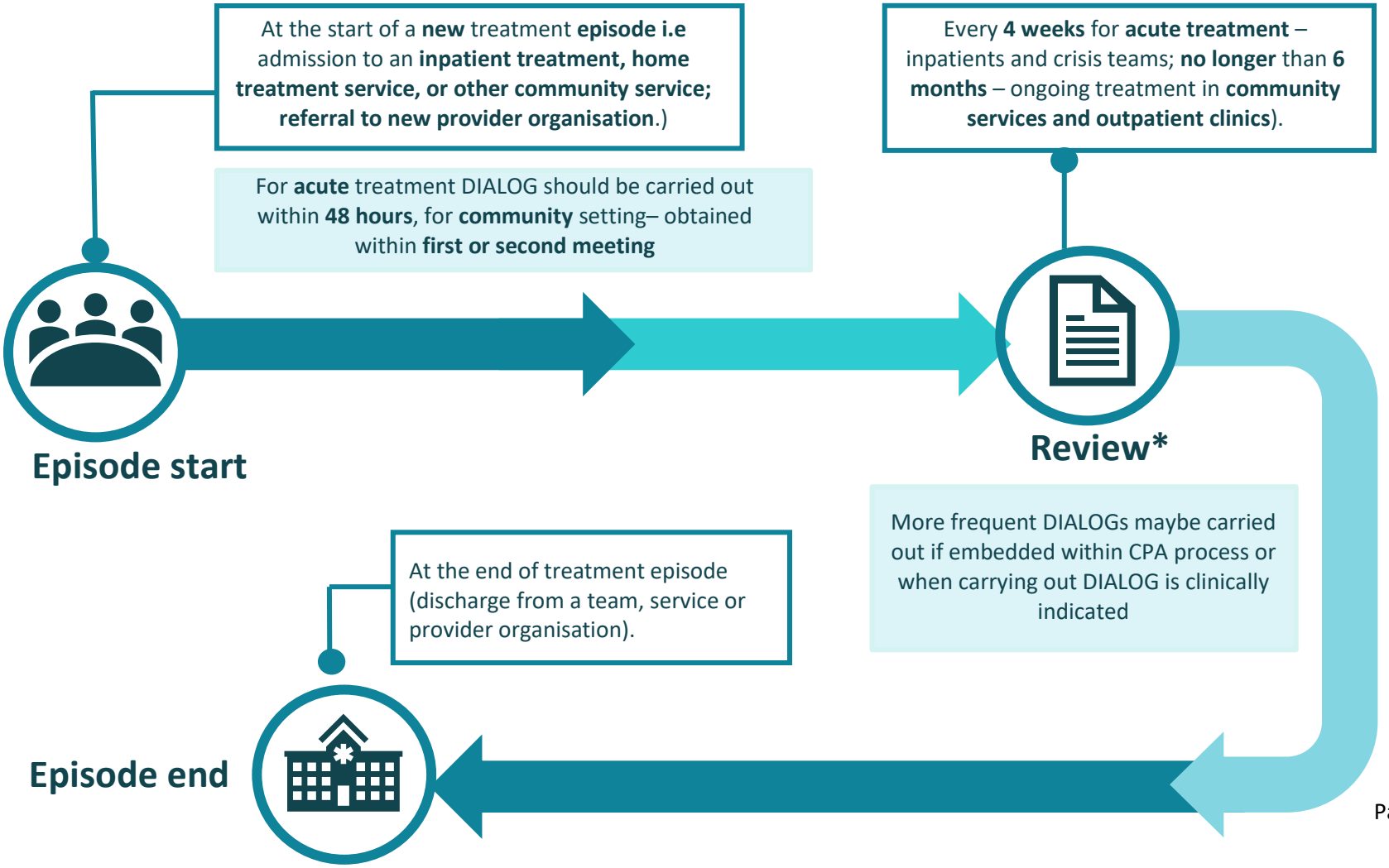
Organisation

- Follows same principles as the interpretation for all patients in a service.
- Aggregating up means patient groups are very large, differences between mean scores tend to become smaller.
- % of explicit dissatisfaction or satisfaction rather than mean scores may be more informative

9. DIALOG Data and reporting

When to carry out DIALOG?

Figure 4 Overview summary of when DIALOG scores are obtained. *For teams using DIALOG as part of care planning the DIALOG review score may be carried out more frequently



- **Recording DIALOG with Electronic Patient Record Systems**

Completion of DIALOG needs to be linked to a referral or admission within the electronic patient record.

See Figure 4 for the critical time points for when DIALOG should be carried out and the timescale for which DIALOGs need to have been completed.

If a service user declines completing a DIALOG form this is recorded as 8 within the Likert scale options

- **Open and Closed Cases**

Paired data is critical to measure change. Paired scores by take time to be reported depending on the care being received. For data to be meaningful, DIALOG scores need to be collected in completeness (as far as practicable) and at critical time points (see figure 4)

With the analysis of DIALOG data there is an option to review cases that are open to the team, discharged (closed) or both open and closed.

It is important to keep in mind the differences between the service user groups for open and closed which may affect the analysis and clinical interpretation of the DIALOG outcome scores.

There is a presumption that cases that are closed or discharged to the team have improved or got better and so would be different to those who are open, who are likely to be either early in their recovery journey, receiving long term care or people who have more complex conditions and have greater needs. People with more complex needs who require long term care are likely to show smaller improvements or may not show any improvements but show no deterioration, which in itself shows effective treatment in much the same way as people with chronic complex diabetes will not show vast improvements in their clinical outcomes.

- **Missing scores**

Mean scores can be calculated even when one item (of the 11 scales) is missing (that item is then ignored when calculating the mean). Yet, when more than one item is missing, mean scores may be substantially affected.

Unrepresentative and incomplete data prevents comparisons and limits the utility of feedback. Trusts are therefore encouraged to improve the data quality and collection of DIALOG paired scores, in order to enable more meaningful analysis and interpretation of the data.

- **Paired data**

Paired data is when two sets of DIALOG scales have been recorded for a person – for example at new treatment episode (T1) and end of treatment episode, or at review (T2) (See Figure 2) and can be displayed graphically. Paired data may represent admission to discharge, admission to review or review to discharge and (rarely) review to review.

When understanding team level data to assess efficacy or effectiveness of interventions offered, higher levels of completeness (proportion of service users who have two-point data

reported) is warranted. Smaller datasets involving smaller proportions of the service user population are prone to greater bias and the results might not be truly representative of the team's entire work. However, at the first instance we would like to encourage regular data gathering and internal analysis of such data.

The greater the percentage of people who have paired outcomes recorded, the more representative the data and analysis will be. We propose an aspiration of recording DIALOG pairs for 70% of a team's treatment episodes. Meaningful analysis is limited where paired scores represent less than 30% of activity.

For this reason, publication of outcomes data should specify the percentage of all closed episodes that are represented by the sample with DIALOG pairs.

- **Data reporting and Dashboards**

It is important that DIALOG outcome data is reported by all Trusts through the Mental Health Services Data Set.

In order to make the most of DIALOG, it is recommended that the DIALOG data is captured and summarised via an easily accessible electronic Dashboard. Suggested questions to capture within the Dashboard include:

- Why are people accessing services?
- Are they improving?
- Are service users up to date with completing their DIALOG forms?

Figures 5-9 provide examples of graphical charts used to explore these questions that could be adopted.

Figure 5 A snapshot in time of East London NHS Foundation Trust DIALOG Completion Rates by 9 different directorates (anonymised) The total number of open forms on this occasion was 26369.

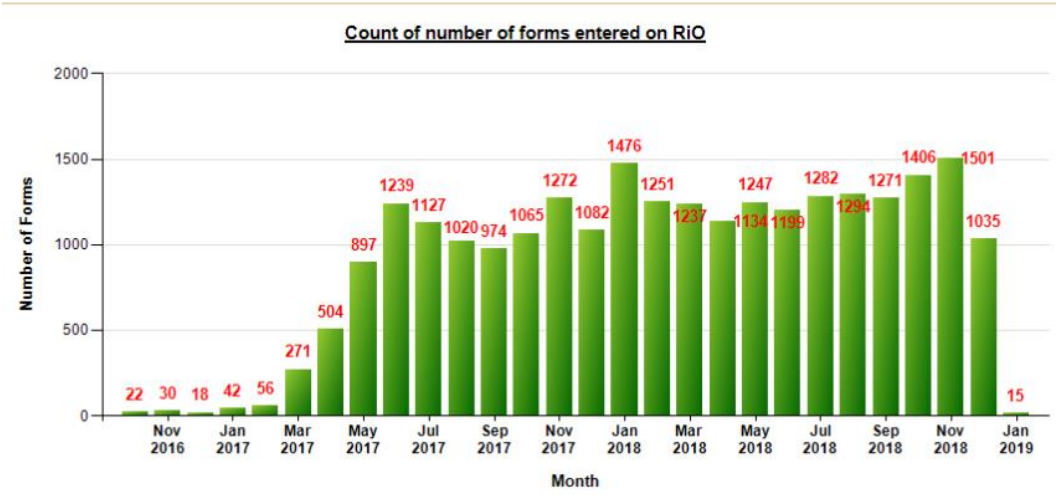


Figure 6 DIALOG Year to date monthly completion rates of open DIALOG forms (No 24967)

elft.informationreporting@nhs.net

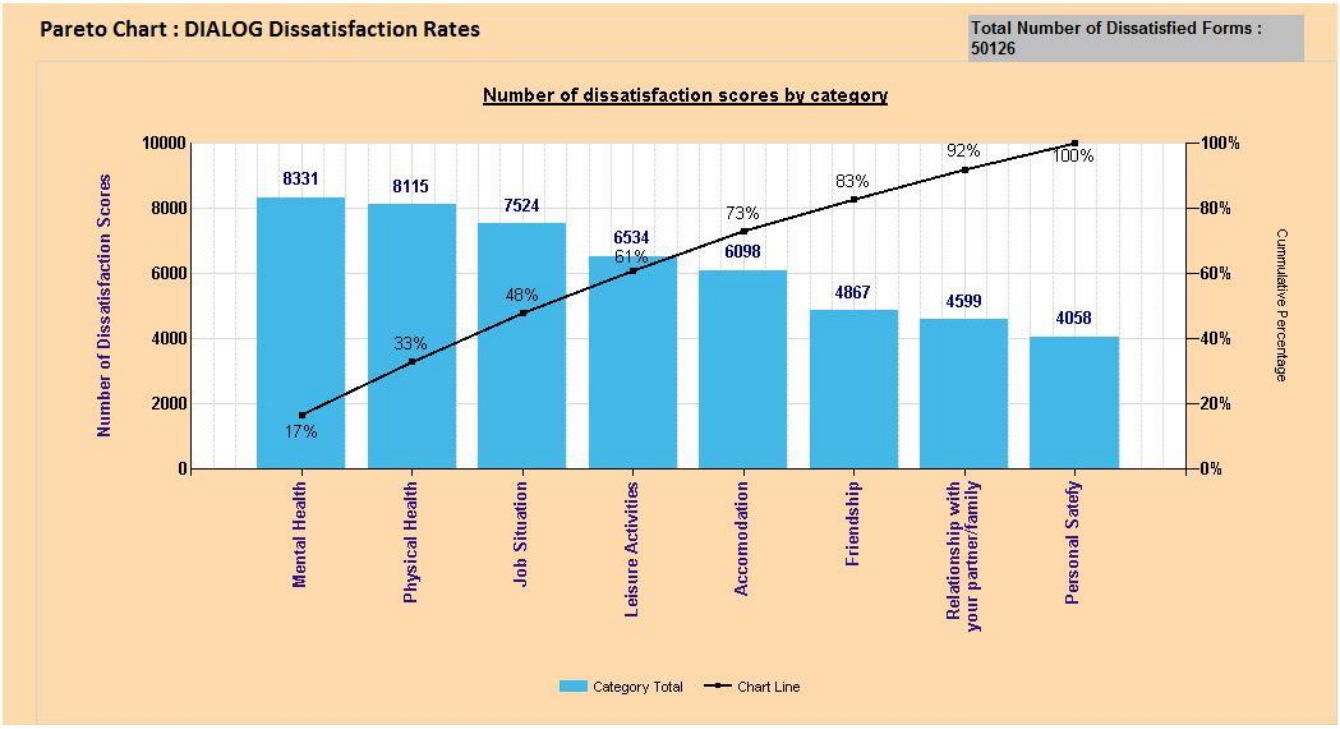


Figure 7 A pareto Chart showing DIALOG dissatisfaction rates. Pareto charts show frequencies of data items ordered from highest frequency to lowest frequency. The cumulative percentage curve shows the percentage of data covered by the items. In the example above 63% of data is accounted for by the first 4 items

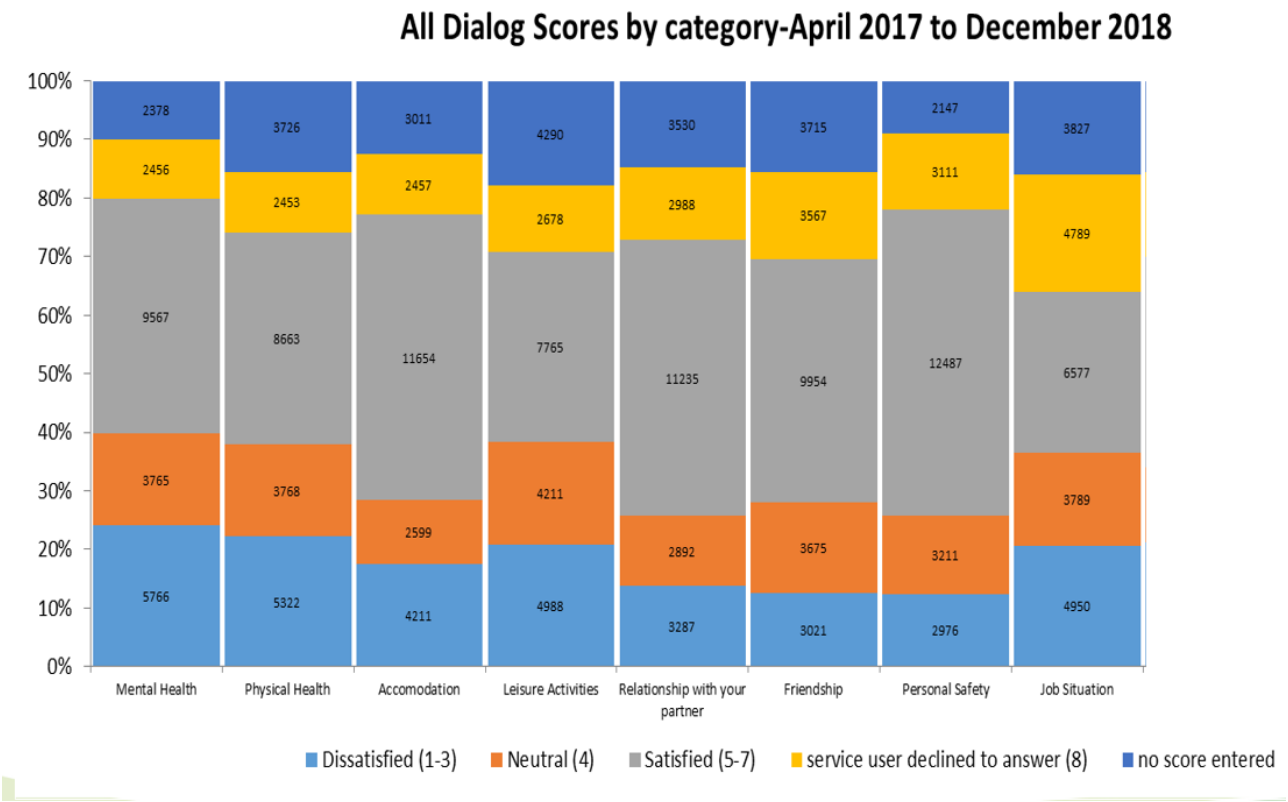
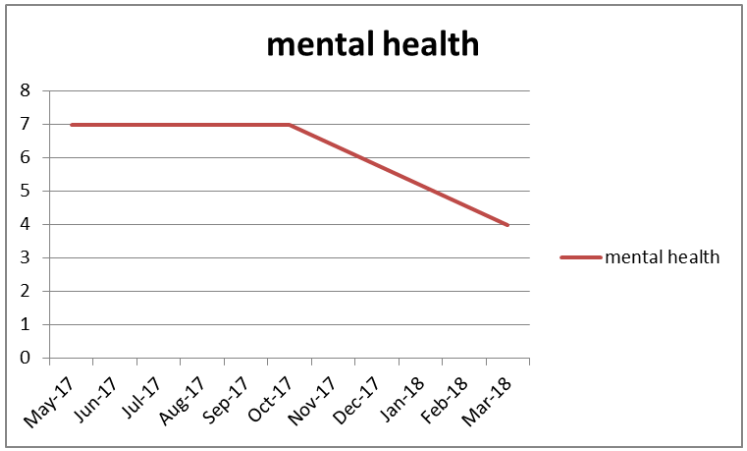
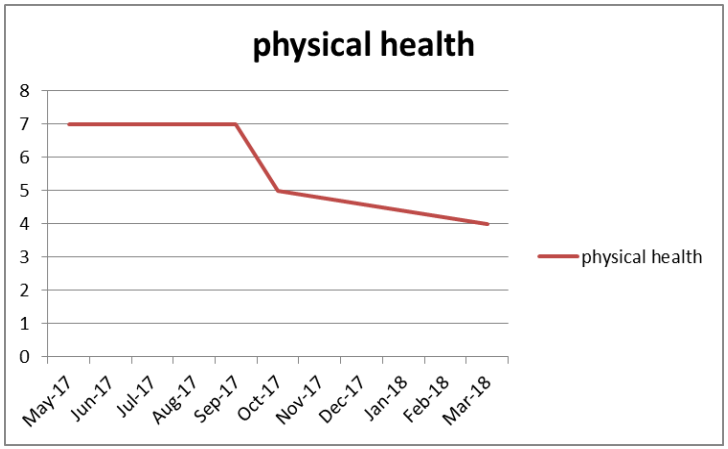
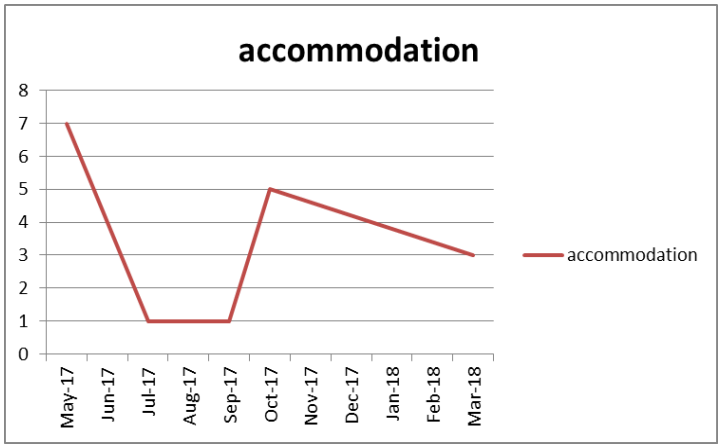


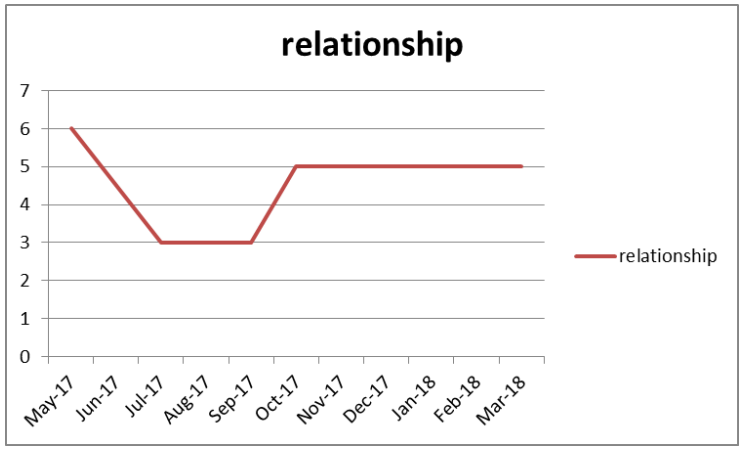
Figure 8 Categorical Change chart showing DIALOG scores by each category from April 17-Dec 18 summarising the key areas of support people are requesting help with when accessing services

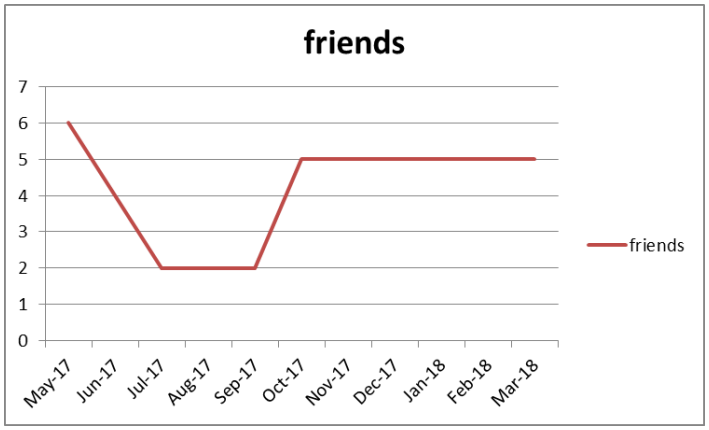
Figure 9 Charts exploring DIALOG data at an individual level. The chart shows how individual DIALOG question categories can be viewed to explore trends over time. The example is over a 10-month period.











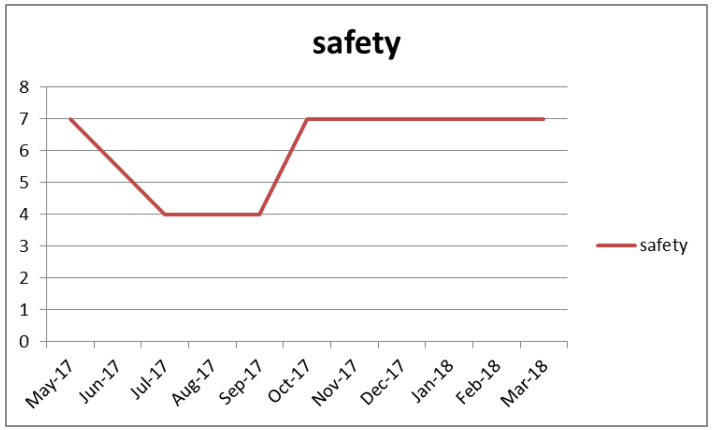


Table 2 sets out the London DIALOG implementation steering group suggestions for DIALOG reporting.

Table 2 –Suggestions for DIALOG reporting & analysis

	Reports
Process measures	Number of DIALOG forms – year to date monthly completion rates
	Number of DIALOG forms entered into EPR systems by Directorate, Team, HCP, cluster and CPA status.
	People with DIALOG recorded more than once
	% of caseload with DIALOG recorded more than once
	People with DIALOG recorded once
	% of caseload with DIALOG recorded once
	People with DIALOG not recorded
	% caseload with DIALOG not recorded
Clinical Interpretation of data (reporting maybe split by trust, team type, specific team, or individual level)	Individual scores to review a person's strengths and problems areas they would like to address
	Number of satisfaction scores per item
	Number of dissatisfaction scores per item
	Single items or paired scores items 1-8 mean scores or % of **quality of life** measures or single domain
	Single items or paired scores items 9-11 mean scores or % of **aspects of treatment** or single domain
	Paired scores across 11 items
	Adhoc: review of domains that explore an understanding of a particular service.

10. Education and Training

To support the implementation of DIALOG a number of tools have been developed to help socialise the use of DIALOG with service users and to support service users and healthcare professional to understand how using DIALOG/DIALOG+ can be used to help a person with their recovery.

- DIALOG animation
- Service user vignette video of experience of using DIALOG/DIALOG+
- Education and Training slides for Trusts

11. List of resources

We have a number of resources available of the HLP website to support Trusts with their rollout of DIALOG across the Trusts. For further information please see Healthy London Partnership website

DIALOG Scale

- Plain english DIALOG scale – can be used for people with learning disabilities
- Plain english version - explanation for service users what is DIALOG and why is it collected
- DIALOG available in different language formats – Albanian, Bosnian, Croatian, English Italian, Luganda, Macedonian, Montenegrin, Portuguese, Serbian, Spanish, Urdu

DIALOG+ resources

- DIALOG+ manual (QMUL/ELFT)

Data capture and reporting

- ELFT Technical & Operational guidance for documentation
- RIO CPA Process Map

Education and Training

- DIALOG+ 4 step approach training videos