Using DIALOG in measuring impact of Mental Health services

Healthy London Partnership

Introduction and purpose

In 2017/18, The London senior Mental Health (MH) leaders agreed that DIALOG would be London's Patient Reported Outcome Measure (PROM).

London MH Transformation Programme (London MH senior leaders), Cavendish Square Group (CEOs, COOs, MDs and Nursing Directors) and clinical and technical leads from every MH Trust in London all agreed to using this measure across London.

Healthy London Partnership established a London DIALOG working group to:

- Promote learning and engagement across London.
- Support implementation and development in a consistent way.
- Provide a platform to share good practice and scale up learning.

The purpose of this document is to provide a framework that will help ICSs develop a system matrix for using outcomes measures to better understand the impact of their community MH Transformation. This document focuses on DIALOG /+

Core Principles

It is critical to ensure that everyone has a good understanding of the use, purpose and role that DIALOG plays in helping to measure the impact of community MH transformation. The following principles will be key to ensure that DIALOG does not loose its value or integrity as a meaningful measure.

1 Identifying the purpose of using DIALOG

1. Are we using it as a PROM or as a Care planning tool or both
2. When looking at data, are we looking at individual, service and population level
3. Are we looking at PROM or PREM or both

2 Understand who your population is

If you are looking at numerical elements within PROMs at a pooled level, it is imperative you have an understanding of what is an expected outcome. You will need to consider their condition/ diagnosis and where they are in their journey/ course of illness. We therefore need to acknowledge that we cannot be sure of what a good outcome would look like.

Failure to do this by focusing solely on improvement of numerical scores may introduce unintended consequences such as moving away from preventative / early intervention treatments e.g. delaying progression of illness to more severe level to allow greater 'numerical' improvement or lack of clinical buy-in.

3 Understand DIALOG + is an intervention

As well as an outcome and the 'process' of co-production itself has shown to improve Quality of Life. There is value in promoting the process of DIALOG + co-production even in absence of numerical improvement.

4 Understand and develop systems to allow DIALOG PROM measure to be collected electronically in a partnership model of care within ICSs.

It is important that systems problem solve around DIALOG data gathering where multiple recording systems are in operation and think through the need of pooled DIALOG scores versus the individual DIALOG + care plans being generated iteratively across the system.

What value does DIALOG/+ add?

DIALOG is simple to use and it enables proactive, personalised conversations at an individual level, supporting self-management and helping service users move forward with their journey of recovery.

Capturing this information gives a powerful indicator of patient satisfaction levels where health and social care services need to focus for improvement.

It helps to guide a structured conversation between a health professional and service user that is patient centred with a focus on change.

It has also been used to help inform the redesign of care planning processes within mental health services.

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

DIALOG+ can help co-produce care plans with the person and the information can be used for planning for individual patients and whole services

The use of DIALOG + has been shown to improve quality of life (subjective) by agenda setting, shared decision making and positive commentary and solution focused approach

Service users report satisfaction in using it

Watch this short video that tells you how DIALOG has helped a service user and a carer

Identifying the purpose of DIALOG / DIALOG+

Understanding DIALOG

DIALOG is a person centred and patient rated scale that measures **Patient Reported Outcome** (PRO measure or PROM) as well as a measure of **Patient Experience** (Patient Reported Experience measure).

DIALOG is not condition specific e.g. there are no rating scales specific for a mental health condition such as depression or psychosis.

DIALOG + builds on the rating scale to 'co-produce' a Care Plan. Therefore DIALOG+ promotes co-production and creates a personalised care-plan.

Before you start to analyse the DIALOG data, you need to consider the end goal (outcome) you want to achieve e.g. as an outcome measure or for a care planning session.

If you would like to use this for a care planning session, you may not be able to cover all the DIALOG domains (questions) at one sitting.

You may need to consider the implications of incomplete questions (missing data) in this instance - how this impacts on your overall data when using this as an outcome measure?

What type of measure should you choose to measure the desired impact?

ICS's system metrics to measure the impact of the community MH transformation should be chosen with the type of measure that you want to use.

Outcome measure

Provides a way to help us understand the impact of the care provided. Outcome measures can be used to identify patient needs and understand the effectiveness of any care or treatment. This will help the system measure the impact of the patients health and wellbeing.

For example, overall improvement of people's rating of mental health.

Things to consider

- What impact of health and wellbeing do you want to focus on?
- From pooled data identify areas of discontent and need to inform future service design and inform resource allocation.

Experience measure

Can help understand a patients perspective on their experience of a range of interactions which can help to improve patient-centred care.

For example, experience of meetings with healthcare professionals

Things to consider

- In individuals and/or populations with a long term mental health condition there might not be huge changes in PROM but a positive PREM can be the focus in such populations.
- Meaning of 'healthcare professional' in a community setting
- Variability over time may make the trajectory of improvement inconstant

Process measure

Are measures of whether an activity has been accomplished to help determine if parts or steps in the process have helped to achieve the desired outcome. The process of DIALOG+ and coproduced care plans may be a useful exercise here and important to capture when measuring impact.

For example, patients received evidence-based intervention, no of DIALOG's on MHSDS, completion of DIALOG at T1 and T2 or completion of a co-produced DIALOG care plan.

Things to consider

- What are the steps to achieve the desired outcome that you want to measure?
- DIALOG might not cover the process of access.
- There is value incentivising the 'process' of DIALOG + care planning e.g is it being done for all new people entering the service / early in their assessment?

Balancing measure

Determine whether changes designed to improve one part of the system are causing new problems in other parts of the system - it helps us spot unintended consequences of the changes we are making.

For example, staff reports of time taken to do the care plan coproduction with the patient

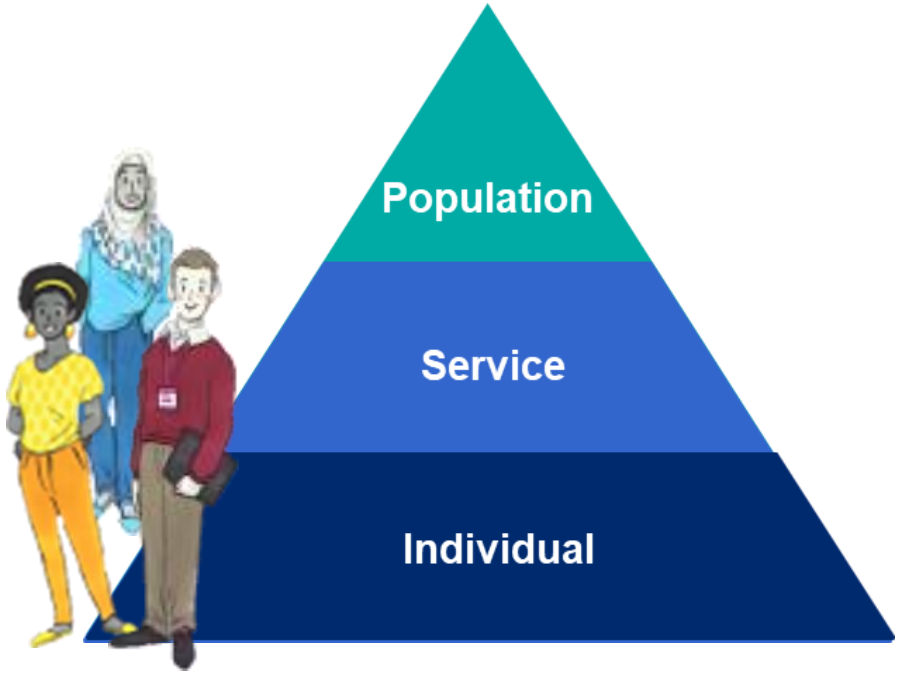
Things to consider

- What are the unwanted things that you want to watch out for?
- Monitor potential risks that the proposed change model can introduce into the system?
- There may be unexpected changes such as staff well being etc which will not be captured by DIALOG co-production.
- Staff training requirements or IT systems

Who are you looking at?

DIALOG scores can be used at an individual level or scores can be pooled for example to understand the data at a service or population level.

A pyramid of framework may be a helpful way to understand which metrics can help you to understand the impact at different levels.



Population

This is the impact across the ICS population (e.g. across several Trusts or Boroughs). It will help understand the impact of CMH Transformation across the local population within the ICS footprint. These may reflect the overall responsibilities of all ICS partners which may include MH Providers, LA, CCG, and VCSE organisations.

E.G Reduction in the stigma around MH and increase understanding of mental wellbeing

Pooled DIALOG scores can help identify differential levels of discontent (0-3 scores in pooled result) or resilience (4-7) in sub-populations. Pooled DIALOG scores grouped according to identifiable features such as ethnicity, gender or orientation or age might inform the ICS on valid local differences and help in future planning.

Service

This is the impact across all services - this may focus on one specific service such as EIP teams across 5 boroughs.

E.G Improved satisfaction of MH for BAME groups OR % of PH checks completed

It is critical that pooled service level data is then available and presented back to the services to promote data gathering both for clinician engagement where data is not being gathered as well as to sustain continued engagement. It can demonstrate improvement and impact to the team and help in minimising stigma and improve morale. It can also be the tool for focused QI projects e.g. focusing on improvement in an individual domain of DIALOG score.

Individual

The impact will be understanding the impact of CMH Transformation on a persons individual experience (PREM) or impact on their rated outcome (PROM).

E.G Improvement in rating of mental health

Individual data also offers the opportunity to look for change around PROM scores and measure PREM. However, at an individual level it is important to focus not only on the score but the care planning and the qualitative element around it. If the focus is care planning (DIALOG +) not all domains may be covered.

What are you measuring? PROM

The first 8 DIALOG questions are patient reported outcome measures (PROMS) and therefore can measure the impact of CMH transformation on health and wellbeing of the population.

Measuring change

Any improvement in subjective quality of life (including one point on only one item) should be seen as an achievement as it reflects a meaningful increase of satisfaction in at least one life domain.

There needs to be two DIALOG scores to measure change.
To compare 2 points it is important to note when the two sets of DIALOG PROM scores were collected in the context.

Using mean change for pooled data makes it more comparable for example across different boroughs.

A change of overall mean scores of >0.125 reflects an average improvement of at least one scale point in at least one life domain and may be seen as a guide for an overall meaningful improvement.

Examples include…..

1. Overall improvement in peoples satisfaction with their MH.
2. Improvement of people's satisfaction of their physical health for all people that rated 1-3 in 2019.
3. Improvement of peoples MH satisfaction scores of BAME groups.

Where is improvement possible?

- It is far more difficult to have an impact if the service user has low need to start with (rating score 5-7). It may be more meaningful to look at supporting someone with lower levels of dissatisfaction (rating score 1-3).
- Do you want to measure overall improvement or focus on specific areas of dissatisfaction to measure improvement?
- You can therefore measure pooled dissatisfaction and over time measure whether less people are dis-satisfied.
- It may be less realistic to demonstrate improvement when you are dealing with domains that are settled and everyone is trying to score 5/6.
- Patients that remain at (5-7) is also a positive indicator.

What are you measuring? PREM

The last 3 DIALOG questions are a Patient Reported Experience measure (PREM) and can be used to measure the impact of CMH transformation on the experience of a population care – this includes for example the satisfaction of the help that a person receives.

In Patient Reported Experience measure you can measure change but a single PREM score is a rich source of information

Examples include…..

- **The PREM scores within DIALOG allow personalised data on experience, unlike the standard Friends and Family Test.**
- **Being linked with the patient records also allows looking into pooled data based on service or any population subgroup and can support drilling down into inequalities.**
- **Like PROM data, an individual domain might be the focus of specific quality improvement project e.g. pharmacist speaking to patients – does that improve patient experience?**

DIALOG + offers benefits that cannot be measured looking at scores

How can DIALOG+ support this?

There is value in using DIALOG+ as a care planning tool as it promotes co-production and is strength based.

Co-production: DIALOG+ can help facilitate a person-centred approach by supporting meaningful conversations between service users and the healthcare professional about what aspects of their lives are important to them. Using DIALOG questions to better understand what aspects of their lives are most important for good mental and physical health can tailor care to their greatest needs.

Strengths based: this approach focuses on an individual's strengths (including personal, social and community networks) and not on their deficits. It is commonly used in social work and helps to have a holistic and multidisciplinary approach to promote health and wellbeing. For example, DIALOG questions can be used to understand 'what matters most to me'.

> **Every person who requires support, care and treatment in the community should have a co-produced and personalised care plan that takes into account all of their needs…**
>
> Community MH Framework for Adults and Older Adults (pg13)

Research shows that just doing DIALOG+ itself and having co-produced care plans can lead to improvement

Simply using DIALOG+ has shown to improve Quality of Life * with patients reporting positive experiences with the intervention including better self-expression and improved efficiency of meetings.

DIALOG+ was considered to change and utilise the existing therapeutic relationship between patients and clinicians in CMHTs to initiate positive change, helping the patients to improve their quality of life. Therefore the 'process' of creating DIALOG + can provide an assurance of better outcomes for patients in absence of numerical change over 2 time points

Trying to measure improvement through the DIALOG scores is only part of the whole picture

As part of the wider system outcome matrix, you may want to look at if DIALOG+ care plans are being co-produced with patients or even having one care plan per patient around DIALOG+ principles.

* Priebe et al (2017) and Omer et al (2016)

Greater risk of fragmented care planning

Operating across multiple patient record systems is likely to add to the challenge of fragmentation that will be an important consideration for ICSs.

ICS's are transforming the way that MH services are delivered to support people with serious mental illness (SMI).

In a recent report from MIND, they demonstrate that **those whom were already struggling with their mental health are now reporting more complex challenges,** and so it is **essential that support is holistic** and service users are given a choice in how they receive support.

Working across multi-professional and ICS system partners will become more common but it is **essential that care does not become more fragmented**.

Having **one care plan will help coordinate care and ensure that a multidisciplinary teams are all working toward the same goal** to support the persons needs.

However this will **not be a simple process** that takes **significant resources and time** to develop one IT system across different partners. This requires extensive work with system suppliers in order to **better understand the suitability of using one IT system** OR 'develop fit for purpose interoperability solutions'.

Short, medium and long term improvement to demonstrate efficacy

Long and short term measures

To read the full research paper click here >>>>>>

Research by **Mosler et al** (2020) has shown overall improvement over time when analysed for research purposes (based on a limited sample which needs caution when drawing quick conclusions).

However, having a limited view on using DIALOG as an outcome measure to demonstrate numerical improvement may cause unintended consequences by disincentivising early interventions or preventative approaches when numerical improvement is expected too early.

For example, early intervention into psychosis may improve outcome long term but may capture worsening mental health in the short term. Trying to encourage the opposite would incentivise teams to delay engagement against the ethos of early intervention.

Equally this can be seen in dementia or neurodegenerative conditions where there are no disease modifying treatments- it is likely that as a person may deteriorate, dissatisfaction scores will increase.

It is important to recognise **there is not an established benchmark around what would be a realistic desired good outcome in DIALOG score(s)** in sub-populations either grouped together by diagnosis or intervention or service.

Promoting and incentivising a process that promotes regular and routine DIALOG data gathering will allow colleagues to develop these understandings.

Systems will need to consider the unintended consequences when choosing metrics to measure the impact of the CMH transformation.

Analysing DIALOG data in absence of a well established benchmark needs to be treated with caution- premature numerical analysis, either looking very short term compared to the course of the condition or looking into pooled data where there are very few DIALOG forms being filled in may result in a unrepresentative sample. Other challenges may include incomplete DIALOG rating scales.

It is important to have a good understanding (and agreement) on the short, medium and long term timepoints that will demonstrate meaningful improvement.

This will help systems move towards a ‘learning opportunity’ where DIALOG is understood as a tool to measure continued improvement - the purpose should be getting the best for the person / population.

Suggested timepoints include:

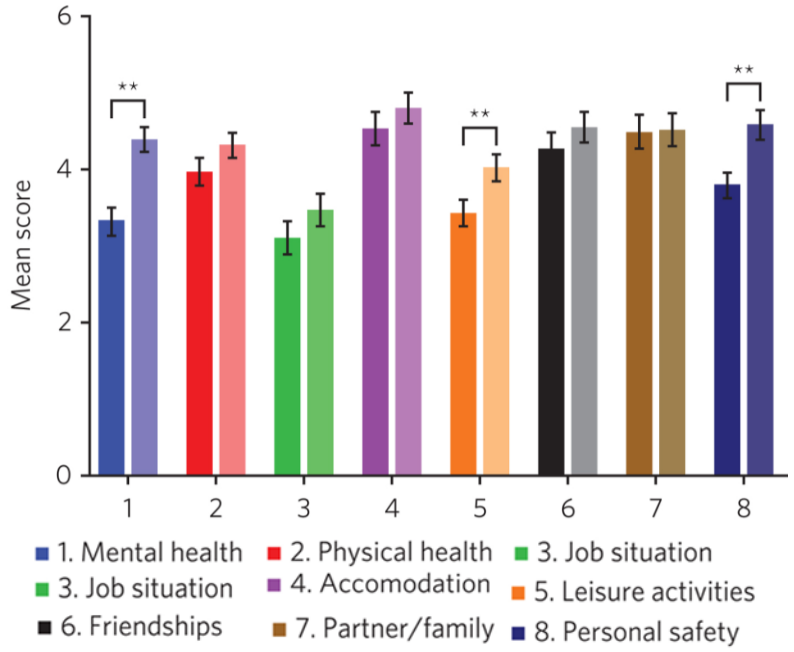
Short: 0-1 years **Medium:** 1-5 years **Long:** 7 +

Mosler et al (2020) Routine measurement of satisfaction with life and treatment aspects in MH patients – the DIALOG scale in East London. Here

An example of continuous improvement

The below examples provide an example of improvement of DIALOG across different timescales.

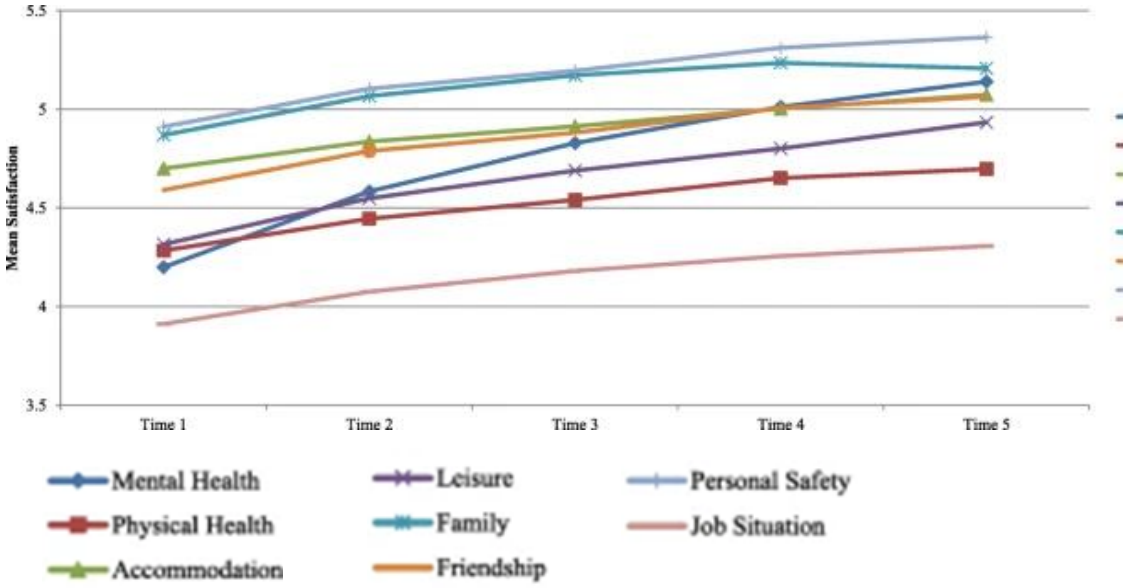
DIALOG PROM intervention



DIALOG can capture improvement over short period / brief interventions. The bar graph demonstrates improvement from a brief intervention in a crisis house over a short timeframe (days/ weeks).

To read the full research paper click here:

Routine measurement of satisfaction with life and treatment aspects in mental health patients – the DIALOG scale in East London



The line graph shows trust wide improvement (all services) over a longer time frame (years).

To read the full research paper click here:

Accountability and coordination

When should rating be attained?

DIALOG is a person centred and patient rated scale that measures **Patient Reported Outcome** (PRO measure or PROM) as well as a measure of **Patient Experience** (Patient Reported Experience measure). DIALOG can be used as an outcome measure and a care planning tool.

Using DIALOG as an outcome measure- important considerations for analysing the data:

- How DIALOG is going to be used is an important consideration to ensure that when it is used as an outcome measure, DIALOG keeps its integrity and value as a tool.
- Using DIALOG in a community setting, across numerous geographies, organisations and staff groups can introduce new challenges when several people or partner organisations are completing the DIALOG form with the same person.

For example a Care Coordinator from the VCSE sector may visit a person and complete the DIALOG questions and three weeks later another DIALOG may be completed by a MH nurse. This may make the person feel disillusioned to the purpose of DIALOG.

- It is important that when looking at data we are able to differentiate DIALOG + care planning entries from the PROM collection entry- if each data entry of DIALOG scores across multiple healthcare professionals is entered as a new PROM the scores can be misleading.
- Considerations on when and where in the patient journey the DIALOG score is collected is important when gathering PROM. E.g. initial assessment v. review v. end of intervention OR discharge.
- When a service user is working across multiple service provisions it is important to consider the number and regularity of DIALOG scores completed. If these are by the same service provider, it is advisable that the exit / discharge DIALOG from the previous service might serve the purpose of the entry / admission DIALOG for the new service or vice versa (e.g. admission DIALOG scores for the new service can serve the purpose of discharge DIALOG scores for the previous service).
- Provider collaboratives need to be mindful of the burden of data gathering and avoid duplication for better service user experience.
- We recognise there is a challenge when there are multiple providers supporting a service user in their journey to recovery using different electronic record systems. The desirable solution lies in electronic interoperability platforms or other digital solutions that lie beyond the scope of this document.
- Who is accountable for what? ICS, neighbourhood, Trust, clinical and non-clinical?
- When developing person centred care plans ICSs need to consider how a partnership model may duplicate information in care plans and cause further fragmentation.

Who is responsible for what?

Using DIALOG across the community setting poses an added **challenge in understanding who is responsible for what** when completing, inputting and storing DIALOG data and developing the care plan.

These are important considerations to ensure that there is not a fragmented approach that impacts on the purpose of DIALOG – using it as an outcome measure vs. a care planning tool.

Using DIALOG as an outcome measure

- ICSs will need to work with NHS and wider ICS partners to agree who is best placed to input DIALOG data so that multiple DIALOGs do not risk the integrity and value as an outcome measure (e.g. too regular DIALOGs being completed).

Using DIALOG+ as a care planning tool

- Wider ICSs partners such as VCSE, LA and community groups may use DIALOG+ as a care planning tool alongside NHS healthcare professionals. They may want to focus on specific areas such as housing or leisure activities in relation to their expertise and knowledge.
- It is important that all colleagues using DIALOG check when the last DIALOG was completed. This may be important to ensure that the service user does not get disillusioned by the frequent use of DIALOG.

Things to consider

- Who is responsible for what at different ICS levels, for example ICSs may be best placed to understand population level data VS neighbourhood teams understanding borough level data
- Should we be focussing on usage of DIALOG at an ICS level so the data is more representative and a greater understanding of where people present with issues?
- Who is accountable for ensuring that DIALOG data is recorded correctly?