

Using Clinical Outcomes for Service Improvement v1.0

A Guide for Commissioners

Prepared by Healthy London Partnership/ London and South East CYP IAPT Learning
Collaborative

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Clinical Outcomes and Service Improvement

Why clinical outcomes?

There may be a range of areas in your services that you might want to measure. This document gives information about *clinical* outcomes specifically. It will help you think about what is meaningful and realistic.

Why should I look at clinical outcomes?

Many national KPI's currently focus on access and waiting times but these are only important if people are being treated effectively. Figures about activity and throughputs of services allow you to see what a service is doing to some extent, but they do not tell you about the **difference** they are making for the people using them or the **quality** of the service: the clinical outcomes.

There is now a nationwide push towards measuring clinical outcomes (see next page for relevant policy documents and initiatives) and an expectation that all service providers should be transparent and be commissioned based on the impact they are having on children and young peoples (CYP) lives.

To take an example from physical health: imagine measuring a hospital's success purely on the number and speed of operations they performed. Without knowing if people got better from the operations we cannot measure success.

As a commissioner it is important to be able to understand and use clinical outcomes data appropriately to inform your work with services.

"Good information is the foundation for commissioning; to understand need, to plan, secure and monitor services"
[Future in Mind](#)

Encouraging use of outcome measures in provider services also:

- enables CYP and families to have their views heard more effectively
- keeps services accountable and efficient
- flags up areas of excellence and for improvement
- provides an opportunity to celebrate success
- providers can use as evidence to promote services (when tendering)
- can guide commissioning, service improvement and delivery.

Incorporating outcomes into KPIs & CQUINs

There is a risk with any target that it may introduce **perverse incentives or unintended negative consequences**. For example, services may begin to focus on specific areas where there are financial benefits at the expense of meeting local needs.

It is vital that outcome measures are used with the **needs of the client** in mind and implemented in supportive and well-supervised environments to mitigate against possible harms.

If outcome measures are perceived or experienced as part of a 'top down' or tick box culture by clinicians they may undermine or even harm collaborative working. Any KPI's should support **good clinical work**, such as allowing the flexibility to collaboratively choose the measures that are most appropriate to the client.

Please see the [CORC's Position on Commissioning for Quality and Innovation \(CQUIN\) targets concerning outcome measures](#) for more guidance.

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Clinical Outcomes and Service Improvement

National policies and initiatives

National policies and initiatives are emphasising the need for services to collect and use clinical outcomes in order to monitor and improve treatments, services and the system as a whole.

The Five Year Forward View For Mental Health

The recommendations from the [Five Year Forward View for Mental Health](#) (2016) have been **accepted in full** by the government. This includes urgent action on the **“black hole of data”** in CYP services. The report include recommendations to:



- Ensure better data across the board – including outcomes – *“A data and transparency revolution is required”*
- Develop national metrics for CAMHS
- Improve transparency and choice
- Provide rapid data sharing through HSCIC (now NHS Digital)
- *“Understanding how quickly people are able to access services, what sort of care they are receiving and **what outcomes they are experiencing** is vital to good care.”*

Future in Mind

The independent taskforce report, [Future in Mind](#) (2016) and the related [Data and Standards Task and Finish Group Report](#) emphasised the focus on clinical usefulness, as well as the importance of clinical outcomes for service improvement.



- *“The primary goal of data collected through routine outcome monitoring is to **improve therapeutic intervention and inform supervision and service planning**. However this data also plays a critical part helping us to **understand service provision, patient experience and outcomes**.*
- *Routine reporting will make data more accessible and transparent, allow **benchmarking** across services and help us to identify areas of **good practice and demonstrate value for money**.”*

Mental Health Services Data Set (MHSDS)

All providers of NHS-funded mental health care are mandated to record and submit data as part of the [Mental Health Services Dataset](#) (MHSDS). This is with the aim of *“ensuring that all NHS-commissioned **mental health data are transparent** (including where data quality is poor) to **drive improvements** in services”* ([Five Year Forward View for Mental Health](#)).



- The MHSDS will provide the opportunity for national benchmarking
- As well as this, NHS England have begun publishing a quarterly [Mental Health Five Year Forward View Dashboard](#). At the moment this includes some specific patient flow indicators, but clinical outcomes and goals will be included in future publications.

Local Transformation Plans for Children and Young People Mental Health and Wellbeing

[LTP guidance](#) specifies that plans should demonstrate commitments to:



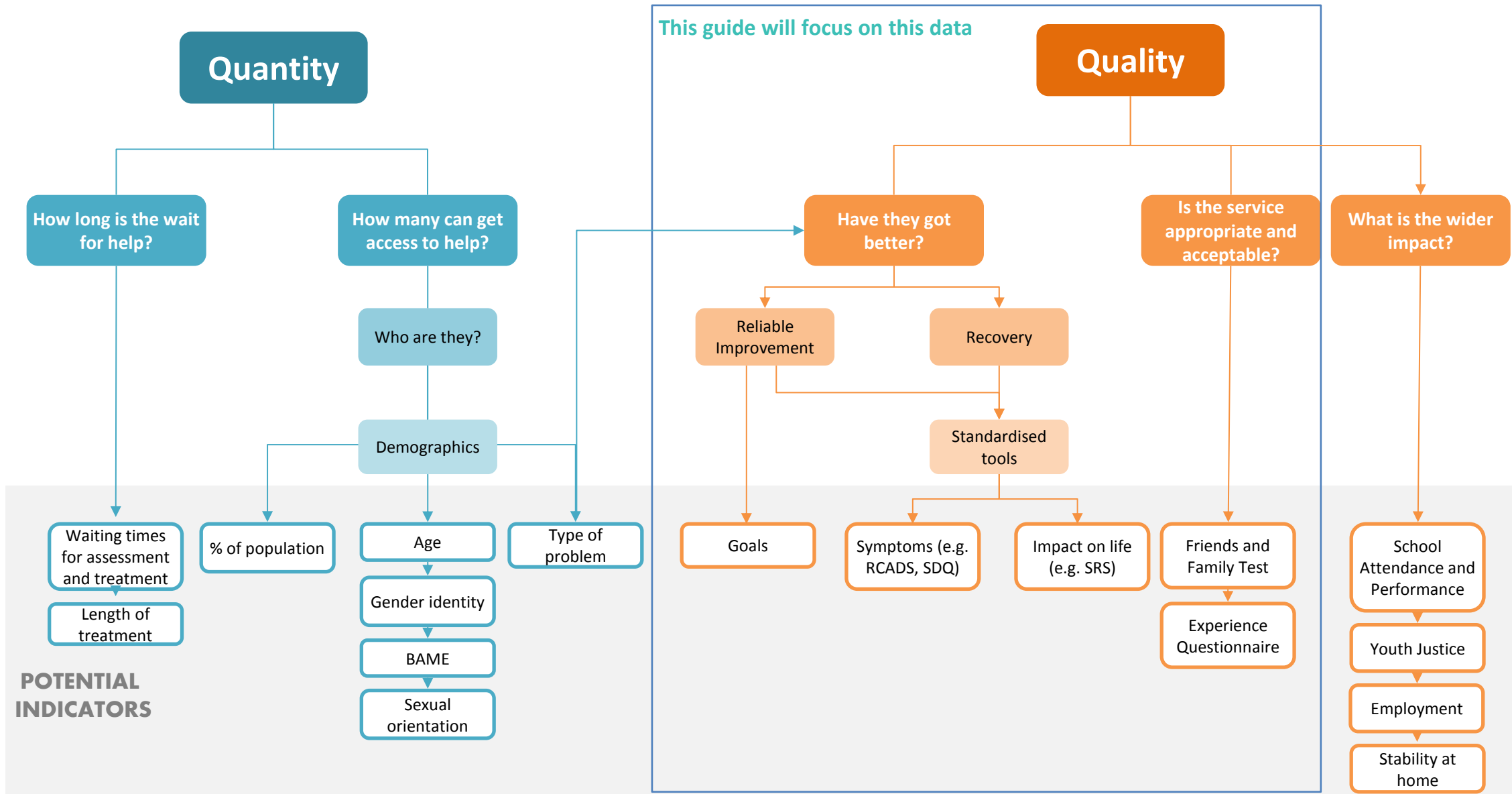
- Incorporating outcome monitoring into regular practice: *“...regular feedback of outcome monitoring to children, young people and families and in supervision”*
- Flowing data to the MHSDS: *“...plans will need to include both changes and improvements to system infrastructure and training programmes for clinical, administrative and managerial staff on how to record the data and in particular **how to routinely collect/use clinical outcome data and other feedback and monitoring in treatment sessions to the benefit of their clients**.”*

Care Quality Commission (CQC)

The CQC uses data (including national datasets) to monitor services and looks at whether care, treatment and support are **effective**, that staff involve and treat people with **kindness and respect**, and that services are **meeting peoples needs** (amongst other areas). Outcome and feedback tools can help to demonstrate these areas.

What do I need to know about services?

The chart below gives examples of data that could be collected for different purposes in your services



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What type of data might I need?

Types of outcomes

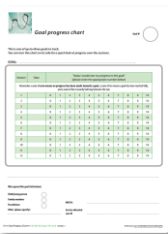
Three main types of outcome measurement (symptom/impact trackers, goals and experience of service) can be useful for services to collect. Choice of which measure to use should be led by patient choice and clinical judgement.

Types of clinical outcomes

Three types of outcomes are useful to collect. See the next page for some specific examples used in services.



Symptom or impact – can measure if the CYP is getting better. They can track changes in specific symptoms (e.g. [Revised Children's Anxiety and Depression Scale \(RCADS\)](#) or [Strengths and Difficulties Questionnaire \(SDQ\)](#)) or measure the impact a problem is having on someone's life (for example [Outcomes Rating Scale \[ORS\]](#)). These can be used throughout treatment to track progress. Many of these questionnaires are 'normed' which means that the scores may indicate severity of symptoms or the likelihood of a disorder.



Progress towards goals – these are tools that indicate movement towards personal goals (for example [Goal Based Outcome \[GBO\]](#) tool). Goals can facilitate shared decision making in interventions which can in turn lead to better engagement. They can be used as a measurement across interventions and can be used throughout treatment to track progress.



Experience of service – these questionnaires tell you about what individuals think of the quality of service that they are using (for example, the [Experience of Service Questionnaire \[CHI ESQ\]](#)). Typically used at the end of the intervention, they can give a service valuable feedback about how acceptable and accessible the service is, and whether any improvements need to be made. Feedback from these forms can be used as evidence of a responsive service.

What measures should services be using?

There are no one-size-fits-all measures

- **Choice and clinical judgement is important.** To take another example from physical health: you wouldn't measure success of hip operations with same measures as cancer care, maternity services, or end of life care – mental health interventions are as diverse so **a range of tools are needed that fit the service and the CYP**
- As long as they are normed (have standard 'cut offs' for comparing across groups – [see the reliable change and recovery page](#)) you can get reliable data and compare across services
- Specific questionnaires may be recommended as part of national pathways but young people **should be able to use the tools that are most helpful to them**
- Anything is better than nothing!

Keeping it clinically meaningful

Research shows that good clinical use of outcomes and feedback tools help CYP improve faster and better and reduce DNAs and dropouts (e.g. [Miller et al., 2006](#), [Bickman et al., 2011](#), [Gondeck et al., 2016](#)). This means using information from the questionnaires and tools to feed back into sessions and inform the direction of the intervention.

Restricting services selection of outcome measures can lead to CYP filling in forms that may not be relevant and helpful for them. This may in turn lead to poor data quality and decisions that are not based on real experience (read more about variables that effect data quality [on page 9](#)).

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What type of data might I need?

Clinical outcomes in practice

There are many resources that can provide information and guidance about selecting clinical outcome measures

Examples of clinical outcomes in services

There is a huge array of outcome measures that can be used for a variety of different purposes (you can see a summary table of some of the different measures and what they are commonly used for in the [Guide to Using Outcomes and Feedback Tools with Children, Young People and Families pg 23-26](#), as well as general guidance on selecting measures), allowing services and clinicians to select measures that are most appropriate and useful.

Many services have integrated clinical outcomes into their day to day work.

Click the links below to see some **case examples** from CORC:

- [Bromley Y speak about making assessment more efficient with use of the RCADS and SDQ](#). You can also watch a video about how Bromley Y created an outcome focussed culture within the service and their use of data reports [here](#).
- [Northumberland, Tyne and Wear NHS Foundation Trust share a case example of using Goals Based Outcomes](#)

For some specific populations, the London and South East CYP IAPT Learning collaborative have produced **clinician developed outcomes recommendations** documents that also explain the various considerations around using measures with these groups: [Learning disabilities](#), [Looked After Children](#)

A '**Logic model**' approach can be used by services to break down and pinpoint the outcomes that can be measured for the specific interventions offered – you can [read more about this here](#).

How much data is needed?

Services should aim for outcomes data on **90% of all cases** seen for an intervention in their services. Ideally this would be 'paired' data - a pair of scores repeating the same questionnaire with the same person at the beginning and the end of an intervention - in order to track change across the intervention. If only a small number of cases have outcomes data, the dataset may be skewed by atypical results meaning it is not very representative.

You can download outcome measures, look at training videos and find out more information from the [CORC website](#). Free online training is available through [MindEd](#) and bespoke training is offered for services that are part of the CYP IAPT programme.

The [National Clinical Content Repository](#) is a service that can give users access to copyrighted tools included in the [Mental Health Services Data Set \(MHSDS\)](#) or explain alternative ways that services can access measures

*"Data collected from a meaningful clinical use of feedback and outcomes data is likely to lead to **more valid and reliable data**, than data collected from high-level administrative processes disconnected from clinically-meaningful use."*

[Data and Standards Task and Finish Group Report](#)

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What type of data might I need?

Questionnaire scoring

To get the most from using outcome measures, the data should be considered in context

Questionnaire scoring

Questionnaires will have different scoring scales, so a 10 point decrease in scores on one questionnaire may not indicate much of a change on one, but it could indicate a huge change in another. Questionnaires included in the [CYP IAPT dataset](#) are **normed** which make it possible to compare scores with others of the same age and gender etc. and establish cut offs/bands which give some indication of the threshold where a particular diagnosis becomes more likely or the severity level of symptoms.

However, it is important to note that questionnaire scores can be influenced by a variety of factors such as interpretation of questions and the effort of the person filling it out ([see page on Data Variables](#)).

What is 'Reliable' data?

As there is generally a lot of 'noise' in the questionnaire scores that could potentially obscure the changes, having access to reliable change, reliable recovery and/or recovery data can help to minimise the risk of misinterpretation. If a case shows reliable improvement (a positive reliable change) or reliable recovery, we can be more confident that the scores are reflecting 'real' change rather than change in scores being due to other factors.

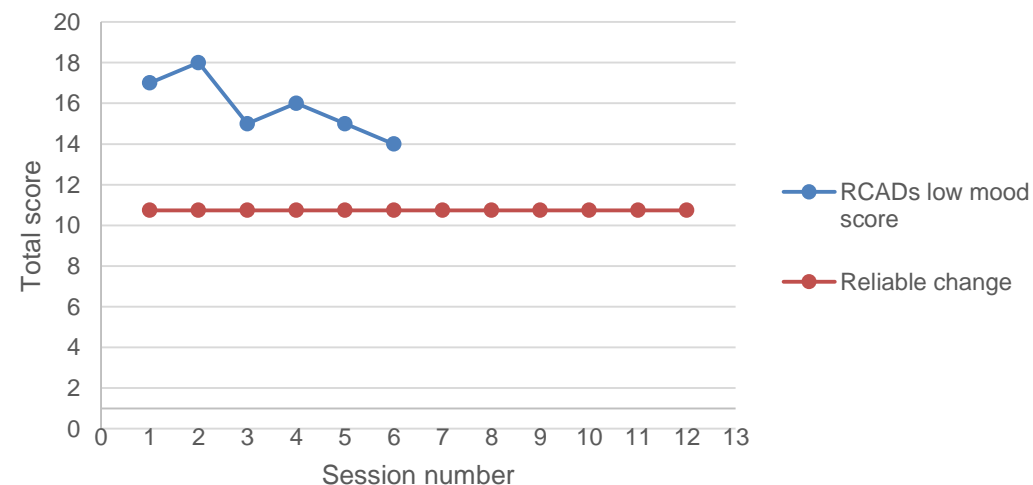
Please note that these are statistical terms and may not fully capture the experience of the CYP.

Scoring case study

Sarah, a 13 year old girl, completed the [RCADS](#) when she attended her first session. From her completed questionnaire, her clinician totalled her scores [using the Child First scoring spreadsheet](#) which showed an above threshold score for depression.

Together they decided to use the RCADS [low mood/depression tracker](#) at each session to track Sarah's Mood.

Sarah's clinician kept track of the scores every session by plotting a simple graph. She looked up the reliable change criterion ([using a helpful CORC spreadsheet](#)) to make sure that any changes seen during the intervention were 'reliable'. By session 5, both Sarah and her clinician could see that not a lot had changed with Sarah's mood and so they thought together about how to move forward.



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What type of data might I need?

Reliable change and recovery: making comparing different tools straightforward

How can I compare different questionnaire scores?

It can seem confusing to compare different changes in scores with the many different tools that clinicians use, and it can be tempting to try and limit the number of tools clinicians use - DON'T.

If clinicians are limited in the tools they can use they will get less helpful data for you. Making sense of outcomes across a range of tools is straightforward as long as you are given the **reliable change**, **reliable recovery** and **recovery rates**. Services should be able to provide this for you and you may want to put it into contracts that data is supplied in this way to make sure what you get is what you need.

To read more in depth about different approaches to analysing changes in outcome measure data, and the pros and cons of each, see this CORC paper: [‘Recommendations for Using Outcome Measures’](#)

Recovery rates

The number of individuals above the ‘clinical cut off’ before the intervention, that are below the ‘clinical cut off’ afterwards

Reliable change

When a significant change in scores is seen that can be attributed to the intervention rather than other factors (positive change can be called reliable improvement and negative change can be called reliable deterioration).

Reliable recovery

The number of individuals showing ‘recovery’ (as defined above) who’s scores have moved by a significant amount

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How do I get this data?

Data variables

The below table give some examples of ways in which the data gathered by services might vary. Some of these variables might impact on the ability of the services to gather 'trustworthy' outcomes data, either by collecting enough data to get a good picture of all CYP that use the service, and/or that data's ability to describe the experience of CYP using the service.

User	Clinician	Service
Motivated to respond accurately (e.g. not worried about consequences, understand why it's useful to them, trust in clinician)	Able to access the relevant questionnaires (e.g. paper forms need to be printed, electronic forms may need wi-fi)	The ability to collect data at at least 2 time points with the same measure over a minimum of 3 sessions
Immediate influences such as mood fluctuations and context, method of delivery, understanding of questions and ability to match feelings to response, environment, literacy, intuitiveness of interface, developmental stage.	Understands how to use questionnaires and usefully use them in a session (incentivised by clinical utility rather than arbitrary targets)	IT/admin systems that support data to be collected and extracted securely and with minimal burden.
If the user is feeling a lot better, they may not keep attending services and so time 2 on or post discharge may be difficult to organise. Likewise if the user is unhappy with their experience with the service or is not able to complete on discharge.	Has the time/resource/know-how to score, interpret and feedback data in session, use in supervision and input onto data entry systems	All users of the service fill out questionnaires (avoiding biasing data towards those who have improved/deteriorated)
	Has support from commissioners, management and colleagues to incorporate new ways of working into their practice (e.g. more admin time than before)	Support from commissioners etc. to be able to share data without it being misinterpreted, taken out of context or be unfairly penalised

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Expectations

It is not easy for services to produce good quality, meaningful outcomes data. Few services have attained the national target of 90% for paired data – a more likely figure is somewhere around 25% (for CYP IAPT services - figure from [CYP IAPT data report by CORC](#)).

The use of feedback and outcome tools in sessions is a new way of working for many clinicians that needs **training, support and time** to integrate into their practice, otherwise it can become a mechanical data collection system rather than a therapeutic tool.

Common barriers for services starting out

- **Progress may be slow** - quantity then quality.
 - Perhaps in the first year, use the collected data as additional information rather than jumping into a full set of KPIs
 - Start with a specific clinical pathway perhaps based on what is most prevalent (or sees the most referrals) locally, and build from there.
- **Problems with IT**
- **Fear** about new ways of working, judgement and/or criticism. Or arrogance in that somehow collection of outcomes data is not needed to demonstrate effectiveness – they already know
- It will be **harder for some services** than others. For children under 5 and with Learning Disabilities, most measures will not be suitable but it is possible to get good quality outcomes data because the questionnaires or tools needed to measure change in some specialist groups are not well developed (or none exist yet) but you need to be very cautious with interpreting this data.
All services can measure goals and get experience of service.
- Agree / negotiate with the provider what the **expectations** are. What would they expect to see ?
- Where do they find outcome measures most helpful in their Clinical practice?

Infrastructure and other considerations

Implementing new ways of working has a cost - many services cite lack of **appropriate IT systems and resources** as a roadblock in collecting and using outcomes data, resulting in reduced capacity for clinical time because of increasing administrative burdens. Some managers may not be able to access their own services data so it may take some longer than expected to report. Development of infrastructure to support routine outcomes monitoring may take time and investment.

As well as practical issues, clinicians and services may be reluctant to collect and/or share data with commissioners as they might have concerns about being data being taken out of context or funding being withdrawn due to unrealistic expectations.

How commissioners can help

Service Improvement plans can be developed in partnership with providers to address the specific circumstances and requirements of the service. These plans can be gradual and may include investments in IT or change management planning.

Having a collaborative approach to discussing and planning for collection of outcomes data may help services to feel less vulnerable (see '[Conversations](#)' section for more about this).



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Mindful data use

As a starting point for conversation

Outcomes data cannot stand in isolation and should always be seen as a **starting point for a conversation**. There will be numerous influences that create 'noise' in the data, and so it is important to recognise that there will be variation in how 'trustworthy' the data is.

The **context** of the data is important to keep in mind when making interpretations and comparing services - makeup of local community, service type, type of referrals etc. can all impact on expected outcomes.

Finally, studies have shown that a large proportion of CYP will experience **no change or an increase in symptoms** over the course of treatment and so we should not expect services to 'achieve the impossible'.

What is a good outcome?

- **It is difficult to say** - even the best RCTs show **only about CYP half improve** and **many experience no change or deterioration** (e.g. 32% no reliable change, 24% higher symptoms ratings in [Warren et al, 2011](#))
- In an analysis of child-reported CYP IAPT data by [CORC](#) showed **1 in 4 children reliably 'recovered'**, and **1 in 10 reliably deteriorated**. However, CORC emphasise that the data used was Flawed, Uncertain, Proximate and Sparse.
- But there doesn't have to be a big change to make a difference in the long run (see [Centre For Mental Health Report](#))
- The more data we collect from real provider services the better we get at answering these questions...

'Mindful' use of data

One framework for considering data in a safer and more effective way is using the MINDFUL framework:

"...we suggest adoption of a MINDFUL framework involving consideration of:

- *multiple perspectives,*
- *interpreting differences in the light of current evidence base,*
- *focus on negative differences when triangulated with other data,*
- *directed discussions based on 'what if this were a true difference' (employing the 75–25% rule),*
- *use of funnel plots as a starting point to consider outliers,*
- *appreciation of uncertainty as a key contextual reality and*
- *the use of learning collaborations to support appropriate implementation and action strategies."*

[From 'reckless' to 'mindful' in the use of outcome data to inform service-level performance management: perspectives from child mental health](#)

It is an approach that emphasises what the data could mean at service level, given the complexities and challenges of using outcomes data.

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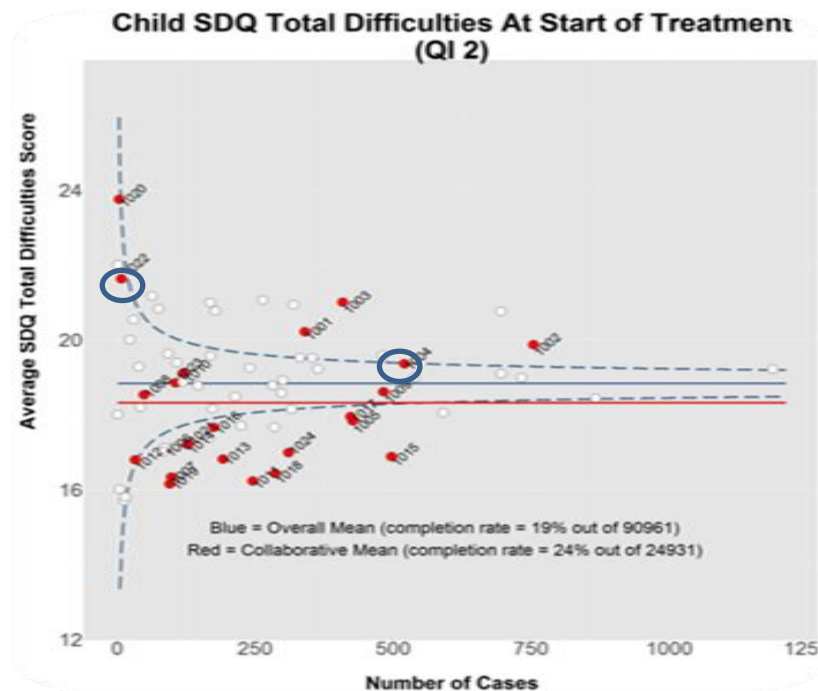
Visualisations

Commonly used data visualisations: Funnel Plots

Funnel plots are a way of showing the data without it getting distorted by caseload. That means you can compare different services data on the same indicator in a more accurate way as it gives the data context.

The key thing to remember with funnel plots is that dots falling within the funnel lines are around average, with the dots outside of the funnel showing data that is significantly above or below average.

Funnel plots are a scatter plot of data set against a 'funnel' – lines that show the upper and lower confidence intervals around the mean of the dataset. These lines put the data in **context** and give you an idea of whether data is likely to be trustworthy. They can be used to compare different services.



Funnel plot by CORC

An Example

- The plot to the left shows average scores on a questionnaire (vertical axis) plotted against number of cases in each service (horizontal axis). The shape of the funnel in the plot shows that the lower the number of cases, the more error/'noise' there is likely to be in the data (e.g. skewed by unusual cases). Funnel plots can add this context whereas this information is not available on a bar chart which could lead to misinterpretation.
- To the eye, the difference between the two points circled in blue looks large, but as they both fall within the funnel we can conclude that their results are probably around average for their caseloads. We can, however, assume that those data points that fall outside the funnel are showing significantly better or worse results than average.

How can data be improved?

Conversations

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What if the outcomes look different to what might be expected?

If, after considering the possible effect of the context and the trustworthiness of the data, the outcomes data appears to be different to what you had expected, perhaps consider some of the following questions:

- Did you agree with the service provider what would be expected from the outset?
- Is there any training needed?
- Is the service working collaborative way with children, young people and families?
- Are referrals appropriate?
- Is your service equipped to see CYP with difficulties at this level (skill mix, resources, capacity)?
- Does the service meet the needs of the population using it?
- Does the service use regular outcome monitoring to inform interventions and supervision? Is there a mid-intervention review to monitor how things are progressing or if any changes need to be made?
- Does the service share best practice with other similar services?
- Are the interventions used evidence based and aligned with NICE guidance?
- Is there a lot of variation with the outcomes of clinicians? Why might that be (Case mix? Staff skill mix? Fidelity to therapy model?)
- How are feedback tools used? Timing, spirit, delivery, training, feedback loops, supervision
- Are caseloads too high?
- Does the service respond to feedback from CYP and parents?

What does a good conversation with services about outcomes data look like?

“Creating the right culture needs to come from the top down (commissioners, chief executives, managers, service leads, supervisors) as well as from the bottom up (clinicians and practitioners). It is also important to recognise what is realistic and possible within CAMHS, given the current clinical and scientific knowledge and resources available.”

[Guide To Using Outcomes And Feedback Tools](#)

Normed symptom trackers, as well as goals and experience feedback questionnaires can all be used as a good starting point for conversation with services about their outcomes. However, considering change in questionnaire scores alone could be misleading. Asking for **reliable improvement and reliable recovery rates from normed questionnaires** (you can see a list on the [Child Outcomes Research Consortium \(CORC\)](#) website) can give you more confidence that the outcomes you are seeing are because of the intervention from the service, and not due to other factors that could influence responding (e.g. understanding of the items, motivation to respond accurately etc.).

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How can data be improved?

What services want you to know

We asked services what they wanted commissioners to know when it comes to outcomes data

Consistency across data requests

Have discussions with the provider about how to answer your questions, and as far as possible, try to be consistent with your data requests. It may take time and resources to prepare the data that you need (e.g. writing scripts to analyse or 'cleaning' the database for errors and outliers) but processes can often be repeated with much less effort if the parameters are already identified – for example, the timeframes involved, the type of data required and the key pieces of information you need.

Long documentation

Data reports should be accompanied by a fact sheet or a meeting in order to discuss the content of the report. This can help by adding context or clarification in order to prevent misunderstandings or misrepresentation.

Have an understanding of what is involved

Taking some time to understand the services process of collecting outcome data will allow you to be on the same page with your provider when planning and setting expectations. This could include how the service deals with CYP who stop attending

Give direct feedback to teams/managers about the importance of outcomes

Having a feedback loop can be useful to help culture change within services. If the services know why you want the data and how you are using it, it may prevent any misconceptions about 'tick box' exercises.

Value qualitative data/case studies/testimonials too

These can give a richness of data that can compliment quantitative data reports

Don't forget about consultation/outreach work/systemic work/liaison

Much of the work that services are doing cannot be or is not easily measured through activity, outcomes or experience of service measures. However, this is still a hugely important part of work services do.

Value to the patient

CYP like using outcome measures if they are used in a clinically meaningful way. They can help CYP communicate, facilitate shared understanding with their clinician, allows them to keep track of their progress and understand their own difficulties better. However CYP don't see the value if there is no conversation about their answers after filling them out.

"Outcomes tools can be really useful, not only for the therapists but for the young people. They allow you to evaluate where things are going well and where they could be improved. Feedback is important for us to learn and grow. However, I do think you must use outcomes tools with the correct intention and in the right way."

Quote from YP: [Guide To Using Outcomes And Feedback Tools](#)

Adding use of specific outcome measures into contracts

As there are no one-size-fits-all measures, specifying a particular form to be filled in with all CYP can take away choice, add extra burden and detract from clinical usefulness. Selection of outcome measures should be informed by clinical judgement and in collaboration with the person filling them out.

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How can data be improved?

Potential Actions

An [analysis of Children and Young People's mental health Local Transformation Plans](#) by NHS England contained the following actions for improving outcomes monitoring in mental health services:

Improving and standardising the frequency and quality of outcomes recording

Commissioners performance managing providers through levers such as Commissioning for Quality and Innovation (CQUIN), and embedding measures into CYPMH service specifications

Extending ROM training to across staff and developing outcomes-based key performance indicators

Joining CYP IAPT learning collaboratives

Extending the coverage of ROM and promoting its use beyond CCG commissioned services, such as in voluntary services, statutory services and local authority commissioned services

Increasing transparency by integrating outcomes in patient records systems

Involvement in a cross-sector outcomes and data linkage project, led by CORC

Implementation groups within trusts to ensure embedding of ROM

Engaging with children, young people and their families to gather feedback on using outcomes information

Using funding to make sure that providers are inputting to the MHSDS, such as appropriate equipment and secure connections

Integrating feedback and outcome tools into everyday use in services can be easy for some services but very difficult for others. As an example, small providers may need lots of funding and infrastructure support but larger NHS trusts may not. We encourage commissioners to share their experiences and what works with other commissioners.

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Useful links and resources

- [Healthy London Partnership](#) - working across health and social care, and with the Greater London Authority, Public Health England, NHS England, London's councils, clinical commissioning groups, and Health Education England.
- [London and South East CYP IAPT Learning Collaborative](#) – a collaborative of services in London and the South East implementing the CYP IAPT programme
- [Mental Health Services Data Set \(NHS Digital\)](#) – national reporting
- [The Child Outcomes Research Consortium \(CORC\)](#) – supports the effective and routine use of outcome measures in work with children and young people (and their families and carers) who experience mental health and wellbeing difficulties
- [Goals and goal based outcomes](#) (2013) A brief guide to Goals
- [Guide to Using Outcomes and Feedback Tools with Children, Young People and Families](#) (2014) Comprehensive booklet about outcomes. Includes service structures and implementation and understanding data, as well as clinical use of tools.
- [CORC norms and reliable change criteria spreadsheet](#) – for calculating reliable change for CYP IAPT measures
- [Guide to available datasets and reports for children and young people's mental health and wellbeing](#) – HLP document giving information and resources about various available datasets

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