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Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/1653/14

Ann Jones AM
Chair
Children, Young People and
Education Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

28 August 2014

Dear Ann,

I was pleased to attend the Committee on 17 July to provide further evidence to inform the inquiry into Child and Adolescent Mental Health Services (CAMHS).

I hope it was clear from the discussion that I value the important work of CAMHS, but recognise that there is a need for clarity over what we can, and should, expect a small, specialist service to provide. This is the overarching driver behind the changes I am seeking to implement in CAMHS over the course of the next year.

I attach the further information requested in your follow-up letter of 4 August. I also include information, and a supporting paper, relating to the evaluation of the mental health core data set pilot scheme. This is not included in your 4 August letter, but was requested during the Committee meeting (paragraphs 60-63 of the meeting transcript refer).

I look forward to receiving the final Committee report in due course.

Best wishes,

Mark.

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Further information on the 'national CAMHS improvement plan' and the money that the WG has allocated for it (paragraph 22 of transcript)

A copy of the CAMHS Service Improvement Plan is attached at annex a. The Plan was developed in 2013 with the aim of taking forward a range actions to enable the service to adapt to meet current challenges. The plan was amended to incorporate the actions required to implement the recommendations from the WAO/HIW report when the CAMHS follow-up review was published. The Plan requires concerted effort by LHBs and partners over the next 12-18 months. It is overseen by a Project Steering Group which is chaired by Welsh Government. CAMHS lead clinicians; LHB management; WHSSC; the NHS Delivery Unit; and the Chair of the CAMHS/ED Planning Network are represented on the group.

Supporting the Plan, my announcement, in October 2013, of an additional £250,000 annually for CAMHS to improve Eating Disorder Services, is also intended to improve the ability of the service to adapt and reduce out of area placements. The associated savings being reinvested back into CAMHS. Whilst it is still early days, there is some evidence that this is beginning to have the desired effect, with increasing capacity at the two CAMHS in-patient units.

Welsh Government will also be funding service change expertise to support the Plan. This will take the form of a nationally recognised clinical leader to shape and inform CAMHS strategic development in order to promote service change. This role will be supported by a senior 'turnaround manager', and Sian Richards, a former NHS Chief Executive and the current Together for Mental Health Strategy implementation lead has agreed to take on this role, as CAMHS forms a key theme within the Strategy. Work has already commenced including leading Welsh academic input, activity by the NHS Delivery Unit and national benchmarking work. Activity will be funded over the remainder of this year and next, and is expected to cost around £100,000.

Clarification on the position regarding AOF targets. During the meeting, your official referred to "old targets" (paragraph 39 of the transcript). Was this a reference to the AOF targets?

Yes, as my original evidence of 2 June set out.

Mental Health Core Dataset (MHCDS) evaluation

At Committee you asked that the evaluation of the pilots of the dataset be provided to the Committee. I attach this at annex b. I have provided information that our priority is to begin to measure outcomes, rather than focusing on solely on processes within services such as waiting times or bed numbers. Our Together for Mental Health Strategy (2012) committed us to developing a Mental Health Core Dataset (MHCDS) which will capture data to allow us to measure the impact and outcomes of actions as well as processes.

Whilst not limited to CAMHS, work is progressing to develop the MHCDS for all ages. The Welsh Government and Public Health Wales are project managing the work to develop a specification for a nationally standardised mental health core dataset. The dataset covers both primary care and secondary care mental health services. Phase 1 of this project commenced in 2014 with work continuing into 2015-16. Innovatively this incorporates outcomes from a service user perspective, enabling service users to monitor and report their perception of the achievement of outcomes agreed in their care and treatment.

A note on the specific issues raised in relation Betsi Cadwaladr LHB (paragraph 48 of the transcript)

The Abergele inpatient unit opened in July 2009. Welsh Government invested £15m capital funding for this project, with the revenue funding being provided from existing LHB funding. It was planned to provide 6 acute care/emergency admission ward beds and 12 planned treatment beds. Initially WHSSC commissioned the 12 planned beds but the acute/emergency beds provision was not opened pending further evidence of demand for those beds.

The commissioning of specialised services, including CAMHS Tier 4 beds is delegated by all LHBs to WHSSC. Funding for the Tier 4 CAMHS inpatient unit in Abergele (which can also accommodate residents of Powys or south Wales) is provided via WHSSC to BCUHB.

WHSSC has worked with both Tier 4 providers in Wales to reduce out of area placements by both increasing intensive community services and increasing the bed occupancy within the units in Wales. In the context of north Wales, WHSSC has worked closely with BCUHB regarding the balance between Tier 4 and local services given the shared funding responsibilities.

The plan agreed between WHSSC and BCUHB is to reduce the number of out of area placements required by both supporting the unit to be able to deliver to funded capacity and to develop a new community intensive team (CIT). The CIT commenced during the latter part of 2013 and has already started to impact by working with the in-patient unit to help manage patients more effectively within local services and reduce the need for escalation to Tier 4 beds. The CIT also helps with supporting patients post discharge. The BCUHB CIT began operating last year and was funded by reducing the cost of out of area placements. The final component of the plan is to assess the impact of the development of the CIT, together with the improvements in the Tier 4 service, on the balance of demand for Tier 4 services.

The new CAMHS/ED Planning Network will assist in sharing best practice between the different assertive outreach/intensive community CAMHS teams across Wales. This will enable an improved view of demand for Tier 4 beds and the type of beds required. As part of this plan it is important to understand that owing to case mix complexity there will always be a need to have a mix of internal and external capacity on the grounds of safety and quality. The overarching aim of the plan is to maximise delivery within BCUHB supported by specialised outsourcing as required on an exceptional basis.

One of the key drivers for the development of the CAMHS Improvement Plan is to ensure that the two in patient units in Wales are working at optimum capacity to reduce the need to refer outside Wales. The occupancy rates of the units in Wales have been increasing steadily since the 2nd half of 2013 and have continued to make further progress in 2014 to date. Clearly there will always be a need to use out of area placements for certain young people to ensure their specific needs are met but I am encouraged that these appear to be falling in the period from 1st April 2014 to date (with 5 new referrals inc 2 Forensic CAMHS) as more Community Intensive Teams become available across Wales and by making fuller use of the Welsh units.

A note on Local Authority funding (paragraph 77 of the transcript)

By law, Local Authorities are required to set a balanced budget for each financial year and should consider the range of funding sources available to them. In addition

to core revenue funding provided by the Welsh Government, they also receive a significant amount of funding in targeted grants from various sources, and are able to raise income through the council tax, fees and other charges. Local Authorities have considerable flexibility in how they manage the resources available to them and the majority of resources at their disposal are unhypothecated. Local Authority Leaders and Councillors are democratically elected by residents to ensure local needs are appropriately represented and provided for. Authorities are expected to be open and transparent about the decisions they make and are encouraged to consult with their communities before formally setting budgets and most do this as part of their annual process.

Ministers are fully aware of the financial and demographic pressures on all public services. We must acknowledge, however, that Local Authorities are facing an unprecedented financial situation from 2014-15 onwards as a result of significant cuts to the overall Welsh Budget by the UK Government. In the current financial climate, effective forward planning will be crucial in ensuring citizens can continue to receive these services. The Minister for Local Government and Government Business has been clear that ultimately, Local Authorities need to be prepared to do things differently, and they need to focus on delivering efficient, innovative and collaborative services. The Minister meets regularly with Local Authority Leaders, the Welsh Local Government Association and the Welsh Police and Crime Commissioners to discuss a range of finance matters.

The Welsh Government has sought to limit the impact of these cuts on Local Government as far as possible and decisions taken by the Welsh Government in recent years have placed Welsh Authorities in a better position to deal with the cuts than their counterparts in England. This has been recognised in various reports by the Institute of Fiscal Studies and the Wales Audit Office.

The 2013 Royal College of Psychiatrists document on building and sustaining specialist CAMHS, to which the Committee has referred several times, defines CAMHS in two ways. One applied specifically to specialist CAMHS provided at Tier 2, 3 and 4, the provision of specialist mental healthcare to children and young people is their primary function. Local Authority input has always been integral to specialist CAMHS and social workers have been core members of multidisciplinary teams. We know from a contacts audit of CAMHS in June 2012 by the Delivery Unit there were 7.5 WTE social care workers in specialist CAMHS teams. This contrasts with Durham Mapping of CAMHS which showed social workers within CAMHS were 11.1WTE in 2008 and 25.7 in 2007. While the number of social workers seconded into CAMHS teams has reduced, the Welsh Government has provided £4.2 million to put in place multidisciplinary teams across Wales for Integrated Family Support Services (IFSS). These teams are supporting families with complex needs with preventative services intended to reduce future demand for other services, including CAMHS.

They respond to referrals where there are problems with substance misuse. The roll out of IFSS has now been completed and they operate across the whole of Wales. The IFSS will deliver family focused services to enable parents to achieve the necessary behavioural changes that will improve their parenting capacity, and will engage with the extended family in the process of that change. They also seek to address the social, cultural and organisational factors which have a direct impact on the safe care of the child or young person and their parents. They seek to meet the needs of all family members. At the heart of the IFSS will be an Integrated Family Support Team which will be multi-disciplinary and multi – agency, consisting of

professionals with the skills and experience in working directly with children in need, their parents and adults with complex health and social care needs.

A separate 2012 Audit report by the NHS Delivery Unit into CAMHS in order to support the introduction of Part 2 of the Mental Health (Wales) Measure indicated that Local Authority colleagues did not attend multidisciplinary team (MDT) meetings, though the reasons for this are not given. A recommendation was made that LHBs and Local Authorities should review the multidisciplinary referral meeting for specialist CAMHS to support integrated working and enhance patient care by having a multi disciplinary approach to decision making.

The Royal College also defined CAMHS on the basis of a broad concept embracing all services that contribute to the mental healthcare of children and young people, whether by health, education, social services, or other agencies. This includes services whose primary or only function may not be mental healthcare (e.g. schools). Tier 0 or Tier 1 providers such as schools, youth services, primary care and social service departments are frequently the first point of contact for the child and their family. They can often deal with the majority of problems, with appropriate support from specialist CAMHS, and prevent those problems escalating to the point where specialist CAMHS needs to take over responsibility for the individual. There are a number of Local Authority funded services that offer such tier 1 interventions.

Families First was rolled out across all 22 local authorities in Wales from April 2012, following a pioneer phase which tested a range of delivery models across five consortia. Families First will run for the life of this assembly, and is funded at £46.9m for the current financial year. Families First succeeds the Cymorth grant which Welsh authorities received from 2003 to support children and young people. We have been clear that as such Families First Funding is available for Local Authorities to utilise for issues such as primary care level interventions. It is however for the LAs to decide where to invest that funding to best meet local need.

Schools are a key CAMHS partner and as part of their work for the Welsh Network of Healthy School Schemes (WNHSS), schools will be looking at all aspects of mental and emotional health and well-being. They will identify areas of concern in the school, and may choose to develop a programme to deal with any issues raised.

From 2008-09 to 2012-13 the Welsh Government also put over £13 million grant funding into school based counselling, with the result that counselling was being delivered in all maintained secondary schools from September 2010. An independent evaluation of the School-based Counselling Strategy (2011) found that link teachers reported counselling services had made a positive impact on the attainment, attendance and behaviour of pupils (65%, 69% and 80% respectively). From April 2013, under the School Standards and Organisation (Wales) Act, local authorities have been required to make reasonable provision of counselling services for children and young people aged between 11 and 18 in their area and pupils in year 6 of primary school. At the same time £4.5m was transferred to the Revenue Support Grant for the continued support of this service.

In June 2013 we published Professional Advice for Service Planners, which was developed by a national expert group of multiagency practitioners. It provides a range of best practice examples of how services need to work across disciplines and agencies to provide for the needs of young people. It is important that consideration be given to ensure a coordinated approach. This will avoid duplication between agencies and facilitate the development of comprehensive and responsive services.

The Social Services and Wellbeing (Wales) Act 2014 gives further impetus to working in partnership to promote resilience and emotional wellbeing for children and young people. All Health Boards have partnership boards which are looking to developing effective, evidence based services across the age range. Some Health Boards have developed partnership boards specifically to address the needs of children and young people to sustain stretched services in the most cost effective ways with local authority partners. Sharing of good practice across Wales and, where appropriate, working across boundaries in collaboration is key to this.

Earlier I refered to the establishment of community intensive treatment teams. I see these as central to the future development of specialist CAMHS. Evidence shows that community based treatment could reduce admission rates and length of stay for severely ill adolescents. Research is increasingly endorsing the benefits of assertive outreach and supports the need for the development of local partnership arrangements across agencies. This is in line with prudent healthcare and wherever possible, when risk allows, young people should be cared for in the community as near to home as possible. Young Minds research shows that young people and families want CAMHS to be delivered flexibly and in a variety of settings including youth clubs, and the home. A community based team therefore needs to be flexible in its delivery. To do so they need to collaborate closely with other agencies involved with the child/family and participate in multi-agency operational and strategic planning of services for children requiring substitute care.

There are many other areas where partnership working, between CAMHS and other agencies, is equally important, such as in relation to the provision of support for those with neurodevelopmental problems, learning disability services and substance misuse.

Information on how much of the £635,000 invested by the Welsh Government in psychological therapies has been spent on therapies for children and young people (paragraph 87 of the transcript).

We are expecting plans for the use of the psychological therapies funding by LHBs to be submitted at the end of August. We have been clear that funding should be equally distributed across service users of all ages in accordance with the local population's age profile. Plans must be agreed by the local Psychological Therapy Management Committee (which includes CAMHS representation) prior to submission.

CAMHS ACTION PLAN (MARCH 2014)

The attached table details the main issues and the actions requiring addressing by in partnership with LHBs and others to improve CAMHS provision. The delivery of the individual actions are underpinned and will contribute to the delivery of the core principles we wish to for CAMHS services in Wales, as reflected in Together for Mental Health, that CAMHS should :

1. be child and family centred, putting the child at the heart of service delivery by promoting early and easy access to provide specialist assessment and intervention, particularly for children in crisis and for those with protected characteristics.

2. promote partnerships with other agencies and disciplines in health, social and education services, criminal justice and voluntary agencies to ensure appropriate interventions.

3. have strong governance structures with robust planning, commissioning, review and reporting arrangements between services and across the age range, which ensure the correct agency/staff are able to deliver the most appropriate intervention, with mutual support from other agencies.

4. be safe and ensuring safeguarding of young people is paramount.

5. involve children and young people and their carers in planning, delivery and development of services.

Risk

Each issue has been risk assessed, using a matrix which measures individual risk and safety, and the political and reputational risk to the Welsh Government and public services. Those issues coloured red are considered the most significant areas of risk.

Impact (An assessment of the consequences of the risk materialising, a combination of the risk to individual/safety issues (scored R/S 1-5) systems risk (scored P 1-5))
L = Likelihood (An assessment of the probability of a risk materialising, scored 1-5)
O = Overall Score (Impact (risk/safety+systems) x Likelihood)

Tolerances:
1- 9 low risk
10 - 19 medium risk
20+ high risk

Individual actions in the plan fall either to the Welsh Government or to LHBs to take forward, though in order to maintain a focus on delivery a workstream lead has been identified who will act as 'owner' for the action ensuring work progresses and reporting progress to the Project Manager and ultimately the

Project Steering Group (which has been established to oversee implementation of the plan). Where an 'expert group' has been identified as the vehicle for progressing the action, then, wherever possible we will look to use existing groups rather than convene new groups.

Issue and Risk	Delivery Plan	What we propose to do and by when					
		Core Principle	**LHBs/ NHS DU/ WHSSC Commissioning**	**Owner**	**Core Principle**	**Welsh Government**	**Owner**
1a. Inpatient Unit S Wales Risk R/S 1 P 4 5 L x4 Score 20	No	2	(i) LHBs to produce proposals (SW letter August 2013) for service reconfiguration, closer working between IPUs and community teams. (LHBs to provide proposals by end of 2013, implementation Dec 2014). Await revised proposals in line with ED funding agreement, **(by January 2014)**	WHSSC	3	(vi) Scope provision in other (English IPUs) in order to learn lessons. **(by March 2014)**	DW
					3	(vii) Convene National Expert Reference Group to review/agree formal criteria as proposed by professionals that determines appropriateness of admission to IPU. Criteria would include those relating to diagnosis/problem type and to a wide range of contextual factors, including risk posed to and by the young person, their social and family situation, and the availability or otherwise of community-based services that might act as an alternative to admission. **(first meeting to scope activity by March 2014)**	DW/ BB
		3	(ii) As part of reporting requirements for £250,000 ED funding, LHBs/WHSSC to report progress in relation to: • bed occupancy • the range of complex conditions being treated within the IPU • reducing out of area placements. • improved out of hours provision • increased staff competency **(first report by December 2014)**	WHSSC			
					5	(viii) Ask Children's Commissioner to consider developing proposals to examine young people's views on access and appropriateness of Tier 4 services as part of his review work with cyp on their mental health needs. **(initial contact by January 2014)**	JP
		3	(iii) DU to identify the outcomes for those CYP referred for a psychiatric assessment in non CAMHS settings. To evaluate any learning from the information collected. **(by August 2014)**	DU			
		3	(iv) DU to assess the possible reasons for CYP not being admitted to a specialist CAMHS Unit. To evaluate any learning from the information collected. **(by August 2014)**	DU			

		2	(v) Consider if practical for Cwm Taf and ABMU to broker agreement for the provision of support to the IPU from Princess of Wales staff, during time of pressure on IPU (i.e. the ability for PoW nurses to provide support to IPU during times of staff absence, on-call arrangements, etc). **(initial discussions and scoping by March/April 2014)**	LHBs + JF			
		2	(ix) Develop proposals for standing cross health board and cross agency group to develop agreed service models, monitor and advise under the auspices of WHSSC. **(by November 2014)**	WHSSC			
1b. IPU (wider) Risk R/S 1 P 3 4 L x4 Score 16	No	3	(i) **From HIW/WAO report** 'Welsh Government makes clear whether or not one of its aims is that out-of-area placements and admissions to adult mental health or paediatric wards should not occur due to a lack of capacity in the two CAMHS units , and, if so, sets a deadline by which the aim should be achieved'. LHBs have been asked (October 2013) for a detailed implementation plan regarding our £250,000 investment, including a reduction in out of area placements. Detailed implementation plan awaited from LHBs **(by 10 January 2014, with evaluation reports expected end 2014-15 and end 2015-16)**	WHSSC	3	(iv) Need to review/develop guidance on criteria for admission to adult/paediatric ward and the acceptability of such an admission for under 18 year olds (specifically 16-17 year olds). **(to be considered as part of expert group activity being pursued as part of 1(vii) above, with first meeting to scope activity by March 2014)**	DW/ BB
		3	(ii) **From HIW/WAO report** 'Welsh Government requires Welsh Health Specialised Services to routinely report the number and cost of out-of-area placements that result from a lack of capacity in the two CAMHS units'. To be reported as part of (i) above.	WHSSC			

		3	(iii) **From HIW/WAO report** 'Welsh Government requires Welsh Health Specialised Services and health boards to establish mechanisms for identifying and reporting admissions to adult mental health or paediatric wards that result from a lack of capacity in the two CAMHS units'. To be reported as part of (i) above.	WHSSC + LHBs			
2. Inappropriate admissions of under 18s to adult wards Risk R/S 3 P 3 6 L x4 Score 24	Y 12.4 by Dec 2012	3	(i) DU to assess the service capacity to respond to CYP requiring a specialist level of intervention that is delivered in the appropriate environment. To evaluate any learning from the information collected and consider whether the audit findings are reflected in the other home countries. **(by August2014)**	DU	3	(vii) **From HIW/WAO report** 'Welsh Government confirms in writing the need for health boards to report to it all admissions of young people under the age of 18 to an adult mental health ward, identifying those admissions that are inappropriate and the steps taken to minimise risks'. We will convene a multi clinician group **(by February 2014)** to review mix of LHB inappropriate admission reports to Welsh Government with a view to considering processes and procedures, particularly for those highest risk admissions, share information about risks and actions needed to ensure safety of the patient. Subsequent guidance will be developed and issued **(by July 2014 see 2(viii))**	JF
		3	(ii) DU to confirm that the WG directive for HBs to report CYP admissions to adult inpatient units as SUIs is being adhered. To confirm that HBs have the appropriate systems in place to report CYPs as SUIs that meets the WG reporting requirements. **(by August 2014)**	DU			
		3	(iii) **From HIW/WAO report** 'Welsh Government requires health boards to validate that they are accurately reporting the number of under 18 year olds admitted to adult mental health wards, by periodically comparing the number of these admissions reported to the Welsh Government with the number registered on patient admission systems'. LHBs will be asked to report periodically to the CYPFDAG that they are validating the numbers of inappropriate admissions reported by comparing numbers reported to the LHB Mental Health Board, with those reported to the Local	LHBs + JD/JL	2	(viii) **From HIW/WAO report** 'Welsh Government clarifies, by providing a range of detailed examples, what constitutes an inappropriate admission of a young person to an adult mental health ward'. Following multi clinician group (action 2(vii)) develop guidance for LHBs to share good practice and produce a range of good practice scenarios to inform LHBs in the management of the range of inappropriate admissions **(by July 2014)**	JF
					2	(ix) Welsh Government will write more detailed guidance on what does/does not constitute an	LR/AG

			Area Children's Safeguarding Board. **(first such report to the CYPFDAG by July 2014)**			inappropriate admission and incorporate this into the revised Welsh MH Act Code of Practice **(by September 2014 for consultation)**	
		3	(iv) **From HIW/WAO report** 'Welsh Government requires health boards to regularly report the number of designated wards, the appropriateness of their environments, and the number of admissions to designated and non-designated wards'. LHBs will report this annually to the CYPFDAB. **(first report by July 2014)**	LHBs + JD/JL			
		4	(v) Ask Heads of MH Nursing to review with staff why there seems to be anomalies around reporting admissions (i.e. is there a lack of clarity over the guidance or other issues?). **(by May 2014)**	LHBs + JF			
		1	(vi) **From HIW/WAO report** 'Welsh Government confirms with health boards and Welsh Health Specialised Services the extent to which the two specialist CAMHS inpatient units should provide initial assessment, emergency and crisis support'. WSHCC need to develop CITT/Assertive outreach capacity to ensure equality across health boards and preferably extended hours. This could be achieved through developing the proposed CAMHS case manager post. **(WHSSC to agree proposals with LHBs by July 2014)** Following this LHB's need to ensure their AMH and CAMHS resources are used together to provide robust OOH provision especially for 16-17year olds, particularly for those young people detained under s135/136 of the MHAct. **(LHBs to report progress to November CYPFDAG)**.	WHSSC + LHBs			
3. Out of	No	3	(i) WHSSC to examine reasons for OOA placement	WHSSC	3	(iii) Review guidance on OOA with expert group,(i.e.	BB

area placements Risk R/S 2 P 5 7 L x4 Score 28		3	of all cases over last year and present findings to future CYPFDAG. **(by July 2014)** (ii) LHBs to report future OOA placements as part of requirements for £250,000 ED funding, in line with agreed evaluation. **(WHSSC to report end 2014-15 and end 2015-16)**.	WHSSC	3	maximum timescale that placements should be for, procedures for considering repatriation, alternatives to OOA, such as community based support and the ability of family and friends to maintain contact with the patient. **(by May 2014)** (iv) Write detailed guidance in new Code of Practice regarding use of use CTP to improve OOA care and support and speed repatriation. **(by September 2014 for consultation)**	AG/ BB
4. Community and crisis (out of hours) provision variability Risk R/S 3 P 2 5 L x3 Score 15	Y 13.3 by Dec 2012	1 1 1 3	(i) LHBs (Powys, HD and AB) to agree deadline for the establishment of community teams in those areas currently without provision. **(agreed structure of teams and plan for recruitment be in place by July 2014)** (ii) LHBs to confirm that joint working pathways exist, which clarify roles and responsibilities between CAMHS and Adult Services for the provision of crisis/out of hours provision. **(by November 2014 in line with 2(iv))** (iii) LHBs to confirm detail of on-call rota system in place to ensure a crisis response from CAMHS is available at all times, including contingency provision to ensure service is not affected by absences or sickness issues. **(by November 2014 in line with 2(iv))** (iv) DU to implement a national process and system that informs on the numbers and outcomes of CYP who present in crisis. To evaluate any learning from the information collected. (**from November 2014 onwards)**	WHSSC + LHBs LHBs LHBs + JP DU	1	(v) Convene expert group as task and finish group to produce crisis guidance which ensures: • CAMHS work with all potential referrers and other local CAMHS, to ensure appropriate requests for a crisis response are received • Details the advice and support from CAMHS to frontline referring services • CAMHS disseminate clear referral criteria to all relevant referring services (including frontline services) for eliciting a crisis response • Referral procedures specify what action is to be taken for children and young people in need of a crisis response, taking account of whether: ○ They are known to CAMHS (e.g. young person's care co-ordinator is quickly identified and contacted); ○ They are *not known* to CAMHS, but present in a crisis and require an urgent mental health assessment **(by September 2014)**	DW/SH

5. DBS checks Risk R/S 2 P 2 4 L x5 Score 20	No				4 3	(i) **From HIW/WAO report** 'Welsh Government sets a deadline for health boards to arrange DBS checks on all staff working in CAMHS, and requires that the checks are updated at least every three years'. Write seeking assurance from LHBs that this will be actioned by August 2014. **(by January 2014)** (ii) Ask LHBs to report to the CYPFDAG the numbers of staff with current DBS checks in place annually. **(first such report by November 2014)**	JL JL
6. Information sharing across health and also with other organisations Risk R/S 3 P 1 4 L x4 Score 16	No	2 2 2	(i) BCU to provide evaluation of progress, effectiveness of implementation of information sharing protocol, ensuring: • protocol is in line with latest version of WASPI Accord, Information Sharing Protocols (ISPs) and Data Disclosure Agreements. • review of existing ISPs (e.g. Children with Additional Needs: Community Development Team - Aged 0 – 4) where Health are engaged **(by June 2014)** (ii) Following BCU evaluation all LHBs to adopt protocol and implementation in their areas. **(by September 2014)** (iii) LHBs to develop proposals to engage other organisations/agencies in information sharing. **(by March 2015)**	BCUHB + PC LHBs + PC LHBs + PC	2 4	(iv) Issue with relationships and links between CAMHS and Schools Based Counselling. Works well in some areas, not so well in others. • Scope good practice where it exists and develop guidance for practitioners • Ensure agreement in place between SBC and CAMHS to promote consistency of provision (ensure these are linked to wider info sharing protocols, or other appropriate protocols/agreements). **(by December 2014)** (v) **From HIW/WAO report** 'Welsh Government agrees with health boards systems for routine monitoring to check, at least annually, on compliance by service provider staff with their safeguarding and information sharing responsibilities, and with the all Wales 'was not brought' protocol'. Welsh Government to ensure routine (annual) reporting by all LHBs to the CYPFDAG **(first such report by November 2014)**	JL JL
7. Discharge	No	4	(i) DU to review whether HBs are adhering to WG Guidance on DNAs for CYP. To evaluate any	DU	4	(iii) **From HIW/WAO report** 'Welsh Government agrees with health boards systems for routine	JL

practices (DNA) Risk R/S 2 P 2 4 L x2 Score 8		4	learning from the information collected. **(by August2014)** (ii) **From HIW/WAO report** **'**Welsh Government agrees with health boards systems for routine monitoring to check, at least annually, on compliance by service provider staff with their safeguarding and information sharing responsibilities, and with the all Wales 'was not brought protocol'. WHSSC to consider HR implications and develop plan to address recommendation **(plan developed by September 2014)** and report to CYPFDAG annually on progress **(see 7(iii))**	WHSSC		monitoring to check, at least annually, on compliance by service provider staff with their safeguarding and information sharing responsibilities, and with the all Wales 'was not brought' protocol'. Welsh Government to ensure routine (annual) reporting by all LHBs to the CYPFDAG **(first such report by November 2014)**	
8a. Waiting times (16 weeks significant variation) Risk R/S 1 P 4 5 L x4 Score 20	No	1 1	(i) LHBs to review and explain the underlying causes of excessive waiting times (i.e. do they relate to repeat DNA rates). **(by May 2014)** Linked to this LHBs to review pathways to ensure these are operating correctly, where the blockages in the system are arising. Work with LHBs with good waiting times to benchmark process and share good practice in waiting list management. **(by May 2014)** (ii) LHBs to develop a plan to reduce waiting lists to acceptable level and in line with (i) above. **(plan by summer 2014, with demonstrable reduction in wait by March 2015)**	AB & BCUHB + DW AB & BCUHB + DW	1	(iii) Scope need for an escalation policy and greater flexibility in the way we use the totality of CAMHS services similar to a South Wales programme approach, sharing capacity to reduce demand and pressures **(by May 2014)**	DW
8b. Waiting times (need to move to	No	1	(i) Equitable waiting times require effective and efficient joint working of all age sectors of specialist mental health services within health boards, particularly in ensuring out of working hours emergency and crisis support. In some cases	LHBs + DW	1	(ii) Issue guidance to LHBs stating that we expect them to ensure, that the range of mental health services it provides is accessible to all ages when required and appropriate. Waiting times for assessment of emergency, urgent and routine	DW/JP

adult measure targets) <u>Risk</u> R/S 1 <u>P 4</u> 5 <u>L x4</u> Score 20			regional solutions may be required. To achieve this, and ensure CAMHS are able to safely deliver services to those who are at highest risk and most in need, (whilst maintaining an achievable input into prevention and shared work in chronic paediatric conditions such as neurodevelopmental disorders), LHBs need to proactively plan and monitor service priorities, demand and capacity, with agreed pathways (associated with defined capacity) between the services, primary care and partner agencies. LHBs to develop plans and agree implementation dates and report these to the CYPFDAG **(by March 2015)**, with annual reporting of progress thereafter.			assessment should be the same for patients of all ages. This includes those currently receiving input primarily from Child & Adolescent Mental Health Services. **(by April 2014)**	
9. Transition to adult services <u>Risk</u> R/S 2 <u>P 2</u> 4 <u>L x4</u> Score 16	Y 11.2 by Nov 2013	2	(i) DU to: 1. assure the processes that HBs have in place for the transition of CYP to adult mental health services meet WG requirements. 2. assure the processes that HBs have in place to meet part 3 of the Mental Health Measure. 3. identify the unmet service needs of CYP aged 17 years evaluate any learning from the information collected.**(by August 2014)**	DU	2 5	(ii) Ideological, structural, functional and organisational differences between CAMHS and AMHS produce complex challenges for those involved in negotiating the boundary. CAMHS and adult services differ in their view of diagnostic categories and processes, treatment focus, service organisation, delivery and availability, and in professional training, all of which accentuate the problems at the interface. Convene expert group as joint adult and CAMHS task and finish group to examine issues and closer working relationships between CAMHS/AMHS; effectiveness of LHB transition protocols and pathways; detail of working of local LHB transition forum; and the extent to which CAMHS and Adult services have shared knowledge and skills among staff. **(Expert group to consider issues between April and November 2014 and report finding to CYPFDAG in Winter)**. (iii) Review user involvement in planning for their	JF AG

						transition needs; their engagement in developing their transition plan; and for those not transitioning what access to help, advice and further support is available. **(by August 2014)**	
10. Training (risk management) Risk R/S 2 P 2 4 L x2 Score 8	Y 14.2 ongoing	4 4 3	(i) LHBs to confirm that risk management training of CAMHS staff is incorporated into LHB training and development plans. Provide details of lead in each CAMHS service and provide details of number of trainers in place to cascade training to staff and numbers of staff trained to date and in what settings. **(by November 2014)** (ii) LHBs to confirm that safer mental health services toolkit (developed as part of confidential inquiry into homicide and suicide) has been reviewed for relevance to CAMHS services. **(by November 2014)** (iii) DU to assure HBs compliance with WG requirements for risk assessment / risk management of CYP is adhered and progressed further to the national CAMHS audit (2011). To evaluate any learning from the information collected. **(by March 2015)**	LHBs + BB LHBs DU			
11. Parc prison in reach, forensic consistency of provision and FACTs and	Y 11.4 ongoing from March 2013 13.7 by Dec 2013	2 1	(i) Develop MoU/SLA between LHB, G4S and YJB for appropriate in-reach for YOI Parc following receipt of Health Needs Assessment (due March 2014). **(by May 2014)** (ii) LHBs to detail forensic provision available to each YOT, which details people in post, rather than just post details, with a named lead in each LHB. **(by March 2014)**	CTLHB + MH/JP LHBs + MH/JP	2 2	(iv) Scope provision in England for similarities within the secure estate against which to benchmark provision. **(by August 2014)** (v) Establish expert group to consider redesign of forensic services to have integrated community forensic, FACTS and PARC in reach service within CAMHS, and scope need for a specialist planning sub group of the proposed all-Wales CAMHS and ED Planning Group. **(Expert group to meet by May**	JF JF/JP/SH

access to CAMHS by YOTs Risk R/S 1 P 3 4 L x5 Score 20		2	(iii) LHBs to enter into formal agreement with the YOTs in their area (with a particular emphasis on the areas covering YOI Parc and Hillside SCH) setting out expectations, referral pathways, etc. Establish a reporting mechanism, with performance monitoring meetings, for monitoring performance data (e.g. each referral by YJB to CAMHS and how effectively it was responded to (speed and appropriateness of CAMHS response)) and what the outcomes were in terms of mental health needs assessed/identified. This can then be reported on an LHB basis to the CYPFDAG annually to inform future service developments for this client group. **(agreements to be in place across LHBs by March 2015, with first reports to the CYPFDAG by September 2015)**	LHBs + MH/JP	2	**2014 and conclude scoping/produce recommendations by November 2014)** (vi) Produce draft Mental Health Policy Implementation Guidance for Children and Young People in the Criminal Justice System (which explicitly ensures that no child detained under s135/136 of the MH Act should be denied access to CAMHS) for consultation **(by April 2014)** and implementation **(by June 2014)**. Review operation one year from implementation and report outcomes to CYPFDAG **(during 2015)**	MH
12. Provision for deaf children Risk R/S 1 P 1 2 L x2 Score 4	No				1 2	(i) Convene meeting of LHB Deaf children CAMHS leads and NDCS to build and establish networks. **(by March 2014)** (ii) Ask LHBs to report detail on numbers trained and types of training undertaken and report progress to CYPFDAG. **(by November 2014)**	JL JL
13. General issues in consistency in service provision	No	3	(i) Ensure clarity of understanding of roles of WHSSC and LHBs and the ongoing development of national planning arrangements, with agreed network arrangements in place and driving improvements and developments within CAMHS and across partners **(by April 2014)**	WHSSC + DW	3	(iii) Expert group to provide guidance on criteria for access to secondary and tertiary CAMHS, as still too many of the wrong children being seen **(by December 2014)** and ask LHBs to produce action plan to move services to compliance with guidance, matched with resource, accessible to all who have the need and ensuring those that are seen receive	LR/SH

across Wales Risk R/S 1 P 1 2 L x2 Score 4		3	(ii) Du to assess HB systems and processes to meet the governance requirements for the commissioning and delivery of CAMHS. To evaluate any learning from the information collected. **(by September 2014)**	DU		safe, effective services from appropriately trained staff. **(by June 2015)**	

Monitoring Outcomes through a Service User Lens Summary Report on Piloting

Executive Summary

Outcomes from a Service User Lens is a priority project for delivery in the 2012 Welsh Government *Together for Mental Health* (T4MH) strategy and is part of the first phase of the development of a National Mental Health Core Data Set to commence implementation in September 2014. The challenge is to evidence whether the strategy is delivering improved outcomes for people who use mental health services.

Robust outcome evaluation requires multiple assessments of change over time (e.g. improvement, stability or deterioration) using a range of different survey tools, ideally with professional/therapist rated assessments, triangulated with service user/carer self assessments. The latter is the focus of *Outcomes from a Service User Lens,* the aim of the project being to establish an easy to use, reliable method to routinely gather the views of service user and carers of the extent to which the goals they set in their care and treatment planning are being met. Following wide consultation with stakeholders, initiated by service user/carer groups and third sector agencies[1], it was agreed to pilot methodologies using Goal Attainment Scaling (GAS) and Goal Based Outcomes (GBO's). These are evidence based and validated methodologies that have received psychometric evaluation.

This report summarises the learning from piloting throughout 2013-14 which has involved over 500 service users in 21 mental health service settings (e.g. community teams, inpatient wards, supported accommodation units) across 6 Health Boards, 15 Local Authority's and two voluntary agencies. All age groups have been involved in the piloting, excluding very young people.

Piloting indicates that the survey tools are easy to use, positively evaluated by the vast majority of service users as well as most staff who have been involved and the approach can be fairly easily and effectively integrated with Care and Treatment Planning processes required under the Mental Health (Wales) Measure. The tools do not, however, suit all service settings (e.g. people in crisis; people with impaired cognitive ability) or all available treatment options, being particularly suited to the Care and Treatment Planning (and review) process itself and also therapeutic modalities where goals, and the monitoring of goals, are built into the process or intervention themselves, e.g. Cognitive Behavioural Therapy (CBT), Cognitive Analytic Therapy (CAT), and Solution Focused

[1] Members of the Wales Alliance for Mental Health (WAMH) and Mental Health Action Wales (MHAW).

therapies. A flexible approach to national implementation is advised, with an 'impact assessment' which is to commence later in 2014.

This report concludes with a summary of the next steps, including the development and piloting of therapist rated assessment tools drawing on learning from their use in specialist services for Eating Disorders and First Episode Psychosis.

National Policy Context

The Welsh Government 2012 *Together for Mental Health* (T4MH) strategy states the need to 'evaluate individual service user outcomes' from a service user perspective and in doing so play a part in 'measuring the wider effectiveness, quality and outcomes of services'. This is Delivery Plan Key Action 19.2 that states:-

- Welsh Government to work with the third sector, NHS and Local Authorities to develop a set of outcome indicators from a service user lens by Dec 2013.
- Indicators to be tested through selected pilot sites across all ages in 2013 for roll out in 2014.

Care and Treatment Plans (CTP) provide a suitable foundation on which to build monitoring of life outcomes for people using secondary care services the following reasons:

- There is a legal requirement under the Mental Health (Wales) Measure to plan outcomes across one to eight life areas as part of co-producing a Care & Treatment Plan[2] and to review the CTPs at least every 12 months[3].
- For many service users, CTPs will be reviewed more frequently (e.g. every 6 months) and it is expected that every service user will have at least a single CTP review (at discharge).
- The Lincoln University guidance[4] states that CTP outcomes should be 'specific, measurable and achievable, realistic and timely' (SMART). Outcomes set in accordance with these principles should provide a suitable basis for service users' self-assessment of progress, or change over time, or in the case of people with chronic conditions, attainment of stability or quality of life.

[2] Part 2 of the *Mental Health Measure 2010*
[3] Part 7 of the *Mental Health (Care Co-ordination and Care and Treatment Planning) Regulations 2011*
[4] Core Unit 4 of *Excellence in care and treatment planning* (the Lincoln guidance) describes this process in greater detail.

In short, Care and Treatment Planning should already provide a process of SMART outcome setting and review that lends itself readily to a service user self-assessment of those outcomes. The *Outcomes from a Service User Lens* project has sought to establish a simple, but effective way of doing this that is (i) suitable across all age groups and conditions, both acute care and long term chronic conditions, and (ii) easy to use, collate and analyse without generating lots of paperwork and administration. Thus, the aim of the project is to enable service users to monitor and report their perception of the achievement of outcomes agreed in their care and treatment in a way that:-

- Builds on and complements Care and Treatment Plans (CTP) under Part 2 of the Mental Health (Wales) Measure with its focus on the co-production of SMART 'outcomes'.
- Uses an evidenced based, validated survey methodology that is easy to implement, analyse and interpret from the perspective of both the service user/carer and practitioner.
- Allows for comparison between service user self assessments and practitioner/therapist rated assessments so as to enable the future development of a robust system of outcome evaluation.

Monitoring Outcomes

Welsh Government strategy *'Together for Mental Health*' is focused on outcomes. The key question is whether the strategy is delivering improved outcomes for people who use mental health services and also for the wider population in terms of improved mental health and wellbeing. This is ambitious as outcome evaluation is poorly developed in mental health services across the globe. This partly explains the current reliance on 'process' evaluation – on data measures to capture service usage, activity, capacity, etc. These are measures that go to service 'performance', but do not tell us whether the service itself, or intervention, is having the desired or intended effect.

The gold standard for outcome evaluation is randomised, controlled trials (RCT's) which are 'double blind'.[5] RCT's are routinely undertaken on prescribed medications and for other types of treatment interventions, such as psychological therapies, and the evidence is profiled in NICE Guidelines. However, whilst RCT's are considered ethical where the benefits of a treatment or intervention are unknown or unproven, it is unethical to use such methodology in the context of the general

[5] Where an experimental treatment or intervention is tested on a suitable sample of people who are randomly allocated to either the 'treatment group' who receive the experimental treatment, or to a 'control group' who received no treatment (a placebo-controlled study) or a previously tested treatment (a positive-control study). It is 'double blind' if neither the provider of the treatment, nor the recipient, know who is in the 'treatment' or the 'control' group.

provision of health or mental health given the obligation of service providers to help people in need and the rights of people to make choices regarding their care.

For these and other reasons, routine outcome evaluation of health and mental health services focuses largely on monitoring change in a person's status or condition over time, using repeat test assessments. There are many survey tools used for this purpose in mental health services. For example, 69 survey tools were selected for the 2008 NIMHE '*Outcomes Compendium'* from an expert review of 188 tools – selected on the basis of the evidence for their validity, reliability and quality. Some are general assessment tools designed for repeat test assessment of change over time, such as the Health of the Nation Outcome Scale (HONOS) or the Child Global Assessment Scale (CGAS). Others are for assessment of specific clinical conditions, usually as an aid to diagnosis – e.g. Beck Depression Inventory or the Obsessive Compulsive Inventory. Each tool has its strengths and weaknesses and its advocates and opponents. There is no consensus, except that robust outcome evaluation requires multiple assessments using a range of different tools, ideally with both professional/therapist rated assessments, triangulated with service user/carer self assessments. This is the intended direction of travel in the development of the Wales Mental Health Core Data Set (MHCDS) and the plan is to move stepwise towards it.

The selection of tools for assessing outcomes within the MHCDS is, therefore, being approached with wide consultation with stakeholders, starting with the views of service users themselves and the priority within the *Together for Mental Health Strategy* for the setting and monitoring of '*outcomes from a service user lens'*. This priority was established by Welsh Government in response to consultation on the Strategy and the Mental Health (Wales) Measure, where third sector and service user groups asked that service users be enabled to monitor and report their perception of the achievement of outcomes agreed in Care and Treatment Plans (CTP) under Part 2 of the Measure. To this end, the Public Health Wales 1000Lives Improvement Service, the third sector and service user groups have consulted widely and agreed to pilot methodologies using Goal Attainment Scaling (GAS) and Goal Based Outcomes (GBO's).

These are established and validated methodologies that have received psychometric evaluation. *Goal Attainment Scaling* (GAS) was originally developed for use in the evaluation of different community mental health programmes (Kiresuk & Sherman, 1968)[6] but has since been applied across a broad variety of health and social care settings. In order to simplify the process of

[6] Kiresuk, T.J., Sherman, M.R.E. (1968) Goal attainment scaling: A general method for evaluating comprehensive community mental health programs, *Community Mental Health*, 4(6), 443-453. Also Kiresuk, T.J., Smith, A., Cardillo, J.E. (2014) *Goal attainment scaling: Applications, theory and measurement* .

measuring attainment, the *GAS-light* approach has been adapted as described by Turner-Stokes (2009).[7] The GBO is already in use in CORC, the CAMHS Outcome Research Consortium. (Ref Duncan Law 'Goals and Goal Based Outcomes', Sept 2011).[8] They are a way to evaluate progress towards a goal in clinical work with service users, and their families and carers. They simply compare how far a person feels they have moved towards reaching a goal they set at the beginning of an intervention, compared to where they are at the end of an intervention (or after some specified period of input).

The goals should be those that the service user (and/or their family/carers) themselves want to reach from coming to a particular service – not the goals a clinician or practitioner might wish to see them achieve, although along with the co-production of CTP's there is often need for some negotiation. As such, it gives a different perspective to clinical outcome measures and can measure different sorts of change that might not always be captured using only behavioural or symptom based outcome measures. Note that goals are, by their nature, varied and subjective - what is important to measure is the amount of movement towards a goal and not the goal itself.

Piloting the GAS & GBO

The GAS and GBO have been piloted during 2013-14 across the range of secondary care mental health services for children and young people, working age and older adults. The pilots involved over 500 service users and/or their family/carers from 6 of the Health Boards and 15 of the 22 Local Authorities. One voluntary agency (Hafal, Housing Support Services) was also involved in piloting, plus ongoing input and advice from the Mental Health Foundation who use the GAS in routine evaluation of a range of services.

The GBO was selected for piloting in services for children and young people by the CAMHS National Expert Reference Group (NERG)[9], largely on the basis of its current use in CORC for both Specialist CAMHS and local primary CAMHS services with the advantage of using a pre-existing set of forms and guidance designed specifically for CAMHS and validated and tested for reliability in this service setting. The GBO was also selected for piloting in a limited number of adult service sites. The GAS was preferred for piloting in services for all adults and was selected for this purpose at national meetings of the Mental Health Clinical Leaders Group, General Managers Group and at national workshops with service user, carer and third sector agencies. The selection of the GAS was informed

[7] Turner-Stokes, L. (2009) Goal attainment scaling (GAS) in rehabilitation: a practical guide, *Clinical Rehabilitation,* 23 (4), 362-370

[8] Law, D. (2006) Goal Based Outcomes (GBOs): *Some Useful Information*. Internal CORC publication; CORC (CAMHS Outcomes Research Consortium). (2011a) CORC Measures. CORC (CAMHS Outcomes Research Consortium). (2011b) CORC Protocol. Available at: www.corc.uk.net

[9] At the last meeting of the CAMHS NERG in January 2013.

largely on the basis of its ease of use and the strength of the evidence base for this methodology. The pilot versions of both tools are attached. Note that small amendments have been made to these using the feedback from piloting and the final version of the tools for impact assessment from September 2014 will be similar, but not identical. Note that there are versions of the GBO suitable for younger children that were not subject to piloting, but are already routinely used in CORC. [10]

The pilot sites were not meant to be representative, but inclusive of the main service settings across all age groups, excluding very young people. Some 25 service sites were initially identified for piloting by General Managers and Clinical Leaders Groups, of which 21 participated (summarised in Annex 1), providing a range across community mental health teams, acute and continuing care inpatient wards, low secure and rehabilitation services, supported accommodation houses, etc. The sites ranged from small time-limited pilots, such as over 10 weeks involving 10 inpatients of an Older Persons' Psychiatric Ward in Hywel Dda Health Board, to a very large scale pilot involving over 200 service users across four services (adult CMHT and Assertive Outreach Team, and older adult CMHT and inpatient ward) in Cwm Taf Health Board. The latter integrated the GAS pro-forma into the Swift information technology system (electronic patient record system) and the pilot was undertaken alongside monitoring and evaluation of service users experience and satisfaction with Care and Treatment Planning. Some pilots involved members of the multi-disciplinary team across a whole service division, such as in the Abertawe Bro Morgannwg Health Board Rehabilitation services. Others involved clinicians from a single speciality, such as Clinical Psychologists in Aneurin Bevan Health Board CAMHS.

Feedback from the pilots was by way of written report and/or interviews, facilitated regional workshops and focus groups with staff and/or service users. Coordination and monitoring of the pilots was led by PHW 1000Lives Improvement, with support for the pilots in CAMHS from Dr Rhiannon Cobner, Lead for Psychological Therapies, Aneurin Bevan Health Board.

In addition to testing if the approach worked, the feedback specifically sought information on how to improve the tools and support roll out nationally with a focus on:-

- How service users felt about the approach, including their sense of ownership of the monitoring and the goals.
- How professionals felt about the approach, including any added burden of the process, with their recommendations and advice on 'how to' and 'how not to' best use it.

[10] Braille and large print copies of the tools will also be produced for people who are visually impaired.

- Baseline processes for analyzing data returns and meaningfully presenting data to a range of different stakeholders.

Learning from the pilots

Overall, the feedback from the pilots indicate that the survey tools are easy to use, quick to implement, positively evaluated by the vast majority of service users as well as most staff involved in piloting and can be easily and effectively integrated with Care and Treatment Planning processes required under the Mental Health (Wales) Measure. Indeed, many service users reported positively valuing the opportunity to identify their most important CTP goal/s and monitor themselves in their 'achievement', not least people whose goal concerned maintaining their current status or 'stability', e.g. with goals relating to maintenance of their quality of life such as by continuing to live independently at home. Only a small minority of service users declined to participate in the survey, averaging 5% across the pilots where these data were routinely recorded, but with a range up to 14% in some pilot sites, mainly inpatient services for people in crisis or detained under the Mental Health Act.

In terms of its practical application, the following consensus feedback from one staff team is illustrative and typical of the feedback from the pilot sites:-

"Comments regarding the advantages of the tool are as follows:-

- *Quick to implement*
- *Not daunting for service users*
- *Simple to use*
- *One sheet therefore service users are not presented with lots of paperwork*
- *A good way of generating discussion; assists in engaging service users*
- *It captures the service users voice*
- *Good visual tool – one services user reported that they liked the tool as they were able to identify with what was on the tool itself*
- *It keeps the focus on the desired goals of the service user and not necessarily that of the health care professional or service*
- *Empowering, the service user can keep ownership of the tool and could be used by the service user during their Care plan review, Care and Treatment Plan meeting or to present it in Ward Rounds*
- *It helps to highlight deficits in the service*
- *Data collection, to assess if we are meeting service user needs."*

Comments regarding disadvantages:-

- *"As with any pilot, and due to service user's levels of engagement, some participants would decline involvement in this process.*
- *Staff perception of the document on the whole, was that of a positive one, as noted above. However, a staff member did report that they felt the tool was too simplistic and that the comprehensive documentation that is currently being used within their specialised area (the Recovery Star) was of greater value, during their reviews with the service users.*
- *Levels of motivation and engagement by staff members are varied and it was felt by the link people that this was reflected in the participation rate and who did engage."*

Staff/clinician engagement is clearly a major factor and the focus of staff concerns was less about the practicalities of using the tools, than on the 'appropriateness' of their use in specific circumstances where 'goal setting' and/or monitoring are considered neither practicable nor useful, or worse, to be 'contra-indicated' in the therapeutic relationship between practitioner and client – e.g. with the potential to change or negatively impact on therapeutic practice. Indeed, in one atypical pilot, only 15% of people using the service were involved in the pilot, the vast majority being considered by staff as inappropriate for inclusion for various reasons. Thus, the pilots indicate that the tools do not suit all service settings (e.g. people in crisis; people with impaired cognitive ability, people with Autistic Spectrum Disorder and Attention Deficit Disorders) and do not suit all available treatment options, being particularly suited to the Care and Treatment Planning (and review) process itself and also therapeutic modalities where goals, and the monitoring of goals, are built into the process or intervention themselves, e.g. Cognitive Behavioural Therapy (CBT), Cognitive Analytic Therapy (CAT), and Solution Focused therapies.

The key learning from piloting is that the GBO and GAS have been found easy and quick to use as part of CTP where services have received training, supervision and support to facilitate clinicians to develop the skills for developing appropriate, realistic goals with service users, carers/families as part of the delivery of Mental Health Wales Measure CTP. Indeed, the tools should be suitable for any therapeutic process that starts with a joint understanding of what the goals of the intervention are (the destination) before the therapy (the vehicle to get you there) begins, although it is noted above that there are circumstances, therapeutic interactions and relationships where clinicians will consider it inappropriate to use goal setting and monitoring. Future implementation will obviously require flexibility for clinicians to use the tools and approach as they deem appropriate.

Data analysis

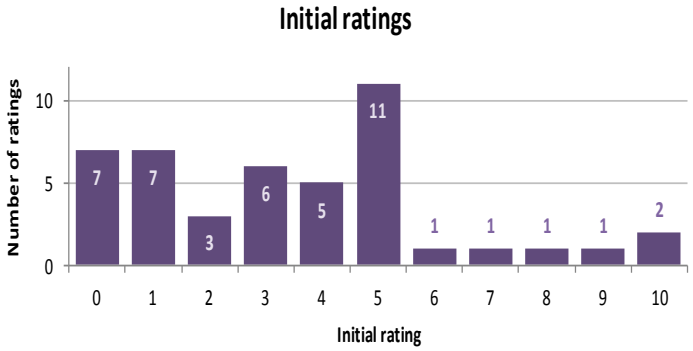
Over 500 service users were involved in the pilots and the collated data analysis indicates that the most important goal/s (at initial assessment -time 1) tended to focus on the following 'life areas' in

descending order of importance (on a basic frequency count):- Accommodation; Work & Occupation; Education and Training; Personal Care & Physical Wellbeing. The latter was the most frequent/important goal for older people, alongside the goal 'to return to my own home' for people in inpatient care. These data, of course, reflect a bias of sampling in that the pilot sites included mostly adult (working age services) and many rehabilitation and supported accommodation services, but they begin to illustrate the potential value of using the data (at clinician or service/team level, as well as locally and nationally) to consider service users' own perceptions of what is most important among the 8 'life areas' of the CTP, as well as the use of the data in clinical supervision and service audit. For example, in focus groups with service users involved in the pilots, a small number reported that their 'most important' goal had not been included in their CTP until they had identified it when first using the GAS. These and other data suggest that the *'Outcomes from a Service User Lens'* project may help support and drive the delivery of Care & Treatment Planning with effective co-production of treatment goals and their monitoring.

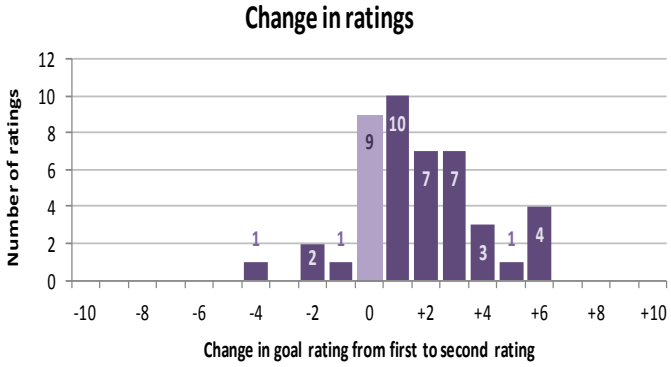
Of more interest are the data from repeat testing (at time 2) from service user self assessment of change over time. The following data from one of the pilot sites is illustrative of the type of collated data analysis possible, in this example using the GBO with young people. The first table below shows their initial rating, for comparison with the second table showing that the majority of the young people reported positive change. Many of the pilots reported similarly positive data.

Of course, these data offer only a partial insight into service 'outcome' evaluation and reinforce the need to develop comparable 'therapist' rated assessment tools to enable us to triangulate the different measures, including other existing data.

Initial Ratings



Change in ratings



Next steps

A flexible approach to national implementation is advised, with an 'impact assessment' which is to commence later in 2014 as part of the wider testing of the first phase the Mental Health Core Data Set. The immediate issue for the development of the MHCDS is to test the capacity and capability of Mental Health Service Information Technology systems, such as to effectively manage the routine data from CTP, including these data from the *'Outcome from s Service User Lens'.* This is a priority for all Health Board Informatics Departments.

Additional piloting in Local Primary Mental Health Services is also planned, the tools being considered suitable for people who receive time-limited interventions - where there is an ongoing therapeutic process, not just a one-off intervention.

Learning from piloting of the *'Outcome Lens'* has been recorded to inform the production of guidance on methods for roll out and the training implications. A 'How to Guide' is now in preparation to support baseline training for further testing and implementation of these tools after summer. The Guide will reinforce the need for flexibility in the use of the GBO and GAS, with practical advice to clinicians to use their judgement on when to introduce the tools; when to review; how to help identify realistic and achievable goals and how to manage 'changing' goals, etc.

Assuming effective implementation of '*Outcomes for a Service User Lens'* which will require clinician engagement and ownership, the next priority is to develop comparable 'clinician/therapist' rated assessment tools. This is a challenge of a different order as there no agreement among clinicians or different professional groups as to the most appropriate assessment tool/s to use nationally. Progress has been made with CAMHS, but an agreement to a limited range of tools reached in 2013 lost momentum and ownership with the dissolution of the CAMHS NERG. However, progress is being made in specialist service areas, with agreement to standardise nationally on a small number of service user and clinician/therapist rated assessment tools for outcome monitoring and evaluation of services for Eating Disorders and First Episode Psychosis. These evaluations are currently ongoing as part of the impact evaluation of the 1000Lives 'intelligent targets' for these services.

Finally, it is noted that the GBO or GAS were piloted in services for people with a Learning Disability and were only partially successful, with some major limitations. PHW is, therefore, currently supporting a pilot evaluation (in ABUHB) of the NDTi Health Equalities Framework (HEF) as the preferred approach to outcome evaluation in Learning Disability services.

ANNEX 1 - Pilot sites

A number of the pilot 'sites' incorporate a number of different discrete services across a range of localities.

Older People's Mental Health – GAS pilots

1. HDUHB – Inpatient ward. With this client group the ability to highlight their own needs is often severely compromised and it was therefore agreed that families, Carers and Community Practice Nurse (CPNs) would need to contribute to identifying the patient's wishes.
2. CTUHB – Older Person's inpatient ward
3. CTUHB Community Mental Health Teams

Adult Mental Health – GAS pilots - some GBO pilots

ABMUHB – Rehabilitation services – Piloting alongside 'The Recovery Star'

4. Locked ward
5. Low Secure ward
6. Women's Rehab ward
7. Mixed rehab ward
8. Mixed community Rehab unit
9. Step down house 1
10. Step down House 2
11. Criminal Justice Liaison Service.

CTUHB

12. Community Mental Health Team
13. Assertive Outreach Team.

14. C&VUHB – Community Mental Health Team
15. Voluntary sector – Mental health Foundation
16. Voluntary sector – Hafal Housing Support/recovery services

CAMHS – GBO pilots with young people and not the 'child friendly' version for very young people.

17. ABUHB – Pilot project registered with R&D Dept and undertaken as formal evaluation involving staff in Clinical Psychology dept (Child & Clinical Psychologists, Systemic Family Therapists) with small numbers of young people whom they expected to at least see twice during 6 week period, with administration of GBO at two or more time points. Practitioner and service user feedback collected at time point 2 on their experience of using the GBO.

18. CTUHB – Commenced pilot using ABUHB methodology, but feedback workshop undertaken before time point 2.

19. HDUHB - Commenced pilot using ABUHB methodology, but feedback workshop undertaken before time point 2.

Learning Disability – GAS pilots

20. BCUHB Community Learning Disability Team

21. ABUHB Community Learning Disability Team