Working Together Toward Common Goals: Outcome Measurement in Wales

Executive Summary

An all Wales framework for the routine use of outcome tools in mental health and learning disability services has been developed.

Improvement in my well-being

Being able to set, agree and achieve my own goals/outcomes

My experience and satisfaction

Tools have been placed in three clusters. It is expected that all practitioners will use outcome tools in their day-to-day practice with service users. A multidisciplinary, multi-sector implementation group will work with all sectors to develop the processes that will support practitioners, service users and as appropriate, family members and carers in the use of tools across services.

Introduction

Much of the conversation in mental health and learning disability services over the last 20 years has been about how we improve and demonstrate outcomes for people receiving those services[1].

What's important to service users, families and carers is at the core of Together for Mental Health[2] (T4MH), the Welsh Government's 10 year cross-sector strategy for improving mental health services in Wales. Services should offer timely, evidence-based interventions that are proportionate and do no harm[3]. Service user experiences of care, the development of consistent data across Wales, as well as improvements in the delivery of psychological therapies are all emphasised within the T4MH delivery plan[4]. See Annex 1.

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[1] http://www.wales.nhs.uk/publications/greenpaper98_e.pdf
[2] https://gov.wales/docs/dhss/publications/121031tmhfinalen.pdf
[3] http://www.wales.nhs.uk/sitesplus/documents/866/PHW%20Prudent%20Healthcare%20Booklet%20Final%20English.pdf
[4] https://gov.wales/topics/health/nhswales/plans/mental-health/?lang=en

Clear processes, procedures and associated assurance are essential to the provision of quality services. However, an understanding of their impact is also needed. There is a growing demand from those who receive services, practitioners and researchers for a change of focus towards achieving agreed, meaningful and demonstrable outcomes.

This includes ensuring that individuals have a voice about what matters to them, an emphasis on strengths and assets and the setting of goals using a co-productive approach. It also involves ensuring that families and wider communities are involved in conversations about care and support as appropriate, as well as the need to be transparent about risk and safety planning[5].

Any proposed changes to practice must also sit firmly in the context of the Parliamentary Review of Health and Social Care in Wales[6] - the quadruple aim, one of which is to:

- "Improve the experience and quality of care for individuals and families" and the Welsh Government's response: A Healthier Wales[7], which states:

- "When people need help, health and social care services will work with them and their loved ones to find out what is best for them and agree how to make those things happen. We call this a 'person-centred approach'."

The introduction of Welsh Community Care Information System (WCCIS)[8] offers a unique opportunity for Wales to collect robust, useful quantitative and qualitative information. It is also a way of supporting staff delivering services to use technology to discuss and record individual goals and outcomes, in a more consistent manner.

Context

There are three main reasons for using outcome tools and gaining service user feedback:

- It is what people, families and carers, who use services want

- To support the provision of outcome-focused interventions

- To ensure we continue to have appropriate services[9].

[5] https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr04050#/hometab0
[6] http://gov.wales/docs/dhss/publications/180116reviewen.pdf
[7] https://gov.wales/docs/dhss/publications/180611ltp-inbriefen.pdf
[8] http://www.wales.nhs.uk/nwis/page/66175
[9]https://www.researchgate.net/publication/277870071_Guide_to_using_outcomes_and_feedback_tools_with_children_young_people_and_families?enrichId=rgreq-220dd391f76c401d98d3354fda5f79b3-XXX&enrichSource=Y292ZXJQYWdlOzI3Nzg3MDA3MTtBUzoyMzgwMzQ1ODMwMjc3MTJAMTQzMzc2MzI3NTE0MQ%3D%3D&el=1_x_2&_esc=publicationCoverPdf

It also supports:

- practitioners to work with service users to jointly develop shared goals/outcomes
- practitioners to reflect on whether interventions are having the desired impact and whether they need to change
- discussions in relation to the achievement of goals/outcomes
- decisions about when to end involvement.

> **The development of shared goals and the measurement of progress towards attaining these outcomes contributes to a greater sense of achieving what matters to people and assists the therapeutic alliance.**

Legislation in Wales supports reflective, person-centred practice. The explanatory memorandum[10] to the Mental Health (Wales) Measure 2010 (the Measure)[11] makes clear that benefits will consist of:

- improved experience for service users, their families and carers[12] [13]
- improved involvement of service users in decision making around their care and treatment.

The Social Services and Well-being (Wales) Act 2014 and the associated Social Services National Outcomes Framework[14] mandates the routine use of outcome tools in all care and support plans and support plans for carers. Two of its key objectives are:

- to describe the important national well-being outcomes that people who need care and support and carers who need support should expect in order to lead fulfilled lives
- to provide greater transparency on whether services are improving well-being outcomes for people who need care and support and carers who need support in Wales using consistent and comparable indicators.

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[10] Explanatory memorandum to the Measure can be found at http://www.assemblywales.org/bus-home/bus-guide-docs-pub/bus-business-documents/bus-business-documents-doc-laid.htm?act=dis&id=173836&ds=3/2010

[11] http://www.legislation.gov.uk/mwa/2010/7/contents

[12] The Mental Health (Wales) Measure 2010 Policy Implementation Guidance on 'Local Primary Mental Health Support Services' and 'Secondary Mental Health Services' states: 'the intended effects of Part 1 (local primary mental health support services (LPMHSS)) of the Measure include providing consistency in primary mental health services across Wales and earlier access to mental health services …earlier intervention and treatment will lead to both an improved experience and better clinical outcomes…. Part 2 is designed to enable greater involvement of service users in decision-making around their care and treatment, and better outcomes for those individuals'.

[13] https://gov.wales/docs/dhss/publications/120322measureen.pdf

[14] https://gov.wales/docs/dhss/publications/171219frameworken.pdf

Matrics Cymru, Guidance for Delivering Evidence-Based Psychological Therapy in Wales[15] and the Wales Psychological Therapies Plan for the delivery of Matrics Cymru – The National Plan 2018[16], supports the provision of psychological therapies and the routine use of outcome tools. The need for other therapeutic interventions, as well as the safe and appropriate prescribing of medication, remain crucial treatment options for those with mental health problems. All interventions must be clearly associated with outcomes that matter to those receiving services. The emergence of support delivered by non-traditional roles also presents an opportunity to expand our understanding about care approaches that lead to the attainment of goals.

The Welsh Government's review of learning disability services – 'Improving Lives'[17] also has an emphasis on improving outcomes and focuses on what matters to people. Health boards in Wales are implementing the learning disability health equalities framework[18], but more needs to be done to support conversations about individual and family/carer goals and priorities.

Good practice, national and local research supports and encourages the routine use of outcome tools in day to day practice. The Public Health Wales, 1000 Lives Improvement Service pilot 'Through a Service User Lens' reported their findings in 2015, having consulted with over 500 service users of all ages in 21 mental health service settings (e.g. community teams, inpatient wards, supported accommodation units) across six health boards, 15 local authorities and two voluntary agencies. Details can be found at Annex 2.

In 2017, a survey asked mental health and learning disability services across Wales what 'scored outcome assessment tools' they were using. Details can be found in Annex 3.

The survey established that whilst the use of outcome tools was widespread in some sectors, there was no systematic approach to their consistent use across settings.

The views of service users, carers, practitioners, the third sector and research[19], together with the results of the survey have informed the development of a framework for Wales to improve the routine collection of outcome information.

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[15] http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Matrics%20Cymru%20%28CM%20design%20-%20DRAFT%2015%29.pdf
[16] http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/2018-05-16%20National%20Plan%20for%20Delivery%20of%20Matrics%20Cymru.pdf
[17] https://gov.wales/topics/health/professionals/nursing/learning/
[18] http://www.1000livesplus.wales.nhs.uk/learning-disabilities
[19] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30162-7/fulltext

Black, N. (2013) Patient reported outcome measures could help transform healthcare
BMJ 2013; 346 doi: https://doi.org/10.1136/bmj.f167

A framework for Wales

The infographic below describes the framework proposed for the use of evidence-based outcome tools in practice. There are three clusters into which the agreed outcome tools have been placed. All tools are free, available in Welsh and can be used in paper and electronic versions.

| Improvement in my well-being | Being able to set, agree and achieve my own goals/outcomes | My experience and satisfaction |

It is expected that all practitioners will use outcome measurement in their day to day practice with service users from the suite of tools. Consideration will be given to any new or emerging evidence based tools. Teams will be supported by a multidisciplinary working group, to review their current use of outcome measures and to consider how the model fits within existing practices and policies. The intention is to support practitioners in their day to day practice, without additional inappropriate administrative burden. The goal is to move towards outcome measurement being routine practice in Wales over time. An implementation plan will be developed over the next 12 months through seven pilot sites across a range of services.

Clark, D., Canvin, L, Green, J., Layard, R., Pilling, S. Janecka, M. (2017) Transparency about the outcomes of mental health services The Lancet, 391

Lambert, Dave A. Vermeersch, Kärstin L. Slade & Kenneth C. Tuttle (2006) The therapeutic effects of providing patient progress information to therapists and patients, Psychotherapy Research, 14:3, 308-327, DOI: 10.1093/ptr/kph027

Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta-analysis. Clinical Psychology: Science and Practice, 10(3), 288-301. doi:10.1093/clipsy/bpg025

Michael J. Lambert, Jason L. Whipple, David W. Smart, David A. Vermeersch, Stevan Lars Nielsen & Eric J. Hawkins (2010) The Effects of Providing Therapists With Feedback on Patient Progress During Psychotherapy: Are Outcomes Enhanced?, Psychotherapy Research, 11:1, 49-68, DOI: 10.1080/713663852

These pilots will develop a quality improvement process that can be replicated and adapted for local use in all services. There are three central tenants:

- To review current process for recording interventions and outcomes with a view to reducing current administrative burden
- Ensuring teams develop a 'solution focussed'[20] approach, both for those receiving services and those delivering them
- Implement a compassionate care approach to team working and organisational support.

Organisations will also be supported to identify which teams are most 'ready'[21] to develop and what they will need to do in order to enable other teams to be able to make the changes needed.

The rationale for the tools selected can be found at Annex 4. Practitioners should continue to use symptom reduction/improving function tools as clinically indicated. This will be of particular importance and relevance in some areas of practice and will clearly support the recovery process.

Improvement in my well-being cluster

This cluster contains the following tools.

For **adults** (working age and older)
Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM)
Recovering Quality of Life (ReQoL)
Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

For **children and young people**
Strengths and Difficulties Questionnaire (SDQ)
Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)

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[20] To ensure that if anticipated recovery/discovery is not progressing as planned, that there is a process of supportive review – this may include, for example – peer support, supervision, multidisciplinary discussion, psychological re-formulation, family meeting – in all cases, it is essential that no one is perceived to have failed but rather a different or amended approach is needed.
[21] R=MC² https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676714/ or similar methodology will be discussed

While individual items (question/statement) within these tools overlap considerably, particularly in the shorter versions, overall they offer sufficient conceptual diversity to allow practitioners a meaningful choice of tools most appropriate to their setting and users.

It is recognised that some services may already be using the Euro Quality of Life – 5 Dimensions (**EQ-5D)[22]** as a measure of quality of life. Though not specifically designed with mental health in mind, it can be substituted for ReQoL where it is already routinely used. Services deciding to use this, or other outcome tools, would need to demonstrate their efficacy for the particular setting or service area to both the service user and their health board management and agree its use.

Being able to set my own goals/aspirations

This cluster contains the following tools.

For **adults** (working age and older)
Goal Attainment Scaling (GAS)
Goal Based Outcomes (GBOs)
Recovery Star
Social Services and Well-being Care and Support Plan 10-point Scale

For **children and young people**
Goal Based Outcomes (GBOs)
Social Services and Well-being Care and Support Plan 10-point Scale

In many services, the setting of goals/aspirations will be an integral part of a care plan[23]. It is expected the use of such tools should be integrated within the care planning process.

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[22] https://euroqol.org

[23] This could be a care and treatment plan as prescribed under the Mental Health (Wales) Measure 2010 or that described in the Social Services and Well-being Act 2014. Individual clinicians may also have intervention specific goals

My experience and satisfaction

The NHS Wales Framework for Assuring Service User Experience[24] has recently been updated and provides a minimal standard that services should already be meeting to assess and respond to service users' experiences. Mental health services and the circumstances in which people come into contact with them may provide specific challenges to assessing their experience appropriately and context-specific tools (which may build on the framework tool), may be used to routinely inform service evaluation and development.

Social services - measuring well-being

The well-being of people who need care and support and carers who need support is measured at a national level by the national outcomes framework for social services. This contains national outcome measures that provide evidence on whether care and support services are improving well-being outcomes for people in Wales.

The contribution of services towards improving well-being outcomes is measured in a performance measurement framework. The code of practice in relation to measuring social services performance, issued under section 145 of the Social Services and Well-being (Wales) Act 2014, requires local authorities to annually collect qualitative information about people who use their social care services.

The qualitative data is collected locally through a satisfaction survey using national questions set by Welsh Government in relation to the provision of care and support. This enables local authorities to engage with all adults, children, carers and parents who are receiving services. People are asked about their experience of social services and whether this has contributed to improving their well-being.

The information collected through the survey helps local authorities to identify areas of improvement and good practice, providing an understanding of the difference care and support has made to people's well-being.

For **children and young people**, following consultation with practitioners, it is recommended the patient experience tool - Experience of Service Questionnaire (ESQ; formerly the CHI-ESQ) is used. There are three versions – (i) parent/carer (ii) self-report 9-11 years (iii) self-report 12 to 18 years[25].

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[24] https://gov.wales/topics/health/nhswales/circulars/quality/?lang=en
[25] https://www.corc.uk.net/outcome-experience-measures/experience-of-service-questionnaire

Learning disability services

A consensus was reached in late-2017 to adopt the Health Equalities Framework (HEF) tool across learning disability services in Wales. The HEF is a practitioner-rated tool that describes the impact of various determinants of learning disability relevant health inequalities on an individual's life. Reducing the scored impact in one of the items of the HEF indicates a reduction in adverse health inequalities for that individual.

The HEF provides an important starting point to allow services to better understand the impact that their interventions are having on addressing the determinants of poor outcomes for people with a learning disability. However, it is recognised that it should be accompanied by service users' own ratings of their outcomes and experiences.

Many learning disability services already use tools that capture such information including the learning disability variation of CORE-OM (CORE-LD), Glasgow Depression and Anxiety Scale and the Psychological Therapies Outcome Scale (PTOS).

Recommendations

It is recommended that the proposed framework is adopted in all mental health and learning disability services in Wales. Initial views about how the framework will be implemented have been sought - see Annex 5. A multidisciplinary, multi-sector implementation group should work with all sectors to develop processes that support implementation across services.

Annex 1

The Together for Mental Health delivery plan includes the following actions:

4.3 To ensure that service users/carers feel listened to and are fully involved in decisions about their own/family member's care by:

- improving the quality of outcome based care and treatment plans
- undertaking satisfaction surveys.

8.3 To ensure people with an identified mental health problem are able to have timely access to a range of evidence-based psychological therapies by:

- improving access in line with National Psychological Therapies Management Committee's national action plan.

9.4 To increase the availability of recovery oriented mental health services by:

- Public Health Wales, 1000 Lives Improvement establishing recovery training incorporating service user and carer views, to improve recovery-focused services and outcomes within care and treatment plans.

11.2 To progress the development and implementation of a national mental health core dataset capturing service user outcomes by:

- developing new measures for recording service need and monitoring service outcomes
- NHS Wales Informatics Service (NWIS) supporting the implementation of the Welsh Community Care Informatics System (WCCIS).

Annex 2

The Northern Ireland Bamford review[26] recommendations about mental health and learning disability services identified the need to undertake five research reviews, one of which was concerned with patient outcomes including the measurement of recovery and the capture of patient feedback.

'A detailed review was undertaken of current available evidence on capturing process and outcome data from service users and feeding this information back to inform treatment planning. Although a wide range of gaps in scientific knowledge were identified, the overall weight of evidence tended to be favourable and further research using measures to improve service user outcomes in the context of the recovery oriented approach, was recommended.

Four principles and four policy implications emerged from the analysis; of the reviewed literature of relevance to this discussion were:

- Each person who uses mental health services should assess routinely the experience of personal recovery in order to identify how much they are experiencing recovery and associated outcomes, such as social inclusion and well-being

- The recovery orientation of the mental health service, as judged by the service user, should be assessed routinely and this information should be used to inform action planning with the individual, as well as local, regional and national service developments

- Routine collection of recovery outcome data will not happen unless politically prioritised and adequately resourced, and implementation needs to be informed by approaches used in other countries

- Developing a recovery orientation involves organisational transformation. Any introduction of routine use of recovery measures should follow from that transformation, rather than being an end in itself'.

The Guide to Using Outcomes and Feedback Tools with Children, Young People and Families[27] states there are three main reasons for using outcome tools and gaining service user feedback:

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[26] http://www.publichealth.hscni.net/sites/default/files/Patient%20Outcomes.pdf
[27] https://www.researchgate.net/publication/277870071_Guide_to_using_outcomes_and_feedback_tools_with_children_young_people_and_families?enrichId=rgreq-220dd391f76c401d98d3354fda5f79b3-XXX&enrichSource=Y292ZXJQYWdlOzI3Nzg3MDA3MTtBUzoyMzgwMzQ1ODMwMjc3MTJAMTQzMzc2MzI3NTE0MQ%3D%3D&el=1_x_2&_esc=publicationCoverPdf

- It is what people, families and carers, who use services, want[28]

- To provide better therapy[29]

- To ensure we continue to have appropriate services[30].

In 2015, Public Health Wales, 1000 Lives Improvement reported on their findings, having consulted widely and agreeing to pilot methodologies using Goal Attainment Scaling and Goal Based Outcomes (through a Service User Lens).

Goal Attainment Scaling (GAS) was developed for use in community mental health services[31], but has since been applied across a wide range of physical and mental health settings across many countries[32]. GAS involves establishing the service user's expectations of achieving their goal and then later asking them to compare their achievement with those expectations. An example is care and treatment planning used in secondary mental health services.

Goal Based Outcomes (GBOs) was developed by members of the Child and Adolescent Mental Health Services (CAMHS) Outcome Research Consortium (CORC) based on existing ideas and techniques[33]. It is now used with children and young people by CORC members across a number of countries and settings and in Children and Young People Improving Access in Psychological Therapies (CYP IAPT) services in England.

GBOs involve repeated measurement of how close the service user feels they are towards reaching their goal and considering the change over time.

The goals should be those that the service user (or their family or 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 in the co-production of care and treatment plans, there is often need for some negotiation).

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[28] 'Young service users, and carers … want their voice heard in intervention decisions, and therapy, and to collaborate in service development. They see the use of feedback and outcomes tools as an important aspect of this process (Badham, 2011)'. Pg. 42

[29] 'One important reason for using outcome measures must be to improve the relationship between service users and therapists and, in turn, to enhance clinical practice'. Pg. 43

[30] 'evidence that the services …. provide good value and are effective, and supervisors and managers have encouraged practitioners to produce more objective information to evidence their practice. Measures are also helpful in guiding us to ensure the level of service provided matches with the severity of the client's problems. The question of whether to monitor outcomes, or not, is no longer in debate.' Pg. 44

[31] 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

[32] Kiresuk, T.J., Smith, A., Cardillo, J.E. (2014) *Goal attainment scaling: Applications, theory and measurement*

[33] Law, D. (2013) *Goals and Goal Based Outcomes – Some Useful Information*

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 functional, 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.
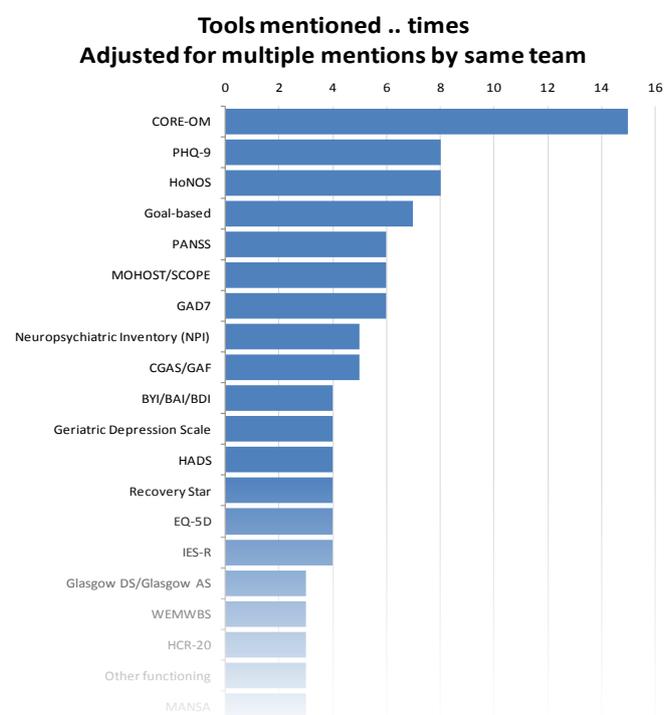
GAS and GBO were piloted widely during 2013-14 across the range of mental health services for children and young people, working age and older adults, including primary mental health service settings. They have been found easy to use as part of care and treatment planning where services have received training, supervision and support to facilitate practitioners to develop the skills for developing appropriate, realistic goals with service users, carers/families, as part of the delivery of care and treatment planning. Indeed, these tools are 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. They are particularly suited to therapeutic modalities where goals and the monitoring of goals are built into the intervention themselves.

Annex 3

A survey was done in mid-2017 of mental health and learning disability services across Wales, asking what 'scored outcome assessment tools' were being used. In order to make the information more useful, responses were grouped both into different families of tools (for example, the various CORE-OM tools were grouped together, the various Beck Inventories were grouped together) and teams were de-duplicated where they were involved in providing multiple services (for example, psychological therapies delivering interventions across multiple settings).

This was done as consistently as possible in order to provide a meaningful snapshot of the prevalence of different tools' in use across Wales.

Roughly 100-150 different 'families' of scored outcome assessment tools were found to be in use and around 400 instances of a particular team using a particular tool. Fewer than 35 families of tools were mentioned more than twice; many tools were reported as being used only by one or two teams. The tools in use were heavily, but far from entirely symptom-severity focused and psychologists were perhaps disproportionately represented amongst respondents (although the reported use of tools by registered mental health nurses and occupational therapists was nevertheless substantial).

Tools mentioned .. times
Adjusted for multiple mentions by same team

Tool	
CORE-OM	15
PHQ-9	8
HoNOS	8
Goal-based	7
PANSS	6
MOHOST/SCOPE	6
GAD7	6
Neuropsychiatric Inventory (NPI)	5
CGAS/GAF	5
BYI/BAI/BDI	4
Geriatric Depression Scale	4
HADS	4
Recovery Star	4
EQ-5D	4
IES-R	4
Glasgow DS/Glasgow AS	3
WEMWBS	3
HCR-20	3
Other functioning	3
MANSA	3

There was a mix of patient-reported tools (e.g. CORE-OM) and clinician-scored tools (e.g. CGAS).

There were a number of areas where the survey failed to give a thorough picture of the use of outcome tools across Wales. For example, certain tools are mandated by the Royal College of Psychiatrists (RCPsych) ECT Accreditation Scheme (ECTAS)[34], but only one health board reported their use, responses were only received from four out of seven of the Local Primary Mental Health Support Services and only a single response

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[34]https://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualitynetworks/ectclinics/ectas/ectassta ndards.aspx

from a specialist Child and Adolescent Mental Health Services (CAMHS). Nevertheless, the survey has provided insight into the diversity of tools used in mental health services, particularly working-age adult services and into the existence of a small number of tools with a substantial user base.

The table below gives selected families of tools in use across multiple teams. In particular, multiple health boards and suggests some of the possible drivers for their spread:

Tools	Possible drivers
Impact of Events Scale IES-R, PTSD Checklist PCL-5, AUDIT	Used by Veterans NHS Wales - a national service, but embedded across health boards
Positive and Negative Syndrome Scale PANSS, MANSA, LUNSERS	Driven by the First Episode Psychosis 1000 Lives Improvement Steering Group and the FEP Research Development Group
EDE-Q	Driven by the Eating Disorders Clinical Network and ED Research Development Group
GAD-7, PHQ-9	Free, widespread use outside of mental health services (e.g. screening for anxiety and depression in primary care), in *Depression & Anxiety* ICHOM set
CORE-OM	Free, endorsed by a number by RCPsych in a number of contexts (OP78, OP86, FR/MP/01), embedded in several psychology services
EQ-5D	Widely used as a measure of quality of life, both operationally and in health technology appraisal (for the calculation of QALYs). Used in the NHS Wales PROMs, PREMs and Effectiveness programmes, in the context of physical health interventions and in several ICHOM sets
HoNOS	Promoted by Department of Health in England and now strongly linked with England's clinician-led 'clustering' of individuals' expected resource usage (the survey found it used disproportionately, but not exclusively, in secure settings and learning disability services in Wales)

Tools	Possible drivers
MOHOST/SCOPE	Widespread use in occupational therapy, integrated with Model of Human Occupation (MOHO)

Various forms of explicitly goal-based measurement were also reported by several services, including GAS and GBOs. The Recovery Star was separated from these in the analysis, but it too emphasises the setting of personal goals and measuring progress towards them. It is recognised that care and support plans (prepared in the context of local authority-provided services) now include scoring of distance-from for personal outcomes.

Annex 4

It is suggested that a choice of patient-reported measures concerned with broad concepts of distress, well-being or quality of life should be promoted across adult services, with the aim of spreading a more consistent approach to outcome measurement.

These tools should ideally be free-to-use, impose very little burden to complete and have recognised utility for detecting meaningful change in the diverse populations that use these services. Existing use in multiple services in Wales and elsewhere, would be one of the best indicators of such minimal burden and sufficient utility.

These broad, common measures would form a base on which services should select additional tools more specific to the presenting problems, interventions and other factors relevant to the service and its users.

Improvement in my well-being

For adults (working age and older), the tools suggested are listed below, a summary of some pertinent features is provided:

CORE-OM	REQOL	WEMWBS
10 or 34 items	10 or 20 items	7 or 14 items
Psychological distress	Quality of life	Mental well-being
Freely available under Creative Commons license	Free to license for NHS-funded healthcare	Free to use with registration
Existing Welsh translation	Translation agreed (in principle)	Existing Welsh translation
	Recovery-consistent	All positive statements
Recommended for use in RCPsych OP78, OP86 in psychological therapy	QALY-compatible (developed as mental health appropriate alternative to EQ-5D)	Used for population data in the Survey for Wales

SDQ	WEMWBS
25 items	7 or 14 items
Impact of difficulties	Mental well-being
Paper versions available without charge	Free to use with registration
Existing Welsh translation	Existing Welsh translation
Informant versions available	All positive statements
Widely used	Used for population data in the Survey for Wales

Being able to set my own goals/outcomes

It is also suggested that in relevant services a goal-based measurement tool is used. These include: GAS, GBOs, Recovery Star and SSW CSP 10-point scale.

GAS	GBOS
Progress compared to expectation	Progress towards goal over time
Light adaptations available	Very simple
Recovery Star	**SSW CSP** scale is very similar

Annex 5

Implementation.

Changing and supporting the working relationship between clinician and service user.

A multi-professional focus group has considered how to make the use of outcome measures part of day to day practice.

IMPLEMENTATION IDEAS
• Emphasis on the centrality of the work to the therapeutic relationship • A broad national implementation structure may be needed to support health boards to introduce a new way of working • May need different approaches in different areas but must have a plan with timescales • Developing a team approach to implementation with local innovation • Tools must be useful for individual clinical use • No aggregated data collection in year 1 - demonstrating the value to the therapeutic process and to service users is the priority, but ensuring the gathering of feedback from practitioners • Opportunities for re-formulation'/new ideas.

Some options for implementation

Option 1

Health boards devise their own plans for introducing the routine use of outcome tools in all sectors and are not required to share plans for implementation

Pros	Cons
Health boards are able to create bespoke plans that fit with their understanding of existing services	May not implement or may implement without consistency
Health boards 'own' the process	May lead to significant inconsistency in use across Wales

	Time and financial resource would not be a requirement to enable implementation	May lead to a lag time resulting from a non-directive implementation approach slowing the pace of change
	Potential skill deficits in the use of tools may not be addressed

Option 2

Health boards devise their own plans for a phased approach to introducing the routine use of outcome tools in all sectors and are required to share plans for implementation

Pros	Cons
Health boards able to create bespoke plans that fit with their understanding of existing services	May not implement or implement without consistency
Health boards 'own' the process	May lead to significant inconsistency in use across Wales
Monitoring is enabled via sharing of implementation plans, milestones etc.	Potential skill deficits in the use of tools may not be addressed
Time and financial resource would not be a requirement to enable implementation	

Option 3

Health boards are provided with a template to self-assess current use of outcome tools across services. Guidelines and templates are developed centrally to support health boards to introduce outcome tools in individual services. These would be co-produced with teams across Wales.

Pros	Cons
This approach may lead to a more structured approach to implementation identifying existing good practice and current gaps	Self-assessment may lead to an inconsistent approach, making the potential to eventually use aggregate data for benchmark purposes more challenging

Guidelines and templates may assist more consistent application of tools throughout Wales	Potential skill deficits in the use of tools may not be addressed
	Would require capacity to develop guidelines and templates

A national implementation plan/process developed for local adaptation to support consistency of approach and equity of service provision. Guidelines/templates are developed centrally to support health boards to introduce outcome tools in individual services. These would be co-produced with teams across Wales. It will offer guidance for training and implementation.

Pros	Cons
A structured approach to implementation would be assisted	Would require capacity to develop guidance and training
Guidance may assist a consistent application of tools throughout Wales	Financial investment would be required to develop a training and dissemination process
Potential skills deficits would be addressed by training programme	Services may be resistant to centrally directed approach