Using Clinical Outcomes for Service Improvement
A guide for Outcomes-Based Commissioning

Version 2.0 revised and updated February 2020

Clinical Outcomes and Service Improvement
Why clinical outcomes?

This document gives information about *clinical* outcomes.

It will help you think about what is meaningful and realistic in outcomes-based commissioning.

Why should I look at clinical outcomes?

National KPIs currently focus on access and waiting times but these are only important if people are being seen effectively. Figures about activity and outputs of services allow you to see what a service is doing to some extent, but they do not tell you about the **difference** they are making for the people using them or the **quality** of the service. Clinical Outcomes help measure quality.

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

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

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

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

Encouraging use of outcome measures in provider services also:

- Enables CYP and families to have their views heard more effectively.
- Keeps services accountable and efficient.
- Flags up areas of excellence and for improvement.
- Provides an opportunity to celebrate success.
- Providers can use as evidence to promote services (when tendering).
- Can guide commissioning, service improvement and delivery.

Incorporating outcomes into KPIs & CQUINs

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

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

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

Clinical Outcomes and Service Improvement
National policies and initiatives

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

The Five Year Forward View For Mental Health

The Five Year Forward View for Mental Health includes the need to:

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

Future in Mind (FiM) (2015) also emphasised the focus on clinical usefulness, as well as the importance of clinical outcomes for service improvement. From April 2020 there will be national reporting of CYPMH outcomes via NHS Digital.

Long Term Plan

The NHS Long Term Plan has far reaching commitments to continuing to expand and improve the quality and outcomes of CYPMH services, building on FYFVMH and FiM, with significant investment. This includes:

- Expanding eating disorder provision.
- Developing a comprehensive offer up to the age of 25 years.
- Access to crisis services.
- Mental health support embedded in schools and colleges.
- Ensuring people with learning disability and autism get better support.

Mental Health Services Data Set (MHSDS)

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

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

Local Transformation Plans for CYPMH and Wellbeing

Local Transformation Plans 2015-2020 should demonstrated commitments to:

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

Care Quality Commission (CQC)

The CQC uses data (including national datasets) to monitor services and looks at whether care, treatment and support are **effective**, that staff involve and treat people with **kindness and respect**, and that services are meeting **people's needs** (amongst other areas). Outcome and feedback tools can help to demonstrate these areas.
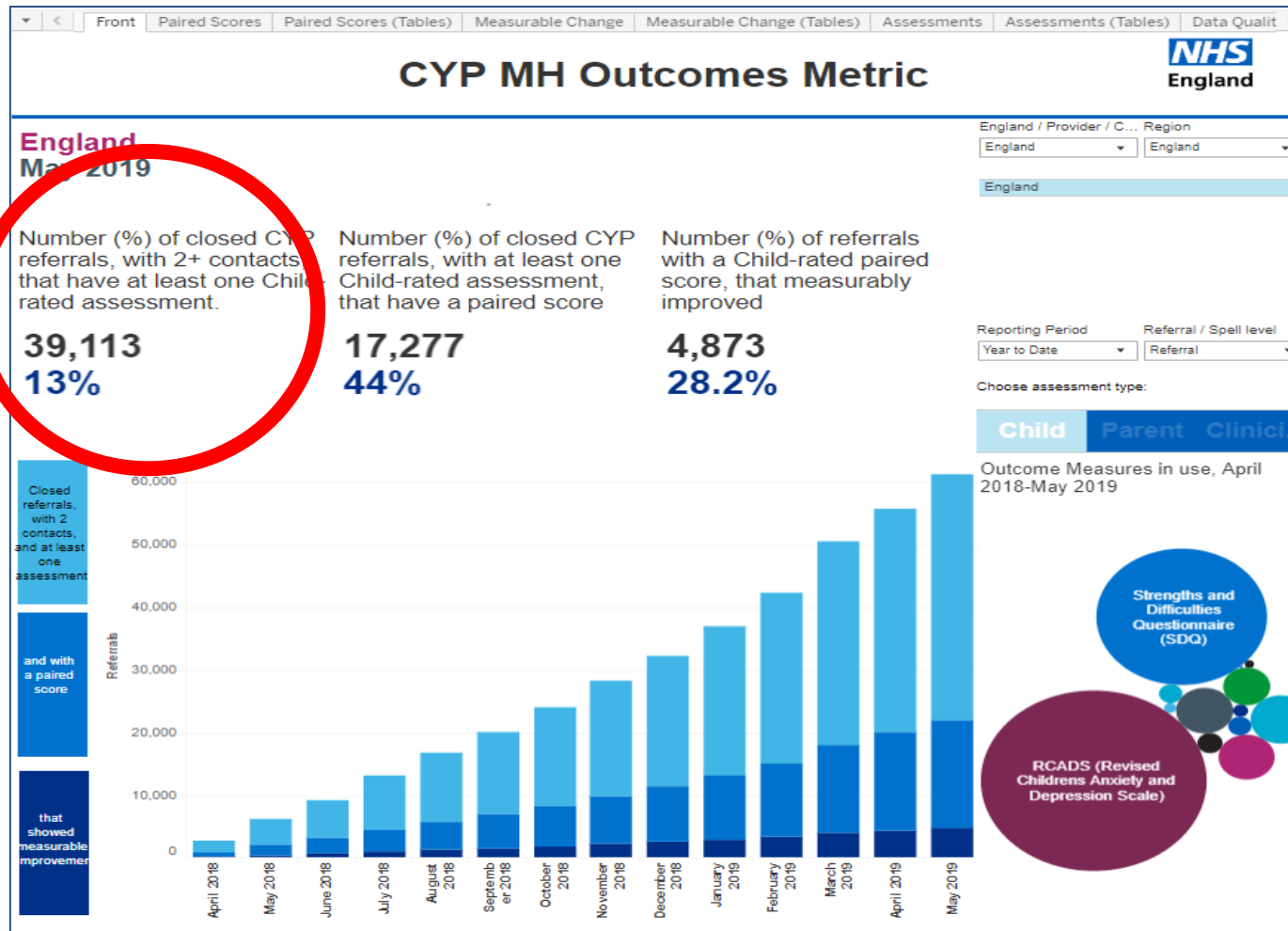
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Clinical Outcomes and Service Improvement
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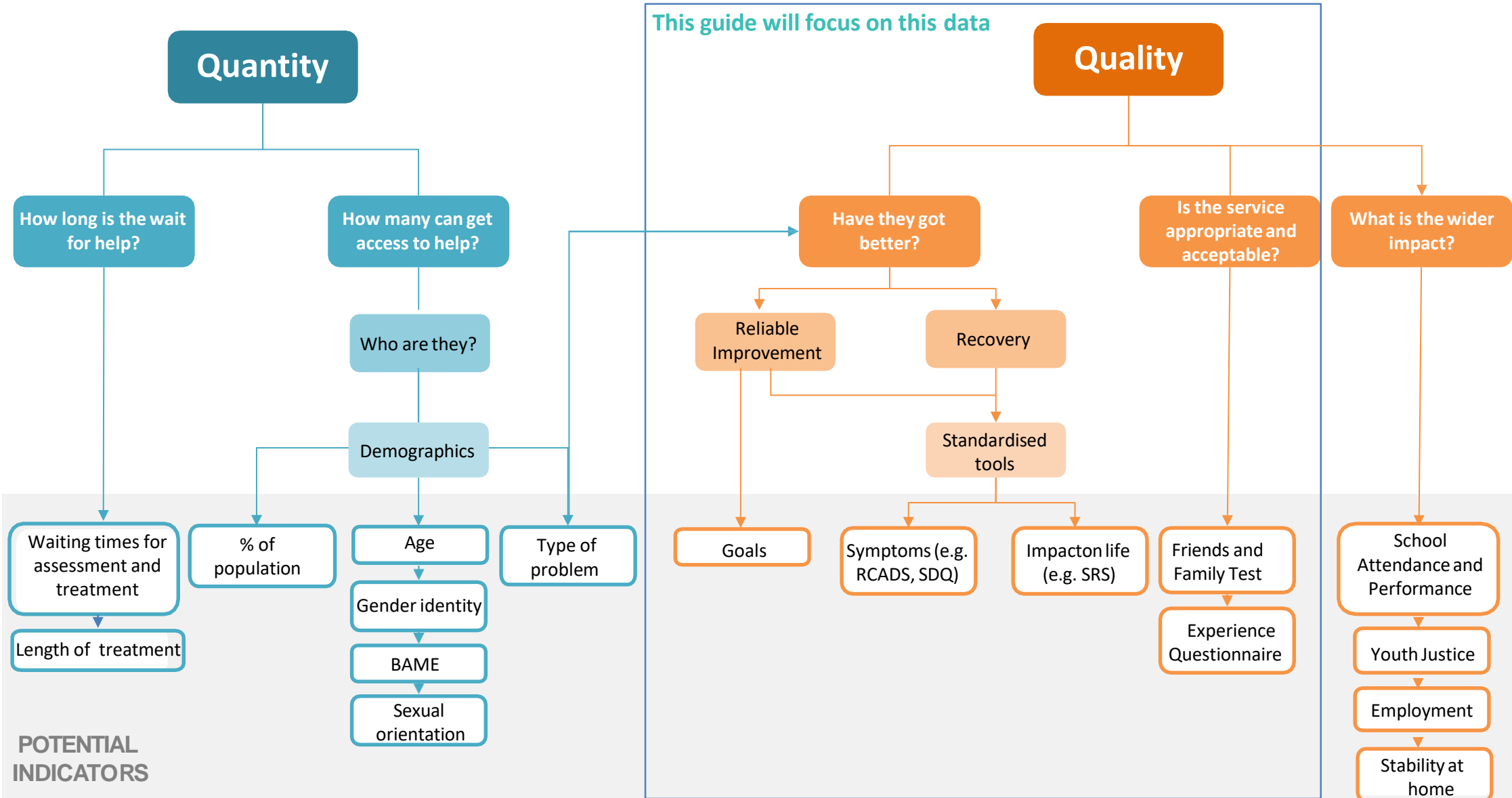
Over the next five years, NHS England and Improvement want to see a further move away from processes to outcomes as a key measure.

- The new dashboard has been launched on the FutureNHS Collaboration Platform – highly interactive and enables view by provider and commissioner, work underway to include view by ICS/STP.

- Focus continues to be on improving data completeness for paired scores, see the data in the red circle to the left.

- The most important thing is that outcome measures are used with service users in partnership and in a meaningful way as well as in supervision – in line with CYP IAPT principles.

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What do I need to know about services?

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

This guide will focus on this data

Quantity

Quality

- **How long is the wait for help?**
- **How many can get access to help?**
  - Who are they?
    - Demographics

- **Have they got better?**
  - Reliable Improvement
  - Recovery
    - Standardised tools
- **Is the service appropriate and acceptable?**
- **What is the wider impact?**

POTENTIAL INDICATORS

- Waiting times for assessment and treatment
  - Length of treatment
- % of population
- Age
  - Gender identity
  - BAME
  - Sexual orientation
- Type of problem
- Goals
- Symptoms (e.g. RCADS, SDQ)
- Impact on life (e.g. SRS)
- Friends and Family Test
  - Experience Questionnaire
- School Attendance and Performance
  - Youth Justice
  - Employment
  - Stability at home

For more information about available datasets, please see the HLP Guide to available datasets and reports for children and young people's mental health and wellbeing

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What type of data might I need?
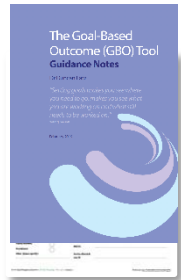## Types of outcomes

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

Types of clinical outcomes

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

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

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

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

What measures should services be using?

There are no one-size-fits-all measures:

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

Keeping it clinically meaningful

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

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

What type of data might I need?
Clinical outcomes in practice

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

Examples of clinical outcomes services

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

Most services have now integrated clinical outcomes into their day to day work to some extent – but more work is needed to improve data quality for commissioners to really be able to monitor the clinical impact of services they are commissioning.

There are measures suitable for use for children with [Learning disabilities](#) on the Child Outcomes Research Consortium (CORC) website and guidance on using outcomes measures on the [London & South East CYP IAPT Collaborative](#) site on Looked After Children and Learning disabilities on the [London & SE CYP IAPT site](#). The site is no longer maintained but many of the resources are still relevant and helpful. The [CORC website](#) also has many useful [resources](#) on how to use outcome measures.

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

How much data is needed?

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

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

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

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

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

What type of data might I need?
Questionnaire scoring

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

Questionnaire scoring

Questionnaires will have different scoring scales, so a 10 point decrease in scores on one questionnaire may not indicate much of a change on one, but it could indicate a huge change in another. Questionnaires included in the CYP IAPT dataset, now part of MHSDS, can be viewed on the CORC website. They are **normed** which make it possible to compare scores with others of the same age and gender etc. and establish cut offs/bands which give some indication of the threshold where a particular diagnosis becomes more likely or the severity level of symptoms. However, it is important to note that questionnaire scores can be influenced by a variety of factors such as interpretation of questions and the effort of the person filling it out (see page on Data Variables).

What is 'reliable' data?

As there is generally a lot of 'noise' in the questionnaire scores that could potentially obscure the changes, having access to reliable change, reliable recovery and/or recovery data can help to minimise the risk of misinterpretation. If a case shows reliable improvement (a positive reliable change) or reliable recovery, we can be more confident that the scores are reflecting 'real' change rather than change in scores being due to other factors.
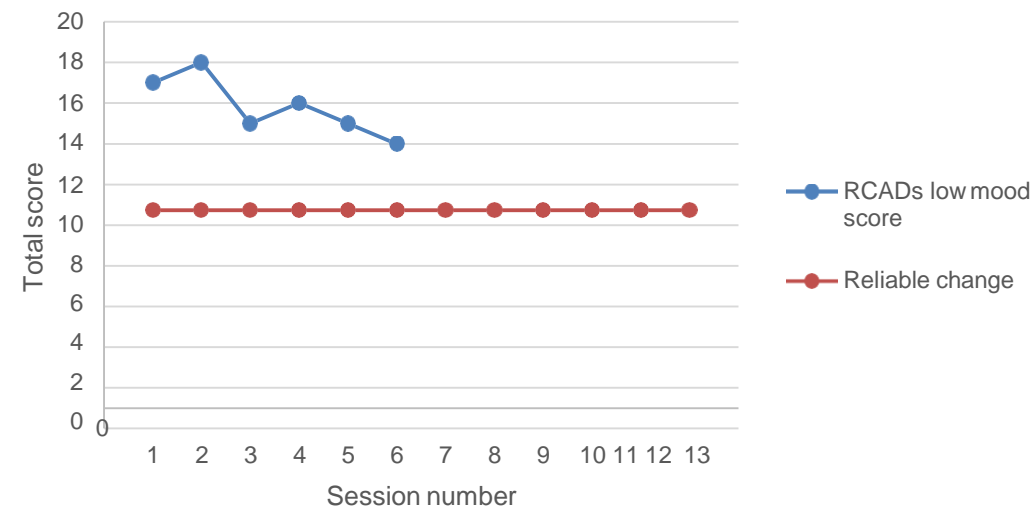
Please note that these are statistical terms and may not fully capture the experience of the CYP.

Scoring case study

Sarah, a 13 year old girl, completed the RCADS when she attended her first session. From her completed questionnaire, her clinician totalled her scores using the Child First scoring spreadsheet which showed an above threshold score for depression. Together they decided to use the RCADS low mood/depression tracker at each session to track Sarah's Mood.

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

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What type of data might I need?

Reliable change and recovery: making comparing different tools straightforward

How can I compare different questionnaire scores?

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

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

To read more in depth about different approaches to analysing changes in outcome measure data, and the pros and cons of each, see this CORC paper: 'Recommendations for Using Outcome Measures'.

Recovery rates	The number of individuals above the 'clinical cut off' before the intervention, that are below the 'clinical cut off' afterwards.
Reliable change	When a significant change in scores is seen that can be attributed to the intervention rather than other factors (positive change can be called reliable improvement and negative change can be called reliable deterioration).
Reliable recovery	The number of individuals showing 'recovery' (as defined above) who's scores have moved by a significant amount.

How do I get this data?
Data variables

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

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

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How do I get this data?
Expectations

It is not easy for services to produce good quality, meaningful outcomes data. Few services have attained the national target of 90% for paired data – a more likely figure is somewhere around 25% (for CYP IAPT services - figure from the 2016 CYP IAPT data report by CORC) and 2017 erratum table.

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

Common barriers for services starting out

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

Infrastructure and other considerations

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

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

How commissioners can help

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

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

How should I understand the data?
Mindful data use

As a starting point for conversation

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

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

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

What is a good outcome?

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

Mindful use of data

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

> *"…we suggest adoption of a MINDFUL framework involving consideration of:*
> - *multiple perspectives,*
> - *interpreting differences in the light of current evidence base,*
> - *focus on negative differences when triangulated with other data,*
> - *directed discussions based on 'what if this were a true difference' (employing the 75–25% rule),*
> - *use of funnel plots as a starting point to consider outliers,*
> - *appreciation of uncertainty as a key contextual reality and*
> - *the use of learning collaborations to support appropriate implementation and action strategies."*
>
> From 'reckless' to 'mindful' in the use of outcome data to inform service-level performance management: perspectives from child mental health

It is an approach that emphasises what the data could mean at service level, given the complexities and challenges of using outcomes data.
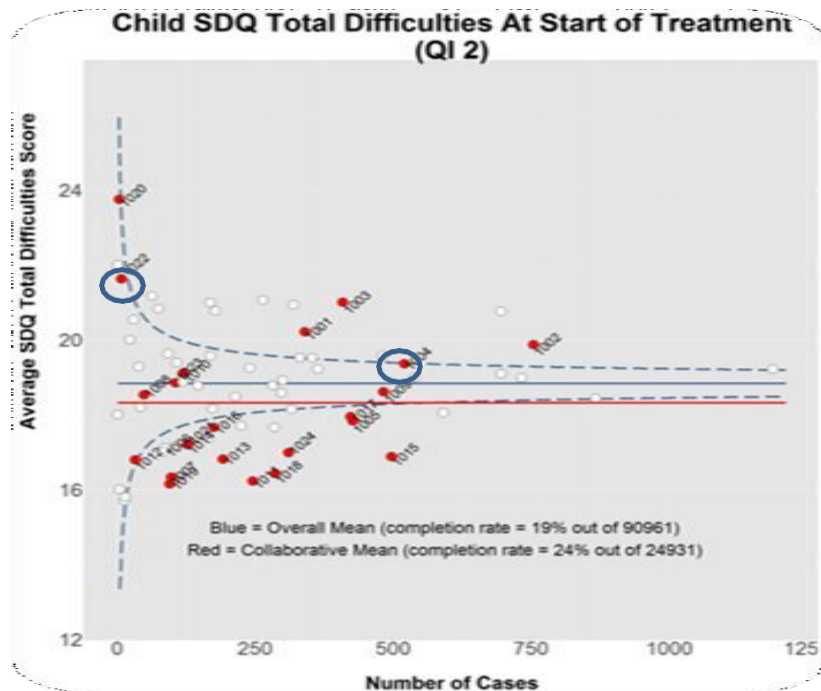
How should I understand the data?
Visualisations

Commonly used data visualisations: Funnel Plots

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

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

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

Funnel plot by CORC

An example

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

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How can data be improved?
Conversations

What if outcomes look different to what might be expected?

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

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

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

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

Guide To Using Outcomes And Feedback Tools

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

How can data be improved?
What services want you to know

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

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

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

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

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

Value qualitive data/case studies/testimonials too
These can give a richness of data that can compliment quantitive data reports.

Don't forget about consultation/outreach work/systemic work/liaison
Much of the work that services are doing cannot be or is not easily measured through activity, outcomes or experience of service measures. However, this is still a hugely important part of work services do.

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

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

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

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

Useful links and resources

- Healthy London Partnership – working across health and social care, and with the Greater London Authority, Public Health England, NHS England and Improvement, London's councils, clinical commissioning groups, and Health Education England.
- London and South East CYP IAPT Learning Collaborative – this website is no longer maintained since the Collaborative ended but it still contains helpful information.
- Mental Health Services Data Set (NHS Digital) – national reporting.
- The Child Outcomes Research Consortium (CORC) – supports the effective and routine use of outcome measures in work with children and young people (and their families and carers) who experience mental health and wellbeing difficulties.
- Goal-Based Outcome [GBO] (2019) – free guidance on using the Goal-Based Outcomes (GBO) tools.
- Guide to Using Outcomes and Feedback Tools with Children, Young People and Families (2014) – comprehensive booklet about outcomes. Includes service structures and implementation and understanding data, as well as clinical use of tools.
- CORC norms and reliable change criteria spreadsheet – for calculating reliable change for CYP IAPT measures.
- Guide to available datasets and reports for children and young – HLP document giving information and resources about various available datasets.

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