Full guide version

Supporting prioritisation of mental health funding related to urgent and emergency care in the East of England

A guide for Integrated Care Systems and Sustainability and Transformation Partnerships

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Table of contents

Preface.....iii

Summary: Key points for the prioritisation of resource use and the utilisation of models for prioritisation.....iv

1. Purpose and context of this guide.....1

2. The prioritisation process.....4

2.1. Prioritisation for mental health urgent and emergency care winter pressures in the East of England.....5

2.2. Further examples of prioritisation from the literature.....6

2.3. The important steps for a pragmatic prioritisation process.....9

3. Using logic models and data to support prioritisation and evaluation: the process in action.....12

3.1. What are logic models and how can they be used?.....12

3.2. Development of logic models for urgent and emergency care winter pressures funding in the East of England.....15

3.3. Logic model 1: Children and young people.....22

3.4. Logic model 2: Mental health liaison.....31

3.5. Logic model 3: Crisis alternatives.....34

3.6. Logic model 4: High impact support.....41

3.7. Logic model 5: Older adults.....46

3.8. Logic model 6: Drug and alcohol misuse.....51

References.....57

Annex A. Further detail on the methodology.....59

Annex B. Checklist for designing, reporting and assessing MCDA studies 61

Annex C. Data sources for monitoring expected outputs and outcomes 62

C.1. Finding the right type of data for a project.....62

C.2. Project data.....62

C.3. Local administrative data.....65

C.4. National administrative data.....65

Annex D. Logic model worksheet.....74

Annex E. Useful resources.....75

Preface

This guide was commissioned by Eastern Academic Health Science Network and NHS England and Improvement. It has been prepared in discussion with Integrated Care Systems/Sustainability and Transformation Partnerships (ICS/STPs) in the East of England to help them and other ICS/STPs with determining spending and planning priorities and evaluating projects within mental health urgent and emergency care.

The first section of the guide highlights the key points to remember when approaching the prioritisation process and the evaluation of what is prioritised. There is a checklist to help systems in this process. We also provide a list of resources that systems may find useful. Subsequent chapters explain the key points in more detail. Supporting information is given in boxes alongside the text and, where greater detail may be helpful, in Annexes at the end of the guide.

You can also refer to the accompanying practical toolkit version. This toolkit brings together key practical resources from the guide and has been developed as a practical workbook to help develop logic models whilst determining spending planning priorities within mental health urgent and emergency care.

This guide should not be construed as a comprehensive review of, nor the final word on, possible approaches to prioritisation. It is a distillation of the knowledge and experience of the authors, strengthened and refined by discussions with ICS/STPs in the East of England.

Summary: Key points for the prioritisation of resource use and the utilisation of models for prioritisation

Purposes and context of this guide

This guide has been developed to support ICS/STPs in the East of England and more widely in determining the funding priorities and evaluation of projects relating to mental health urgent and emergency care. The first section of the guide following this Summary aims to support you with your resource prioritisation, focusing on the key steps and aspects to consider when deciding what to fund. The second section offers an overview of how to think about developing logic models for the work you have funded, which is a way of understanding whether the funding has led to its intended outcomes.

What to consider for practical prioritisation

Prioritising the use of resources between alternative options has four main steps, as shown in **Figure 1**.

Figure 1: A pragmatic process for prioritising options for using resources

Source: RAND Europe

The first step is to be clear about the scope of the prioritisation exercise (e.g. mental health urgent and emergency care); the range and number of stakeholders whose views need to be taken into account given the scope of the exercise and the time available for prioritisation (e.g. service users, commissioners, providers); and what it is you are trying to achieve, meaning the criteria for determining whether one option is better than another.

The second step requires identifying, with your stakeholders, the full longlist of options you could spend your available resources on – while being alive to the possibility that stakeholders may be describing the same option in different ways, so you will need to look out for different versions of the same thing.

The third step is to filter the longlist down to a shortlist, achieving consensus across stakeholders where possible.

The final step is then to rank the shortlisted options, again seeking consensus across stakeholders where possible, so that you know which are the most important to pursue, depending on the extent of the resources that are available.

Table 1 gives a checklist of questions to consider when thinking about how you might approach prioritisation as outlined in **Figure 1**. Chapter 3 of the guide provides further detail.

Table 1: Checklist for approaching the prioritisation process

	Key considerations/questions	Tick when complete
Stage 1: Preparatory work		
1	What is within scope for the resources you have available?	
2	Are there specific rules you have to adhere to, e.g. are you prioritising options for spending funds awarded for a certain type of service or population?	
3	Which type of stakeholders would be useful to involve in the discussions of options for where to direct the resources and how to prioritise those options?	
4	How could service users and/or the public be involved in discussions around options for where to direct the resources and how to prioritise those options (if appropriate)?	
5	Based on the above steps, can inclusion criteria be developed to create a long list of potential projects to support? The same criteria will be applied later on to determining priorities between options.	
Stage 2: Gather information and create your longlist		
6	Can you collect ideas for projects that could be funded with the resources available? Ideas can come from multiple sources, e.g. existing ideas that have not yet been funded, horizon scanning exercises to generate new ideas, engaging with stakeholders from steps 3 and 4 to identify new ideas.	
7	From the ideas generated in step 6, can you collate a longlist of possible projects that could be funded with the resources available, based on your inclusion criteria developed in step 5? In doing so, you will need to check for essentially similar ideas and remove duplications.	

Key considerations/questions		Tick when complete
Stage 3: Filter the longlist to a shortlist		
8	Can you reduce the longlist from step 7 into a shorter list? Are any items on the list clearly superior to others in meeting the criteria from step 5?	
9	How do you know, and how can you show, that these are worthwhile ideas? Answering this question step can be supported by developing high-level logic models for each potential project to explore the resource intensiveness and expected outputs/outcomes of each. See the checklist in the next section for further support with this.	
10	Is there a way to involve the stakeholders from steps 3 and 4 in identifying ideas to take forward from the longlist to the shortlist, achieving consensus about that if possible?	
Stage 4: Ranking and portfolio analysis		
11	For each of the ideas in your shortlist, can you gather evidence on their benefits, costs and risks?	
12	For the ideas on your shortlist, based on the evidence you collected in step 10, can you rank these in terms of their net benefits relative to their financial costs to determine which projects to resource?	
13	Given the resources available to you, how far down the ranking are you able to resource ideas on the shortlist? Would the resulting portfolio be sufficiently balanced overall – and if not, do you need to promote any of the lower-ranked options?	
14	Once you have decided which options to resource, could you think about ways of monitoring and evaluating whether they have been successful? See the checklist in the next section for questions to consider when drafting a logic model.	

Evidencing, monitoring and evaluating projects

Logic models (explained in Chapter 3 of this guide) are a helpful tool to support the prioritisation process, by evidencing options to be considered, informing the shortlisting

and ranking of options, and providing a framework for monitoring and evaluating projects that are implemented. The approach to creating a logic model is straightforward. **Table 2** provides a checklist for developing a logic model for a single project or multiple projects together. Chapter 3 of the guide provides more detail of each of the steps including, for example, the difference between outcomes and outputs. Annex D provides a blank worksheet with a template of a logic model to help your planning.

Table 2: Checklist for developing a logic model to evidence and evaluate project(s)

Key considerations/questions		**Tick when complete**
Step 1: Outcomes		
1	What do you ultimately want your project(s) to achieve, within the resources you have available?	
2	What are the particular needs of the population you are trying to support?	
3	Where and what are the pressures in the system that your project(s) could help alleviate?	
4	What metrics or data could you use to monitor whether each outcome is achieved?	
Step 2: Outputs		
5	What outputs would be produced to achieve these outcomes? E.g. trained staff, ability to offer a service 24/7, new protocols.	
6	What metrics or data could you use to monitor how far these outputs are produced?	
Step 3: Activities		
7	What activities could you implement to produce these outputs? N.B. There may be more than one way of producing such outputs.	
Step 4: Inputs		
8	What resources/how much funding do you have available?	

Step 5: Wider context and assumptions		
9	Can you identify the external factors that may influence your project but are not necessarily within your control (e.g. national policy, wider strategies, local priorities, external events)?	
10	What assumptions are you making, whether explicitly or implicitly, when mapping how the activities lead to the intended outputs and how those outputs lead to the intended outcomes? (E.g. for a new training package aiming to improve the knowledge and confidence of staff working with a particular group of service users, individuals need to have the time and willingness to attend the training.)	

A list of resources for both the prioritisation process and logic model development has been compiled in Annex E.

1. Purpose and context of this guide

This guide has been prepared to help Integrated Care Systems and Sustainability and Transformation Partnerships (ICS/STPs) with planning priorities across mental health urgent and emergency care. It is the result of work carried out by RAND Europe in September to December 2020 with the inputs of colleagues from the ICS/STPs across the East of England. The guide was commissioned by Eastern Academic Health Science Network (Eastern AHSN) and NHS England & Improvement (NHSE&I). Through that work, we have developed a pragmatic process for prioritising planning and resourcing across mental health urgent and emergency care. Particular attention is given to the development and use of 'logic models' to clarify a process for how desired outcomes can be achieved. Logic models support the prioritisation process and provide the basis for future monitoring and evaluation of service pathways.

The guide is intended to be pragmatic and proportionate. There is much literature, by health economists and others, about ways to conduct academically rigorous prioritisation of resource use in health and social care. But these approaches are often time-consuming and data-hungry, meaning that they are better suited to prioritisation when commitments of very large resources are at stake – e.g. equivalent to millions of pounds annually – when a lengthy, and in itself quite costly, exercise to make the prioritisation decisions is justified. In this guide, we have taken a reduced approach, which is designed to be appropriate for local decision making by ICS/STPs where funding prioritisation has to be achieved in a short timeframe (weeks or months rather than years).

The focus for the work leading to this document was specifically on mental health winter pressures funding in the East of England; looking at how options for funding were identified and prioritised for the 2019/20 round. But the process described here is likely to be more generally relevant. The examples presented in later pages, and the corresponding suggestions for data to evidence and monitor implemented services, have been selected to take account of issues and constraints that arise with mental health urgent and emergency care. They are not intended to provide an exhaustive list of all aspects to consider. But the principles exemplified here are likely to also apply to mental health and social care services more generally, and indeed to other areas of health care.

Funding is made available at various times throughout the year. As notice of the specific scale and scope of funding can be measured in weeks rather than months, the process described in the following pages can be applied *in anticipation of* funding, as well as once the resource envelope is known or once the call for a particular set of bids for funding has been received. The box below describes how to use the guide.

BOX 1– USING THIS GUIDE

The key points to note, and corresponding checklists, are in the first chapter of the guide (above).

The remainder of the guide provides more detail and explanation. It has two main sections followed by a brief recap of the key points.

The following two sections describe, with examples and diagrammatic summaries:

- The sequence of steps in the overall **prioritisation process** (Chapter 2 and 0).
- The development and use of **logic models** to support prioritisation and provide a framework for subsequent monitoring and evaluation of services that are funded. As part of this we include examples of appropriate metrics (Chapter 3 and 0).

In providing examples and suggested metrics we have focused on six priority programme areas within mental health urgent and emergency care, as specified by NHS England & Improvement:

- Children and young people
- Mental health liaison
- Crisis alternatives
- High impact support
- Older adults
- Drug and alcohol misuse

In preparing the guide we have:

- **Reviewed high-level guides to prioritisation of public expenditure and the development of logic models**, including HM Treasury's Green Book (2) and Magenta Book (10).
- **Reviewed selected health economic literature on prioritisation of resource use for health services**, in practice at local level (e.g. (1; 27)).
- **Reviewed material provided by NHS England & Improvement and by ICS/STPs in the East England** region of England, related to the latter's 2019/20 bids for urgent and emergency care mental health funding to alleviate winter pressures. This was to understand the requirements and timelines for the 2019/20 funding, what each STP implemented with the funding, and how they planned to monitor and evaluate these projects.
- Conducted **online interviews** in all six ICS/STPs in the East of England with managers involved in prioritising expenditure to alleviate mental health urgent and emergency care winter pressures and with representatives from NHS England and Improvement involved in this funding stream in 2019/20. The aim of these was to understand the processes of prioritisation used by the six STP/ICSs in the East of England when they decide where to spend mental health urgent and emergency care winter pressures funding.
- Held three **online workshops** with stakeholders from those ICS/STPs, NHS England & Improvement and Eastern AHSN. The first of these was focused on the prioritisation process for mental health urgent and emergency care winter pressures funding to discuss the interim findings of the project, and to discuss and refine what makes an effective and feasible prioritisation process for winter pressures funding. The other two workshops were focused on the logic models, in which three logic models were discussed and feedback provided to improve the models in each.
- And drawn on the **research team's prior knowledge and experience** of prioritisation in practice at local levels in the NHS.

The guide is structured in the following way:

- Chapter 2 focuses on how to approach the prioritisation of resources.
- Chapter 3 focuses on outlining the use and purpose of logic models and how they can be applied to six programme areas within urgent and emergency mental health care.
- Annex A provides further detail on the methodology.
- Annex B provides a checklist for designing, reporting and assessing multi-criteria decision analysis (MCDA) studies.
- Annex C provides information on data sources that could be used to monitor outputs and outcomes of logic models.
- Annex D provides a blank logic model template for you to complete.
- Annex E lists some other resources you may find helpful when thinking about prioritising resources and/or monitoring and evaluating your projects.

2. The prioritisation process

Whether explicitly or implicitly, ICS/STPs, and commissioners and planners of services for NHS patients more generally, are always having to prioritise the use of resources. Worthwhile opportunities almost always exceed the funds and other resources available. There are many approaches to prioritising the use of NHS resources, and there is a large literature, much of it in academic journals, devoted to the topic. Our intention in this chapter is to concentrate on some of the practical approaches to prioritisation that are currently being used by commissioners and other planners in the NHS, and to distil from them a proportionate and pragmatic process that can be used when considering resource use for mental health urgent and emergency care. We focus on prioritisation in the context of informing decisions about incremental changes in resource use, because in practice that is where most decision-making takes place, starting from the baseline of what is already funded. (An equivalent process could be used to prioritise where to reduce expenditure below previous levels, but that is not the perspective of this guide.)

The rest of Chapter 2 is organised as follows:

- 2.1 briefly summarises the prioritisation experiences of the East of England ICS/STPs in the 2019/20 round of winter pressures funding for mental health urgent and emergency care.
- 2.2 summarises what can be learned from published literature.
- 2.3 proposes a simplified prioritisation process appropriate to decisions about where to spend 'winter pressures' funding and other resources for mental health urgent and emergency care.

2.1 Prioritisation for mental health urgent and emergency care winter pressures in the East of England

Interviews and workshops were conducted with the six ICS/STPs in the East of England, to learn about the prioritisation process they used for determining the spending of winter pressures funding in 2019/20 and the extent to which this process varied across locations (see Annex A for more details of the workshops and interviews). Across all six ICS/STPs there was an overwhelming sense that early planning and prioritisation was challenging, as the scope and size of the winter pressures funding are not known until a few weeks before the submission deadline. There was, however, widespread agreement that a degree of **advance planning is possible and helpful, despite the time limitations**. There was also agreement that engagement with the full range of stakeholders was hindered by the short timeframes.

With respect to the **criteria** upon which priorities were based, there was consensus that projects are generally prioritised based on the understanding of **unmet needs**. It was also common for winter pressures funding to be allocated to expand existing services or pilots, rather than to wholly new activities. Related to this, a powerful criterion in practice proved to be **readiness for immediate implementation**. That is, priorities for winter pressures funding were based on those projects that could be implemented within the required (imminent) timeframe. The other main criteria used for winter pressures prioritisation in 2019/20 across the East of England were: the ability, where appropriate, to **divert people away from A&E**, and impact on **reducing inequalities** between subgroups of the population.

BOX 2 – ASPECTS OF WINTER PRESSURES PRIORITISATION IN EAST OF ENGLAND ICS/STPS

ICS1

ICS1 identified priority areas in advance of the winter pressures funding call and created a long list of projects. Third sector providers, as well as representatives from a patient and public involvement (PPI) organisation were included in the process. Priority areas were identified by speaking with colleagues and looking at performance data. In the end, projects were prioritised if it was felt that they could reduce A&E pressures and could be mobilised quickly. According to the stakeholders, logic models (see Chapter 3 of the current guide) could help with planning, as they would give a sense of the outcomes of all the projects in the area. Whereas in previous years the funding was primarily spent on new innovative projects, it has recently usually been spent to improve existing services. The impact of the projects was difficult to measure due to their small scale. Repeat A&E visits and patient experience were described as particularly difficult to measure.

ICS2

The process in ICS2 did not involve PPI on the side of the service provider. We were told that the ICS/STP performed risk assessments, but we do not know their extent, or their impact on the prioritisation process. The priority was to divert people away from A&E. The programmes mainly included expanding existing services or pilots. Patient feedback around these services was difficult to collect, but the stakeholders were interested in finding out ways to measure outputs.

ICS3

In ICS3, the prioritisation process was described as informal. However, there was ongoing PPI and consultation with service providers in advance of the winter pressures funding announcement. In particular, a 'resilience group' has been set up, which includes GPs, representatives from hospitals and service users; and it discusses pressures throughout the year. However, once the request for proposals came in, there was no time for a final round of patient engagement. Ultimately, funding was directed towards expanding existing projects. Data from partner organisations would have been useful in the prioritisation process, but these could not be accessed. It seems that in 2019, there was clear evidence showing what should be funded, and there was no time or need for shortlisting and ranking projects. We were told by workshop participants that it was difficult to gather evidence on the outcomes of the projects that were funded.

ICS4

In ICS4, data were described as being used to prioritise key areas and select relevant projects. There was ongoing service user feedback, but no specifically focused PPI during the winter pressures funding prioritisation process. The main criteria used to assess priorities were: feasibility within the timeframe, and accessibility of the appropriate data in the time after the funding announcement. This is because data were needed to support the bids in order to get sign-off from the CCG. The focus was, as elsewhere, on diverting patients from A&E to more appropriate services.

ICS5

In ICS5, planning work for winter pressures funding bids started in September, looking at schemes that were feasible within the timescale. Third sector providers were involved in the prioritisation process, but there was no review of evidence and no PPI specifically for the winter pressures funding prioritisation. In terms of measuring outputs, it was difficult to establish a benchmark that would signify that the projects were successful.

ICS6

The process in ICS6 was described as informal. Some preparatory work started around six months before the winter pressures funding call. But there was no PPI or third sector involvement specifically in prioritising winter pressures funding, and the evidence base was not reviewed for this specific purpose due to time constraints, with the exception of out-of-area placements, which it was hoped could be minimised. Projects were funded based on their feasibility given the time and budget constraints.

In terms of data used to support prioritisation, interviewees considered that although there are some data that could be useful in the prioritisation process, there was in practice rarely time for analysis, unless it was undertaken before the specifics of the scope and scale of winter pressure funds was known.

Particular aspects of prioritisation, particular to their local area, that were raised by interviewees at each of the six East of England ICS/STPs, are summarised in Box 2.

2.2 Further examples of prioritisation from the literature

In practice, there are various approaches to deciding what to spend NHS resources on. Readers interested in a clear and extensive summary of the pros and cons of different approaches on that subject, are recommended to look at Mitton and Donaldson (2004) '*Priority setting toolkit. A guide to the use of economics in healthcare decision making*' (1). At the heart of prioritisation is the need to be clear about the full range of benefits and costs of any options being considered. Some of those benefits and costs can be quantified and given a monetary value, but others may be harder to quantify and value (see HM Treasury (2020) '*The Green Book: Central Government guidance on appraisal and evaluation*' (2) for a good discussion of this issue and how to resolve it). Various techniques exist for combining all benefits and costs even when they cannot all be expressed in the same, financial, metrics. These techniques are generally some variant of 'multi-criteria decision analysis (MCDA)' (see Devlin and Sussex (2011) for a simple introduction to MCDA in a health care context (3)). Box 3 summarises key points about MCDA methods. The time and data inputs required by MCDA are non-negligible but can be tailored to the scale of the resource commitments being considered and the time available to make the prioritisation decisions.

BOX 3 – MULTI-CRITERIA DECISION ANALYSIS (MCDA)

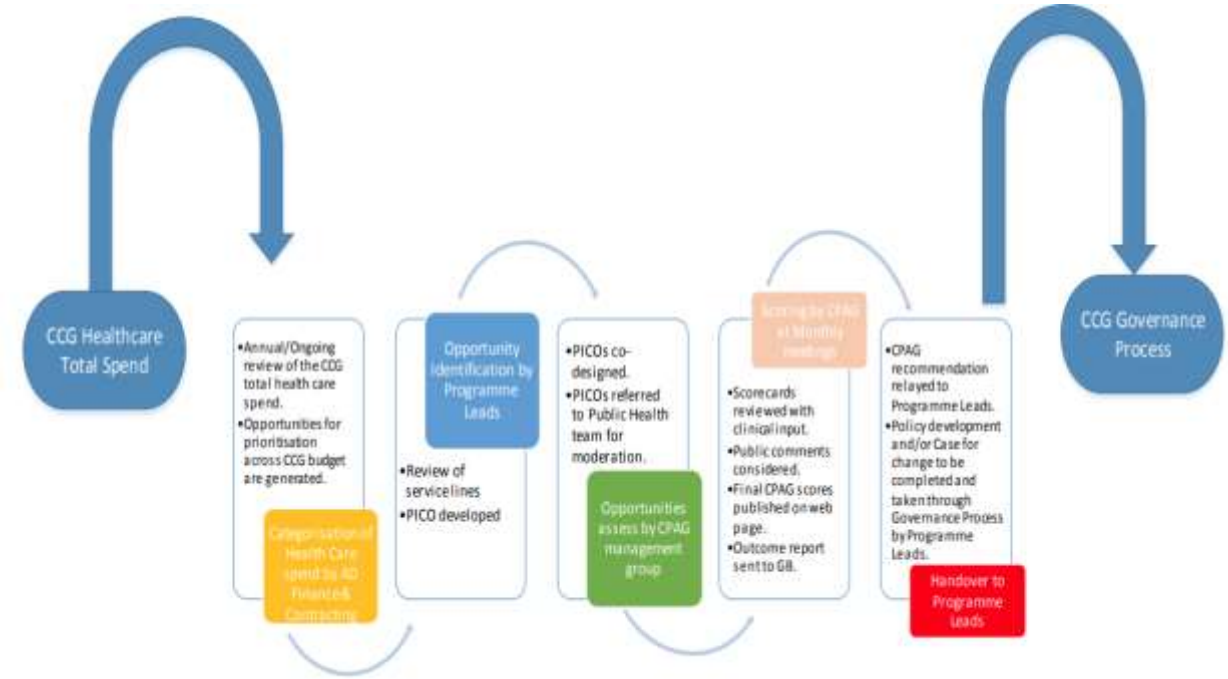
- MCDA is an umbrella term to describe a collection of formal approaches that take explicit account of multiple criteria to prioritise between options for resource use.
- MCDA improves transparency and consistency of decisions.
- The main steps in MCDA are, in essence, to:
    1. Determine the criteria that are relevant to deciding between the options (in the context of this guide: options for using resources for urgent and emergency mental health care).
    2. Decide how each criterion is to be measured or scored – are there natural units such as £, of numbers of staff trained or rating scales (e.g. a scale from 1–5 according to how well a qualitative benefit is achieved, e.g. patient experience of care) – and determine those measures/scores for each option.
    3. Decide the relative weight to be placed on each criterion.
    4. Determine the implied order of preference (ranking) across the options, either approximately (is it a high, medium, low priority) or more precisely (with a weighted score for each option equal to the sum of its score against each criterion multiplied by the weight placed on that criterion).
    5. Note the extent of any uncertainty about the ranking of any of the options.
- Ideally, each step would be taken in discussion with stakeholders – a practical approach is to undertake all steps in a workshop with stakeholders.

The International Society for Pharmacoeconomics and Outcomes Research (ISPOR) has put together a Good Practice Guidelines Checklist to support the design, reporting and critical assessment of MCDA studies in health (4). The checklist is presented in Annex B of this guide.

Guidance published by Public Health England (PHE) recommends MCDA for prioritising public health expenditures (5) and the same approach could be used for prioritising resource use for other types of health services including urgent and emergency mental health care. As stated in Box 3, the first step of this kind of approach involves gathering a group of people to agree on the most important criteria for deciding between alternative options for using resources. Potential criteria are discussed in Chapter 3 of this guide, as they will follow directly from the outcomes desired for the mental health urgent and emergency care services being considered. The group then reviews available evidence about how well each option might achieve those criteria, scores each option against the agreed criteria, and then uses these scores to select the option that would produce the greatest value for money. This process involves a small team of people who might spend, PHE suggests, a combined total of 5–10 days on it (5).

A recent example of prioritisation being used at the level of local NHS commissioning across various types of services is the process described by NHS Birmingham and Solihull Clinical Commissioning Group (6). Their approach is not the only way of doing things, but evidently it is one that provided practical support for them. They define prioritisation as 'the process of ranking competing items, such as tasks or potential purchases, in order of importance…a key component of the process of evaluating health interventions in order to decide what investments and/or disinvestments should be made with limited resources' (NHS Birmingham and Solihull CCG 2019; here page 4). The CCG has adopted its prioritisation approach based, they say, on good practice from across the country. As recommended in the PHE guidance (2019), Birmingham and Solihull CCG use dedicated management groups: the prioritisation process is overseen by the Clinical Priorities Advisory Group (CPAG), which undertakes clinical assessments, and the Service Investment Review Group (SIRG), whose purpose is to score investment requirements. **Figure 2** illustrates Birmingham and Solihull CCG's prioritisation process and Box 4 summarises the steps within it (6).

Figure 2: Overview of NHS Birmingham and Solihull CCG prioritisation process



Note on acronyms: AD: Assistant Director; CCG: Clinical Commissioning Group; CPAG: Clinical Priorities Advisory Group; GB: Governing Body; PICO: Population, Intervention, Comparator, Outcomes.

Source: NHS Birmingham and Solihull CCG (2019) (6)

BOX 4 – THE SEVEN STEPS IN THE BIRMINGHAM AND SOLIHULL CCG PRIORITISATION PROCESS

1. An ongoing review of health care spending
2. Review of interventions by programme leads
3. Co-design of PICO parameters (PICO stands for Population, Intervention, Comparator, Outcome),
4. Scoring of interventions against scorecard
5. Review of the scoring
6. Recommendation of interventions that meet criteria
7. A governance process that reviews the recommended interventions

Similar processes are described by other CCGs, such as NHS West Suffolk CCG (7) and NHS East and North Hertfordshire CCG (8), although Birmingham and Solihull CCG's description is the most detailed and comprehensive we found that is publicly available. The criteria for decision making listed by NHS West Suffolk CCG and NHS East and North Hertfordshire CCG are summarised in Box 5.

***BOX 5** – CRITERIA FOR PRIORITISATION OF DECISION MAKING FROM TWO CCGS IN THE EAST OF ENGLAND*

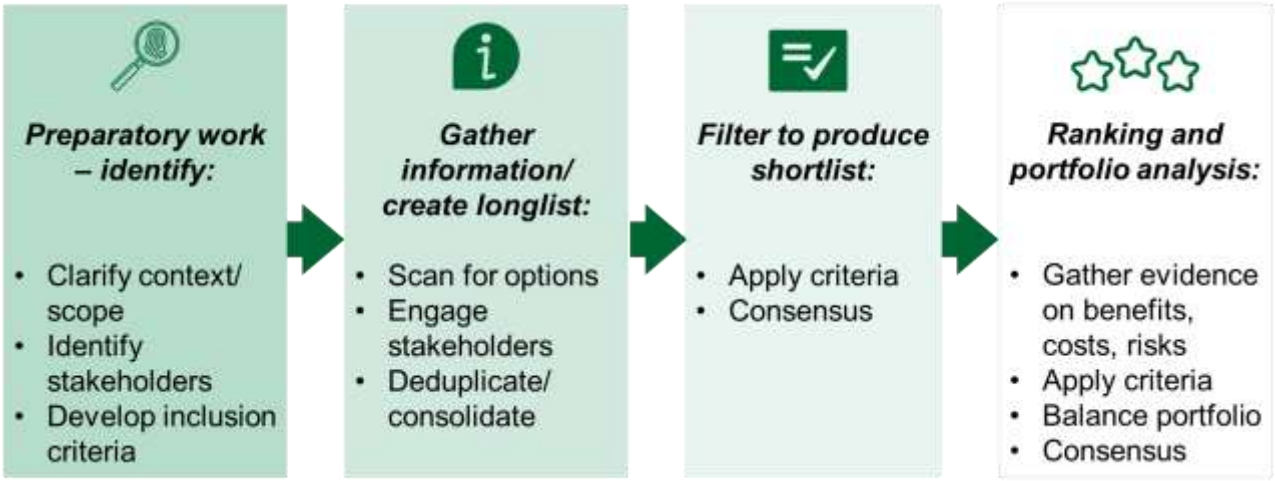
- Effectiveness
- Cost-effectiveness
- Relevance
- Acceptability
- Financial impact/affordability
- Priority status
- Strategic fit
- Impact on Health Inequalities

In the next section, we summarise what was learned from interviews with representatives from the ICS/STPs in the East of England, about the approach to prioritisation that they applied in practice to the 2019/20 round of winter pressures funding for mental health urgent and emergency care.

2.3 The important steps for a pragmatic prioritisation process

The experience of East of England ICS/STPs highlights that time and data constraints can make a detailed process of prioritisation impractical. The processes described in the literature, based on MCDA, are worth aspiring to; and it is possible to prepare to some extent for funding calls in advance of their exact scale and scope being revealed. The practical experience of these ICS/STPs has been combined with the recommended stages of prioritisation processes as described in the literature, to generate a pragmatic and proportionate approach, as is illustrated in **Figure 3**. Adopting such an approach to prioritisation may help support the allocation of funding that delivers good value for money.

Figure 3: A pragmatic process for prioritising options for using resources



Source: RAND Europe

The approach comprises four main stages, which can be repeated/renewed periodically as new releases of funds come into view and as data about the demand for urgent and emergency mental health care and the impact of existing services accumulate. The four stages are:

1. **Preparatory work** – This stage entails determining the context of the prioritisation to be undertaken, including the broad range of expanded and new activities that appear likely to be in scope, and how much detail about funding options is feasible and desirable. The stakeholder groups it is relevant and feasible to involve in the prioritisation decisions should be identified; and a set of decision criteria needs to be agreed on for what to include in a longlist of options for consideration, and for then sifting those to produce a shortlist and for ranking the options remaining on the shortlist (stages 2, 3 and 4). The criteria should be directly derived from the outcomes that are desired (see the discussion of outcomes in Chapter 3 of this guide), as well as pragmatic issues related to implementability within the relevant timeframe.

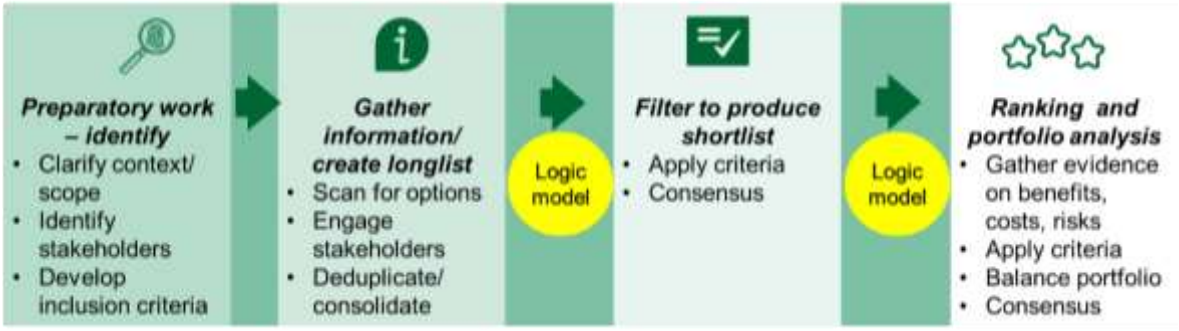
2. **Gathering information and creating a longlist of potential projects** – This includes collecting and collating ideas that may already have been tabled for expanded or new services, including options that may have been considered previously but were not hitherto funded (or only partially funded); and some horizon scanning for new ideas. Such proposals can be sought from all stakeholders, which also has the benefit of achieving meaningful engagement with them. The result will be a longlist of options.

3. **Filtering to produce a shortlist** – It is likely that stage 2 will lead to a list of possible targets for funding that, taken together, exceeds any likely level of funding available. A rapid application of the criteria identified in the previous stage, to filter the long list, may indicate some candidates whom it may be reasonable not to consider further at this stage. The resulting shortlist can then be subject to more detailed consideration in the final stage of the prioritisation process.

4. **Ranking and portfolio analysis** – The options for resource use that remain on the shortlist then need to be ranked for relative importance, according to how well they achieve the desired criteria that were defined in stage 1 (e.g. by using an MCDA approach) and compared with their relative costliness. It is important at this stage to consider the balance of the emerging portfolio of projects, and whether rankings of individual projects may need to be adjusted to achieve better balance. For example, if the highest ranked projects overlooked a particular group of service users, addressing the balance of equality across the portfolio could be achieved by increasing the rank of a project or projects serving these groups.

The production of **logic models**, which we describe in some depth in the next chapter, can be used to support the process of prioritisation for each of the programme areas, both when reducing the initial longlist to a shortlist, and when ranking the shortlisted options in terms of their attractiveness relative to their cost (see **Figure 4**). The logic model approach helps decision makers to acquire an understanding of the potential uses of the resources available, the expected products of those activities (outputs) and their ultimately expected goals (outcomes).

Figure 4: How logic models fit with the prioritisation process



Source: RAND Europe

3. Using logic models and data to support prioritisation and evaluation: the process in action

A logic model can be an important tool for thinking about, and evidencing, the relative priorities among different options for funding services in health and social care, including mental health urgent and emergency care. Logic models support exploring how options for funding are expected to achieve desired outcomes (Box 6). Of course, expectations need to be tested over time to ensure delivery against them.

BOX 6 – USES OF LOGIC MODELS

- Relatively simple and high-level logic models can be used:
  a. To help to filter the longlist of options to a shortlist for more detailed consideration
  b. When ranking the options that remain on the shortlist for funding.
- More developed and detailed logic models can subsequently be the basis for evaluating how well projects turn out when they are implemented.

In this chapter of the guide, we describe logic models developed in collaboration with ICS/STP staff in the East of England, for six programme areas: children and young people; mental health liaison; crisis alternatives; high impact support; older adults; and drug and alcohol misuse.

The chapter includes an overview of the aspects of the logic models that could apply to a range of different programme areas within mental health urgent and emergency care, as well as aspects specific to the individual programme areas. Most initiatives funded by the 2019/20 winter pressures funding for urgent and emergency mental health care were directed at supporting alternatives to A&E, and so have some similar overall goals, as well as goals specific to each initiative.

We present logic models for each of the six selected programme areas in turn. The focus in these examples will be on the more specific outputs, outcomes and monitoring approaches for each programme area.

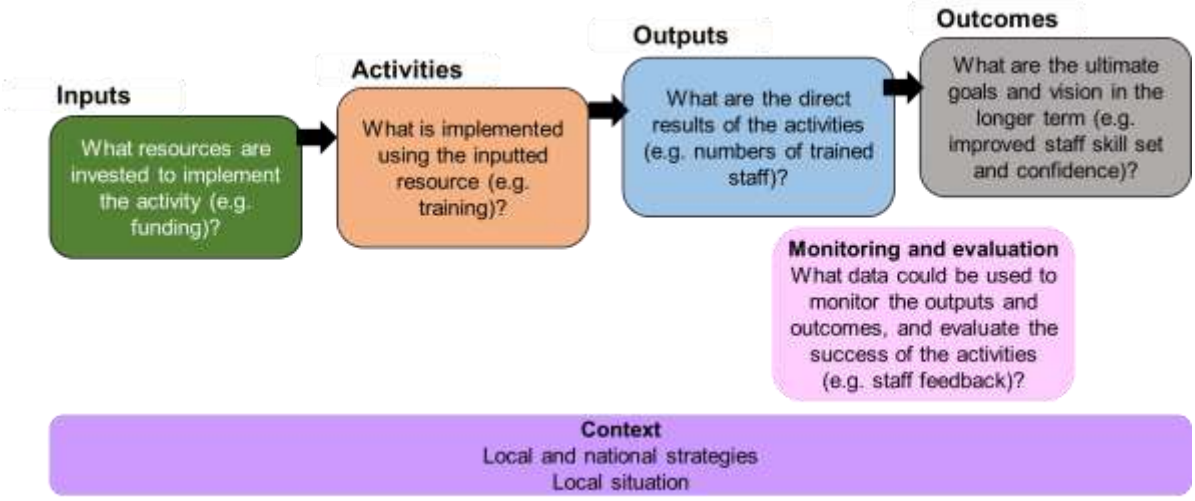
3.1 What are logic models and how can they be used?

'Logic model' is a generic term that describes visual representations of any type of project/programme, linking their contexts, assumptions, inputs, implementation chains and outcomes/impacts (9; 10). Logic models can vary from being very simple to highly complex, depending on the type of programme/project and how much information needs to be conveyed in one place (10). For example, a logic model can be developed summarising the pathway of one or multiple projects, as well as for an overall programme of work.

Logic models generally follow a set template as outlined in **Figure 5**. Logic model diagrams are intended to be *understood* by reading them from left to right (i.e. from Inputs to Outcomes) (9). However, when *developing* logic models, it can be more helpful to work from the right to the left of the model, i.e. starting with thinking about the desired Outcomes (the ultimate aim of the activity) and then working back through the

Outputs that are to yield those outcomes, to the **Activities** that could produce those outputs, and then the Inputs needed for those activities.

Figure 5: Template for a logic model



Source: RAND Europe

BOX 7 – KEY POINTS ABOUT LOGIC MODELS

- Logic models are a visual way of outlining a project's journey from the resources put in to set the project up (e.g. money, staff) to the desired outcomes (e.g. improved mental health).
- There are five key parts of a logic model that move from left to right. However, when developing a logic model, it is often more useful to start thinking about the right-hand side (the outcomes).
- The key parts of a logic model are (see Figure 5):
  - **Inputs:** The resources used to develop, set up and run your project.
  - **Activities:** The project set up using the input resources.
  - **Outputs:** The direct product of your project.
  - **Outcomes:** The overall aim of your project.
  - **Context:** External factors that may influence the project but are largely out of your control.
- It is also important to consider how you will **monitor and evaluate** the outputs and outcomes of your project. These can be mapped onto your logic model under the output and

Inputs

The inputs are the **resources used to develop, set up and run the initiative**. This could include, for example, a certain type of funding, new staff resource, or access to infrastructure such as buildings and equipment.

Activities

This describes the **different types of activities** (e.g. initiatives, interventions, processes) that can be put in place, using the resource in the input section. This could be a range of different activities, such as staff training, offering a new service (or expanding an existing one), or introducing new technology.

Expected outputs

The outputs describe the expected **direct products of the activities**, such as the number of staff trained if a new training package is implemented, or the number of users of a new service like a mental health support helpline.

Expected outcomes

The outcomes describe the expected **ultimate aims of the initiatives** (9) and are often realised on a more medium-to-long-term basis than the outputs. For example, improved mental health in the population, staff having improved skills, or healthcare targets being met.

Monitoring the expected outputs and outcomes

An important aspect of **understanding how far an initiative has been successful** and whether it has reached the intended aims, is to monitor the expected outputs and outcomes relevant to the implemented initiative (9). Understanding how to monitor initiatives and which types of data to use are important both for the prioritisation process and for subsequent evaluation of what has been achieved (Box 8).

BOX 8 – USING DATA FOR PRIORITISATION, MONITORING AND EVALUATION

- For **prioritisation**, an important consideration in deciding what to fund may be the availability (or lack thereof) of data to monitor the outputs and outcomes (13).
- For subsequent **monitoring and evaluation**, understanding how to approach monitoring and deciding what types of data to use is important to be able to measure the outputs and outcomes of an initiative to understand if success has been achieved (13; 11).
- Where outcomes data may be unavailable, at least in the short term, e.g. because of the time it takes for outcomes to become noticeable, then measures of activity may be helpful **proxies**. For example, it may be possible to count the number of staff receiving particular training and the number of service users those staff engage with, even if it would not be feasible in the short term to detect the impact on service users' health.

Deciding which data and information to use to monitor outputs and outcomes involves a number of factors, including identifying the data that can describe the intended outputs and outcomes, but also practical factors such as being able to access the data in a timely manner.

Context

Running across the bottom of all the logic model diagrams is information on the wider context for implementing the activities. This outlines the important **factors that may influence the implementation of the activities** but that those leading the implementation may not necessarily have much control over (9), such as existing policies.

3.2 Development of logic models for urgent and emergency care winter pressures funding in the East of England

For each of the six programme areas, we provide the following diagrams:

1. A **worked example of one possible project within the programme**. The purpose of this worked example is to break down the links between one proposed activity, its outputs and its ultimate outcomes, as well as ways of monitoring and evaluating the success of the activity; so as to illustrate the use of a logic model.

2. A **full, overall logic model** for the programme area, covering all the activities, outputs, and outcomes for the programme.[1]

Box 9 highlights some important points to bear in mind when considering these logic models, and Box 10 summarises the sources of the data they are based on.

BOX 9 – CONSIDERATIONS FOR THE LOGIC MODELS

- When developing a logic model, it is important to consider the factors that may influence, positively or negatively, the success of the activities.
- The logic models are intended to provide an overview and some examples of the different types of activities that could be put in place by using the urgent and emergency care winter pressures funding for mental health, along with examples of possible outputs, outcomes and measurement approaches. These logic models are not intended to be exhaustive lists of all possible activities, outputs, outcomes and data tools. This is a common approach to developing logic models as it ensures that the resulting model focuses only on the 'critical aspects' of how the initiative can lead to the intended outcomes (11).
- We are aware of the importance of local context and of any restrictions attached to funding (such as a specified time period for spending it) and how this may influence the ability to implement and measure some of the activities we discuss in the logic models. For example, the timeframe to submit a proposal for funding may be short, making it challenging to access the required data to inform the prioritisation process. Alternatively, there may be challenges at a local level in accessing data from other organisations.

[1] Logic model diagrams may or may not include arrows indicating different possible pathways through the model (5). For the programme overview logic models, we have not included arrows as many of the activities could lead to multiple different outputs, and many of the outputs may lead to multiple outcomes, and outcomes that are also contributed to by other outputs. This would make the logic model diagrams too complex to read. However, we do make such pathways explicit via arrows in the worked example logic models for individual projects within the programmes.

BOX 10 – DATA USED TO DEVELOP THE LOGIC MODELS

The six logic models in this guide were developed using four key sources of information (further details of sources are provided in 0):

- 14 interviews and 3 workshops with representatives of the ICS/STPs in the East of England.
- Review of documents related to the winter pressures funding 2019/20 for the East of England.
- Brief review of the wider literature on logic models relevant to urgent and emergency mental health care.

Most initiatives funded by the 2019/20 winter pressures funding for urgent and emergency mental health care in the East of England were directed at supporting alternatives to A&E, and so have similar overall goals. **This section outlines the similarities across the six logic models**. The **subsequent, separate sections on each logic model, in turn, focus on what is unique to each particular programme area** within mental health urgent and emergency care.

Inputs

The key incremental input for all six logic models is the winter pressures funding for urgent and emergency mental health care. While not included in the logic model illustrations below, there may be additional resources used alongside this funding to implement the activities, e.g. existing facilities and infrastructure, existing relationships/networks that would have to be drawn upon. Where significant, these should be included in the inputs section of the logic model.

Activities

The activities describe different types of projects that have been, or could be, put in place to support the urgent and emergency mental healthcare provision. For all the logic models, the different activities have been organised into groups to highlight the different types of approaches to supporting urgent and emergency mental health needs. While the implemented activities are specific to the programme area, there is some overlap in the types of activity categories across the logic models (e.g. staff training, new services to support the specific service user of focus, expansion of existing services, recruitment of staff).

Expected outputs

The outputs describe some of the possible direct products of the activities. The outputs have been categorised into the same groups across all six logic models. **Table 3** describes these groups of outputs and the outputs within each group that are similar across multiple logic models.

Table 3: Output groups and outputs that are relevant to multiple logic models

Type of output	Description	Examples of outputs relevant to multiple logic models
Service delivery-related	The outputs of a project related to the **processes, procedures and patient flow within the health care setting**.	• Quicker discharge from A&E • Fewer ambulance conveyances • Increase in the number of referrals to other mental health support services (including specialist services).
Service user-related	The outputs of a project related to the **individual using the service**.	• Increase in the number of users of mental health support services (as alternatives to A&E) • Mental health services available to service users 24/7 • Care plans/follow-up support in place for service users.
Staff-related	The outputs of a project related to **mental health care staff**.	• Increased number of trained staff • A greater number of integrated teams and/or teams with mixed skill-sets.

Expected outcomes

The outcomes describe the expected overall aim of the activity. The outcomes have been categorised to highlight the different types of aims that may be aspired to.

Table 4 describes these groups of outcomes, and within each group the outcomes that are similar across multiple logic models. There are some additional categories of outcomes that are specific to individual logic models.

Table 4: Outcome groups and outcomes that are relevant to multiple logic models

Type of outcome	Examples of outcomes relevant to multiple logic models
Improved urgent and emergency services provision	• Improved flow through A&E • Meeting A&E targets, e.g. 4- and 12-hour breaches • Ability to de-escalate mental distress in an appropriate environment • Reduced pressure on ambulance services • Reduction in A&E (re-)attendance.
Improved hospital care and discharge	• Improved capacity and flow in the acute mental health system • Reduced length of hospital stay • Reduced avoidable admissions to hospital (for acute and mental health hospitals)
Improved experience	• Improved staff experience and confidence • Stronger relationships across different care teams (e.g. physical and mental) •
Improved service user experience	• Support for those with mental health issues to stay in their communities • More appropriate response to service users in mental health crisis • Improved service user experience
Improved health outcomes	• Improved mental health for service users • Reduced risk for service users • Ability to meet NICE guidelines for mental health care provision
Financial savings	• NA

Monitoring expected outputs and outcomes

Given the overlap in outputs and outcomes across the logic models, there are many examples of approaches to monitoring and evaluating projects that are similar across the six logic models. **Table 5** outlines the examples of data that can be used to monitor and evaluate initiatives across multiple logic models. **The monitoring and evaluation aspect of the logic models as presented in this guide does not give an exhaustive list of all possible data that could be used. Rather, it is a collection of examples of the types of data that could be used, depending on the type of initiative implemented, the intended outputs and outcomes, and the practicalities of data collection and analysis.**

Table 5: Example types of data and information that could be used to monitor outputs and outcomes across multiple logic models, collated from the literature and interviews and workshops with representatives from East of England STPs[2]

	Example	Examples of data types that can be used to measure outputs and outcomes
Outputs	• Greater number of users of a service.	• Number of users of a service
	• Increased number of different mental health services available.	• The number of different mental health services available
	• Greater number of mental health services /interventions delivered.	• The number of mental health services/interventions delivered
	• Making mental health support services available in the community 24/7.	• Availability of mental health services 24/7

[2] It is important to emphasise here that this table is a collection of examples and not all will be relevant to every local context. In addition, it may be that some initiatives aim to reduce an indicator where we have said an increase would be desired, or vice versa.

	Example	Examples of data types that can be used to measure outputs and outcomes
	• Increased number of mental health staff.	• Number of staff
	• Increased number of staff attending training	• The number of staff attending training • The number of training sessions delivered
Outcomes	• An increase in the number of users diverted to an appropriate non-emergency mental health service.	• Service user feedback • Number of service users treated in the community
	• More varied composition/skillset of care teams.	• Staff feedback
	• Reduced pressure on urgent and emergency services.	• Ambulance conveyance data • A&E (re)attendance data • 4- and 12- hour A&E breach data • Average A&E waiting time
	• Reduced length of in-patient stay.	• Hospital length of stay data • Hospital admission data

Policy context

The influencing policies were the same for all logic models we identified across the six programme areas,[3] consisting of:

[3] These are described on the NHSE&I website at: https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/.

- The national 2019/20 crisis alternative funding
- The NHS five-year forward view ambitions
- The NHS Long Term Plan aims
- Local ICS/STP ambitions for urgent and emergency mental health care.

We also recognise that there will be a wide range of other contextual factors that could influence a programme of work, such as social, economic, political, etc. Due to the broad nature of these, and that they are not necessarily specific to urgent and emergency care, these have not been explicitly included in the logic models. However, these factors should be considered when developing your own logic model, including those specific to the geographical area you work in as well as national-level factors.

Assumptions

There are assumptions underlying the logic for how the winter pressures funding is expected to eventually enable the desired outcomes to be obtained. For example, for staff training to have the desired effect of increasing staff knowledge and confidence, there are assumptions that staff attend the training and training materials are available. Some assumptions are similar across the individual programme logic models, for example:

- Service users are aware of the activity and use it.
- There is an adequate number of staff to provide the service.
- Staff are provided, and engage, with appropriate training to offer the service.

The common features of all six programmes' logic models are summarised in Box 11.

Box 11 – Summary of common features of all six programmes' logic models

- The **input** is always the winter pressures funding for urgent and emergency mental health care.
- There is some overlap in the types of **activities** (e.g. staff training, new services to support the specific service user of focus, expansion of existing services, recruitment of staff).
- The **outputs** have been categorised into the same groups across all six logic models:
    - Service delivery-related similarities: Quicker discharge from A&E; fewer ambulance conveyances; increase in the number of referrals to other mental health support services.
    - Service-user related similarities: Increase in the number of users of mental health support services; mental health services available to service users 24/7; care plans/follow-up support in place for service users.
    - Staff-related similarities: Increased number of trained staff; a greater number of integrated teams and/or teams with mixed skill sets.
- The **outcomes** have been categorised to highlight the different types of goals that may be aspired to:
    - Improved urgent and emergency services provision: Improved flow through A&E; meeting A&E targets, e.g. 4- and 12-hour breaches; ability to de-escalate mental distress in an appropriate environment; reduced pressure on ambulance services: reduction in A&E (re-)attendance.
    - Improved hospital care and discharge: Improved capacity and flow in the acute mental health system; reduced length of hospital stay; reduced avoidable admissions to hospital.
    - Improved staff and patient experience: Support those with mental health issues to stay in their communities; improved staff experience and confidence; more appropriate response to service users in mental health crisis; stronger relationships across different care teams (e.g. physical and mental); improved service user experience.
    - Improved health outcomes: Improved mental health for service users; reduced risk for service users; ability to meet NICE guidelines for mental health care provision.
    - Financial savings.
- Given the overlap in outputs and outcomes across the logic models, there are many examples of approaches to **monitoring** and evaluating projects that are similar across the six logic models.
- The influencing **policies** are the same for all logic models, consisting of: the national 2019/20

3.3 Logic model 1: Children and young people

This section will go through the logic model for projects relating to urgent and emergency mental health specifically for children and young people, focusing on the aspects that are unique to this logic model (as those that are similar to other logic models are discussed in section 3.2.1). We will start by providing an example of one

pathway through the logic model (**Figure 6**) before going into further detail on the full logic model (**Figure 7**).

Worked example of the children and young people logic model

Figure 6 provides an overview of a worked example of one possible project and its pathway through the children and young people logic model.

The example focuses on the **activity** of introducing a new counselling service for children and young people on the waiting list for Child and Adolescent Mental Health Services (CAMHS) or who have recently been discharged from CAMHS.[4]

For this new counselling service, the expected **outputs** may be, for example, an increase in the number of counselling services for children and young people (service delivery output) and an increase in the number of children and young people receiving counselling (service user output).

The intended **outcomes** may be a reduction in the number of children and young people returning to CAMHS after discharge, supporting children and young people to stay in their communities, improved mental health for service users and improved school attendance.

These outputs and outcomes could be **monitored** in a number of ways, e.g.:

- The number of counselling interventions delivered, the number of children and young people engaging with the service.
- The number of staff members providing counselling, the number of CAMHS re-admissions.
- The number of service users treated in their community.
- Service user feedback/mental health assessments.
- School attendance data.

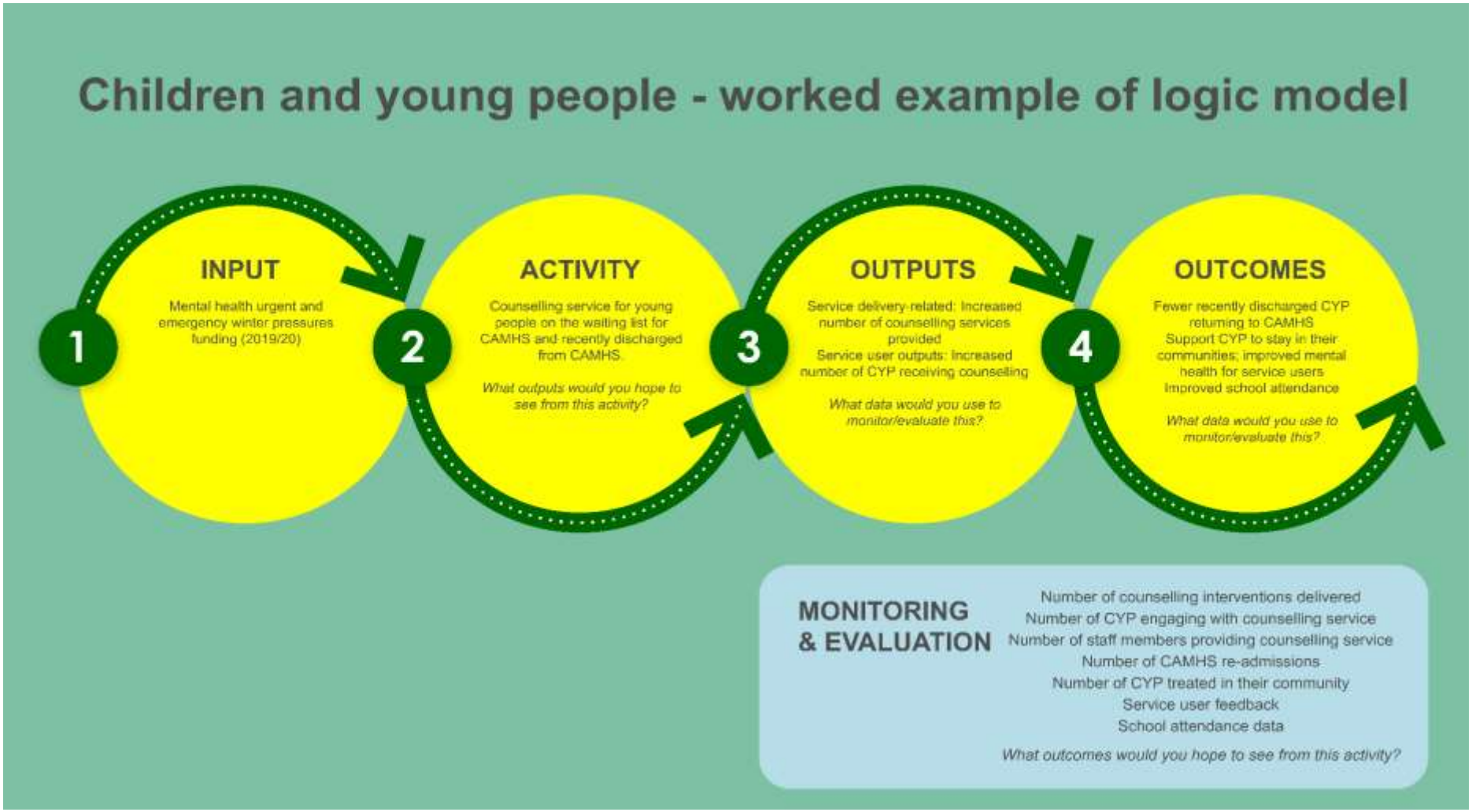
There are a number of **assumptions** underpinning this logic model that are required for the activities to reach the anticipated outcomes. Examples of the assumptions for this logic model are:

- Potential service users are aware of the counselling service.
- Staff are available and adequately trained to provide the counselling services.
- The counselling service is appropriate for the users' needs.

[4] It should be noted that this activity could have a large number of different expected outputs and outcomes, and correspondingly many ways of monitoring these. This worked example is intended to provide only a small number of example outputs, outcomes and approaches to monitoring, and we appreciate there are likely to be many others.

- The service users would otherwise have presented at A&E without the counselling service.

Figure 6: Worked example of a pathway within the children and young people logic model



Source: RAND Europe

BOX 12 – WHAT TO CONSIDER WHEN DEVELOPING YOUR LOGIC MODEL FOR CHILDREN AND YOUNG PEOPLE

When designing a logic model, it is often useful to work from the right- to the left-hand side (from outcomes to activity, as the input (i.e. available resource) is often pre-determined):

1. Think about your **vision (outcome)** for the project. **What do you ultimately want to achieve**, within the resources you have available? It may be useful to think about the particular needs of the young population in your area and where the pressures are in the system. For example, do the young people in your area need additional support after being discharged from CAMHS, or is a triage service needed in A&E departments to direct young people to more appropriate services?
2. Working back from this vision, think about **what needs to be put in place to reach the outcome (i.e. the outputs).** Do you need additional staff to offer community mental health support for young people or do you want a greater number of young people to access counselling services?
3. To achieve these outputs, you can then move to thinking about the **activities**. **What projects could you put in place for these outputs to occur**, to ultimately lead to your desired outcome (within your available resources)? For example, could a new/expanded counselling service be set up specifically available for children and young people, or does a new staff training package need to be developed?
4. Once you have thought about your outcome, output and activities, it is then useful to consider how you might **monitor and evaluate the project** to see if it leads to the outputs/outcome you are looking for. For example, you could monitor the number of staff who have taken part in the new training package, or assess the changes in the mental health of the children and young people engaging with your new service. You could also use data from other services or national data, for example, data from schools or the MHSDS.
5. After you have developed your logic model using the steps above, the final steps are to consider the wider context in which you are implementing your project and the assumptions you hold.
    a. While there is often little you can do to change the **wider context** in which your project is being implemented, it is helpful to consider how these external factors may influence your outputs and outcomes. For example, is there a new policy or programme being implemented that will direct additional resources to young people's mental health in your area, or are there wider mental health priorities in your area?
    b. In linking your activity to the outputs and outcomes, you are making a number of **assumptions** and it can be useful to list these to understand where you may come across challenges in reaching your outputs and outcomes. For example, for a new young people's counselling service to improve the mental health of users, there

Full logic model for children and young people

This section will provide details on the full logic model for children and young people, which incorporates the worked example from the previous section as well as other types of activities and their resulting outputs and outcomes. See **Figure 7** for a diagrammatic representation of the full logic model. We focus here on the aspects of the logic model that are specific to children and young people. The information that is similar across multiple logic models was discussed in section 3.2 (summarised in Box 11).

Activities

The activities to support children and young people have been organised into four types:

1. Hiring **additional staff** trained to support the mental health of children and young people.

2. Offering **additional mental health services** for children and young people.

3. Offering **training for staff** on how to support a child or young person in a mental health crisis.

4. Promoting the development of **integrated care teams** covering both physical and mental health support.

Expected outputs

The logic model for children and young people includes some outputs specific to this group of service users. For example, some initiatives are focused specifically on **reducing A&E attendance for those on the waiting list for CAMHS or who have recently been discharged from CAMHS**, as they are particularly vulnerable groups.

Expected outcomes

When looking at the children and young people logic model, there are a number of possible outcomes that are specific to this group:

- Whether the initiative **prevents children and young people returning to CAMHS who have been recently discharged** and whether it **provides mental health support to those on the CAMHS waiting list**.

- Some of the initiatives were aimed at **reducing 'tier four' admissions, improving the operational resilience of psychiatric teams** and **improving capacity in mental health crisis services**.

- There are some health outcomes that were highlighted as particularly important for the children and young people logic model, including: **(i) a reduction in the need for children and young people to visit the GP for mental health-related reasons; (ii) supporting children and young people to reach their key developmental milestones; (iii) improve physical health**.

- In addition, the impact that mental health support can have on **school outcomes** was highlighted in one of the workshops, such as increased school attendance and reduced exclusion.

Monitoring the expected outputs and outcomes

There are some types of data that can be used for initiatives aimed specifically at supporting the mental health of children and young people. This includes **CAMHS (re-**

)admission rates and the number of cases diverted from A&E directly to CAMHS or other appropriate mental health services.

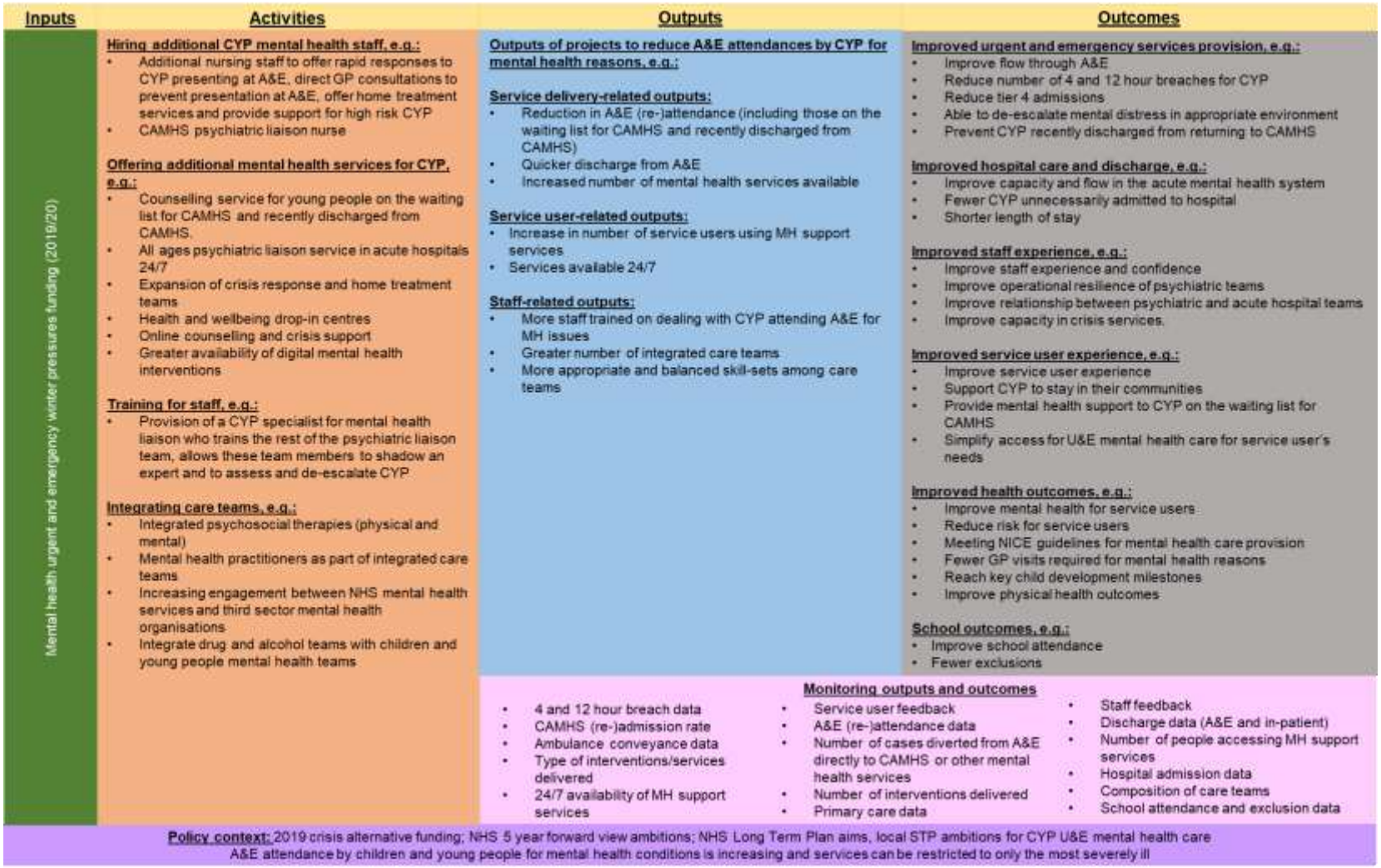
In addition, **data from schools, available on application to the National Pupil Database**[5] could also be investigated, such as attendance and exclusion rates, as well as GP data, such as the number of visits for mental health reasons and health check-ups.

Patient Reported Outcome Measures (PROMs) can be used to monitor mental health and wellbeing outcomes. For PROMs specific to children and young people, **a systematic review of measurement tools was published in 2019, which provides a longlist of tools** that can be used to assess mental health and wellbeing in adolescents (11). This review also provides an overview of the validity and reliability of each measurement tool.

Annex C provides additional detail on types of data that could be used to monitor outputs and outcomes.

[5] This can be accessed at: https://find-npd-data.education.gov.uk/

Figure 7: Children and young people logic model



Source: RAND Europe

3.4 Logic model 2: Mental health liaison

This section will go through the logic model for projects relating to urgent and emergency mental health specifically for mental health liaison, focusing on the aspects that are unique to this logic model (as those aspects that are similar to other logic models are discussed in section 3.2 and summarised in Box 11). We will start by providing an example of one pathway through the logic model (**Figure 8**) before going into further detail on the full logic model (**Figure 9**).

Worked example of a pathway of the mental health liaison logic model

Figure 8 provides an overview of a worked example of one possible project and its pathway through the mental health liaison logic model.

The **activity** of focus in this example is staff to support the 24/7 Crisis Line.

The **outputs** of this could be that the crisis line is available to service users 24/7, more staff are trained, and service users (where appropriate) are diverted away from A&E to other non-crisis services.

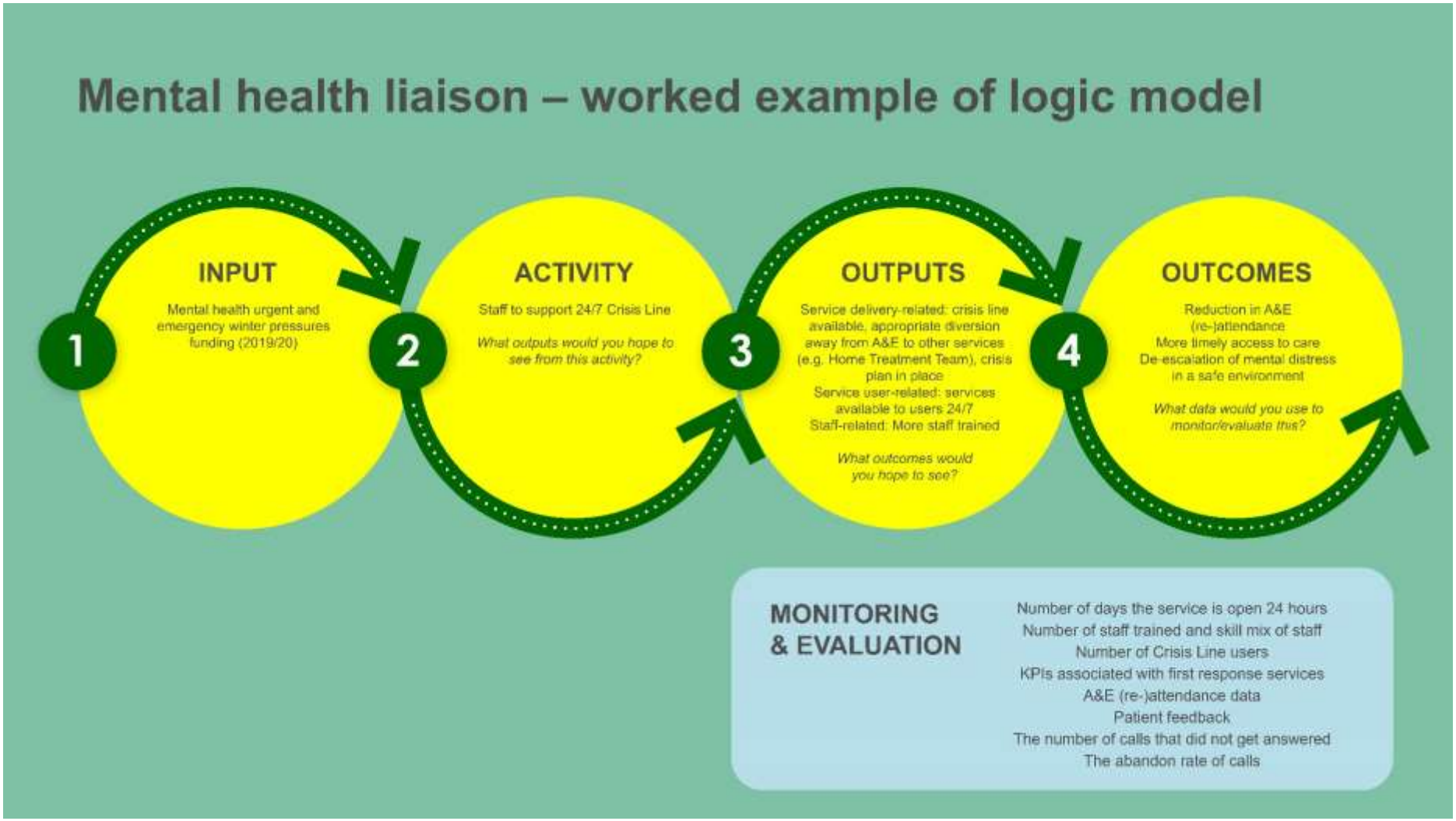
The **outcomes** of this type of project could be a reduction in A&E (re-)attendance, more timely access to care and de-escalation of mental distress in a safe environment.

For the **monitoring** of this, data could be collected and analysed on the number of days the service is available 24/7, the number of staff trained and the skill mix of staff managing crisis lines, the number of calls that do not get answered, and the abandon rate of calls. In addition, the number of crisis line users, A&E (re-)attendance data, key performance indicators (KPIs) associated with first response services and service user feedback could also be collected. Some data can be difficult to obtain. For instance, feedback from service users during a crisis. Staff experiences may be more readily collected. In addition, getting data on the abandon rate for calls (including those who hang-up before the call is answered) can be challenging to obtain but can be an important way of monitoring whether services are meeting demand.

There are a number of **assumptions** that underly the flow from activities to outcomes. Examples of these are:

- The crisis lines are sufficiently staffed to deal with the demand and nature of calls (e.g. staff have psychological training and some mental health experience).
- Tele-coaching training is available.
- Those who need the crisis lines are aware of them.
- Service users use the crisis lines.

Figure 8: Worked example of a mental health liaison pathway



Source: RAND Europe

BOX 13 – WHAT TO CONSIDER WHEN DEVELOPING YOUR LOGIC MODEL FOR MENTAL HEALTH LIAISON

When designing a logic model, it is often useful to work from the right to the left-hand side (from outcomes to activity, as the input (i.e. available resource) is often pre-determined):

1. Think about your **vision (outcome)** for the project. **What do you ultimately want to achieve, within the resources you have available**? It may be useful to think about the particular mental health liaison needs of the population in your area and where the pressures are in the system. For example, is additional support needed outside of regular working hours for mental health, or are additional mental health liaison staff needed in A&E departments?
2. Working back from this vision, think about **what needs to be put in place to reach the outcome (i.e. the outputs)**. For example, do you need more trained staff to offer a new 24/7 mental health service or more appropriate care plans put in place for service users?
3. To achieve these outputs, you can then move to thinking about the **activities**. **What projects could you put in place for these outputs to occur**, to ultimately reach your desired outcome (within your available resources)? For example, could a new/expanded crisis line be set up, or new mental health liaison teams be created?
4. Once you have thought about your outcome, output and activities, it is then useful to consider how you might **monitor and evaluate the project** to see if it leads to the outputs/outcome you are looking for. For example, monitoring the number of users of a 24/7 crisis line or assessing the mix of skills in mental health liaison teams.
5. After you have developed your logic model using the steps above, the final step is to consider the wider context in which you are implementing your project and the assumptions you hold.
    a. While there is often little you can do to change the **wider context** in which your project is being implemented, it is helpful to consider how these external factors may influence your outputs and outcomes. For example, is there a new policy or programme being implemented that will direct additional resources to mental health liaison in your area or are there wider mental health priorities in your area?
    b. In linking your activity to the outputs and outcomes, you are making a number of **assumptions** and it can be useful to list these to understand where you may come across challenges in reaching your outputs and outcomes. For example,

Full logic model for mental health liaison

This section will provide details on the full logic model for mental health liaison, which incorporates the worked example from the previous section as well as other types of activities and their resulting outputs and outcomes. We focus here on the aspects of the logic model that are specific to mental health liaison, as the information that is similar across multiple logic models was discussed in 3.2 (summarised in Box 11).

Activities

The activities have been organised into five categories:

- The **recruitment and training of staff** (e.g. of staff to support mental health service users in A&E for assessment or transfer).

- Additional **liaison services** (e.g. 24/7 on-site mental health liaison).

- Improving **mental health assessments in A&E** (e.g. the creation of safe assessment areas).

- Improving **care planning** (e.g. ensuring service users seen by liaison teams have a care plan in place).

- **Psychiatric liaison** for specific groups (e.g. older adult psychiatric liaison).

Expected outputs

There are a number of possible outputs specific to mental health liaison. These include **staffed crisis lines, availability of safe assessment areas in A&E, having a protocol in place for referrals to mental health liaison teams, services available to service users 24/7 and appropriate referral to other services**.

Expected outcomes

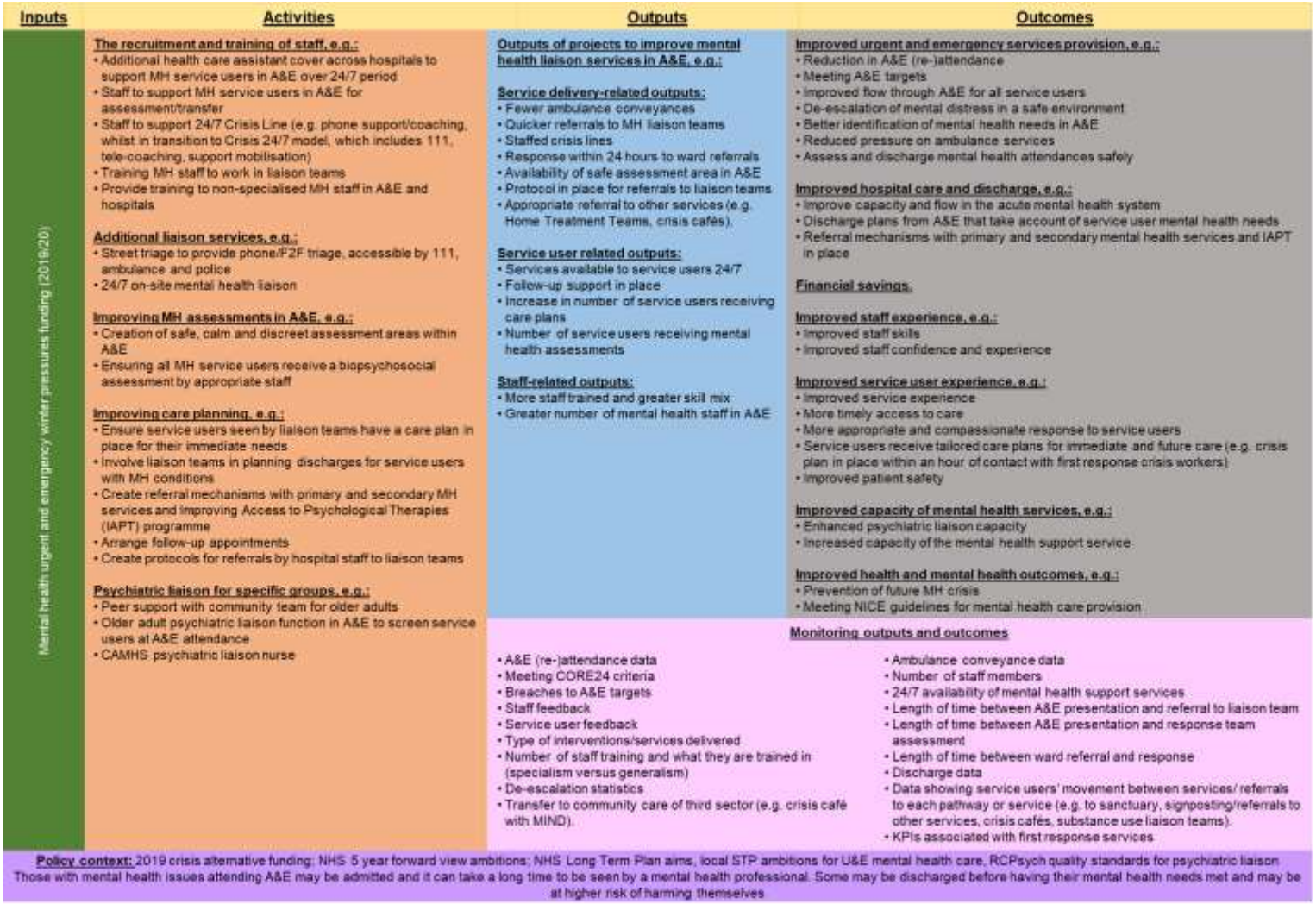
The possible expected outcomes specific to mental health liaison include **quicker referral to mental health liaison teams, the de-escalation of service users in mental distress in a safe environment, discharge plans from A&E that take into consideration service users' mental health needs, more appropriate and compassionate responses to service users, and the receipt of tailored mental health care plans for immediate and future care shortly after contact with first response crisis workers**.

Monitoring the expected outputs and outcomes

To monitor the outputs and outcomes of initiatives to support mental health liaison, there are specific types of data that could be helpful in planning, monitoring and evaluating projects. For instance, **data on the numbers of service users receiving support from liaison services and referred to other services**. This includes services linked with the liaison activities put in place through additional funding (e.g. sanctuary usage and referral to other specialist liaison teams such as substance misuse liaison), as well as other mental health services (e.g. home treatment teams, community mental health teams, and 'Improving Access to Psychological Therapies (IAPT)' services). Data that could be used to support decisions around the use of funds for mental health liaison activities and the monitoring of these also include **the number of de-escalations of service users in crisis** (i.e. service users able to return home rather than being admitted to a psychiatric ward).

Annex C0 provides additional detail on types of data that could be used to monitor outputs and outcomes.

Figure 9: Mental health liaison logic model



Source: RAND Europe

3.5 Logic model 3: Crisis alternatives

This section will go through the logic model for projects relating to crisis alternatives, focusing on the aspects that are unique to this logic model (as those that are similar to other logic models are discussed in section 3.2 and summarised in Box 11). We will start by providing an example of one pathway through the logic model (**Figure 10**) before going into further detail on the full logic model (**Figure 11**).

Worked example of a pathway of the crisis alternatives logic model

Figure 10 shows a worked example of a pathway for a specific project in the crisis alternatives programme.

The **activity** of focus is street triage; specifically, the provision of phone or face-to-face triage, accessible by 111, ambulance and police, as well as having mental health professionals in ambulance, police and NHS 111 centres for triage.

The **outputs** of this could be service delivery-related, such as enhanced call handling/triage, and more varied, integrated and reactive teams/services available. Service users in mental health crisis may receive earlier intervention and the skill mix of staff interacting with service users is likely to be broader.

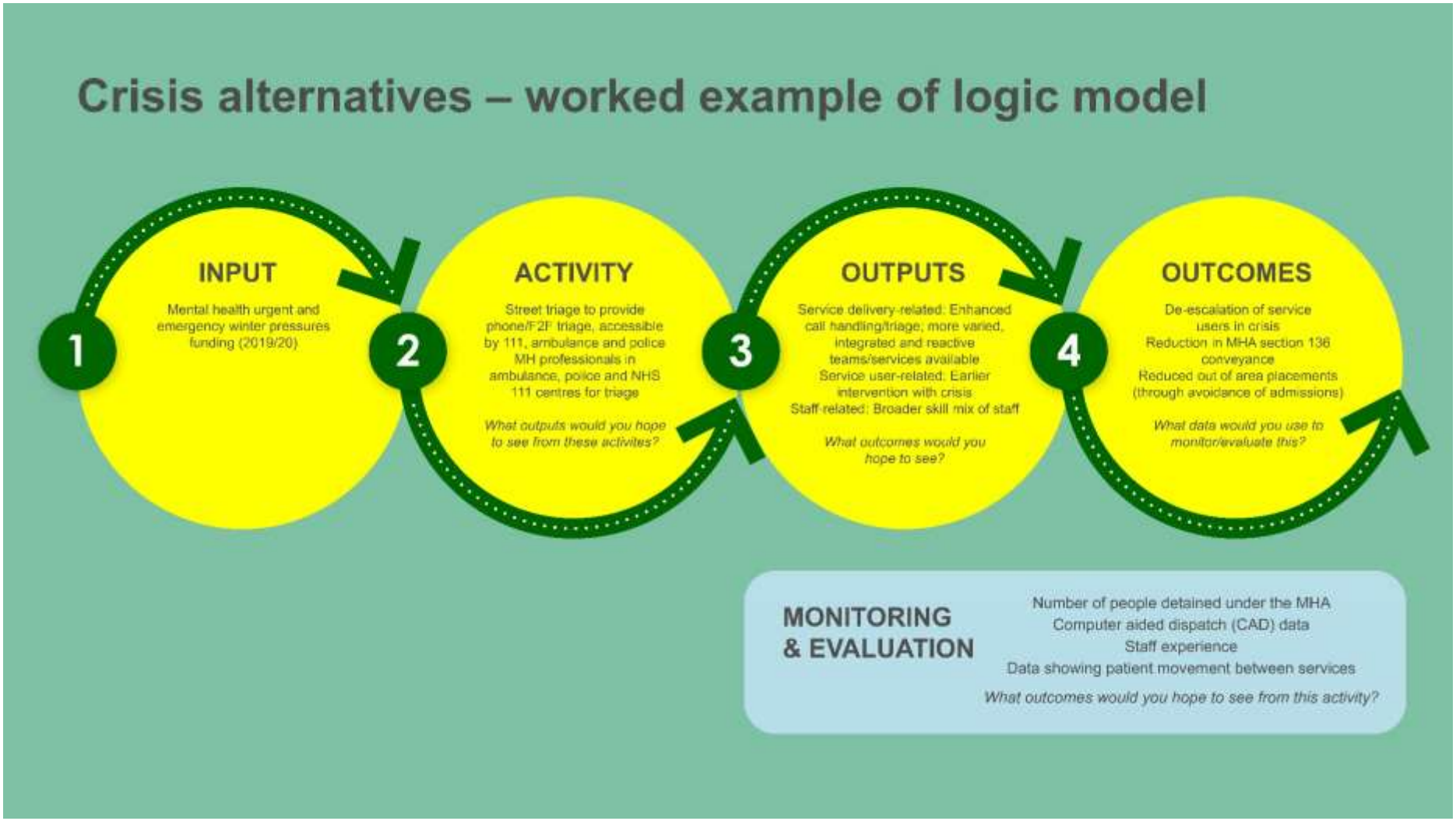
The **outcomes** of this type of project could be a higher proportion of de-escalated cases of service users in crisis, a reduction in Mental Health Act (MHA) Section 136 conveyance and reduced out-of-area placements (through avoidance of admissions).

Data that could be used to **monitor** these activities include the number of people detained under the MHA and whether this changes over time; and information held by the police. An example of how outputs and outcomes for this programme area could be measured can be seen in a study by Heslin et al. (2017), where researchers examined the individual-level cost of linkage between mental health and police services (12). Computer Aided Dispatch data on the number of service users de-escalated through street triage may also assist in the monitoring of these activities, as well as data on the proportion of service users who required an A&E visit for psychiatric reasons within a 30-day period (see (13)).

As with previous logic models, there are a number of **assumptions** that underly the flow from activities to outcomes. Example of these are:

- The triage services put in place can handle demand at the time (e.g. the local geographical and population density is considered during development).
- Existing mental health services that triage staff are making referrals to are able to cope with a potential increase in service users.
- Enough staff are available for these additional roles, or staff with skills and experience appropriate for street triage work can be identified and/or trained.
- There is collaborative working between agencies (i.e. mental health and acute care, police and ambulance services).
- Information sharing agreements are in place.

Figure 10: Worked example of crisis alternative logic model



Source: RAND Europe

BOX 14 – WHAT TO CONSIDER WHEN DEVELOPING YOUR LOGIC MODEL FOR CRISIS ALTERNATIVES

When designing a logic model, it is often useful to work from the right- to the left-hand side (from outcomes to activity, as the input (i.e. available resource) is often pre-determined):

1. Think about your **vision (outcome)** for the project. **What do you ultimately want to achieve, within the resources you have available**? It may be useful to think about the particular needs of the population in your area and where the pressures are in the system when users are in crisis. For example, do the number of out of area placements need reducing or are a greater number of mental health services needed to prevent A&E attendance?
2. Working back from this vision, think about **what needs to be put in place to reach the outcome (i.e. the outputs)**. For example, do you need a wider variety of skills in mental health staff, or to support service users to access mental health support before a crisis?
3. To achieve these outputs, you can then move to thinking about the **activities**. **What projects could you put in place for these outputs to occur**, to ultimately lead to your desired outcome (within your available resources)? For example, could additional triage services be implemented within existing urgent and emergency services, or could the opening times of existing crisis alternative services be expanded?
4. Once you have thought about your outcome, output and activities, it is then useful to consider how you might **monitor and evaluate the project** to see if it leads to the outputs/outcome you are looking for. For example, obtaining staff feedback or obtaining data on the movement of service users between mental health services.
5. After you have developed your logic model using the steps above, the final steps are to consider the wider context in which you are implementing your project and the assumptions you hold.
    a. While there is often little you can do to change the **wider context** in which your project is being implemented, it is helpful to consider how these external factors may influence your outputs and outcomes. For example, is there a new policy or programme being implemented that will direct additional resources to crisis alternatives in your area or are there wider mental health priorities in your area?
    b. In linking your activity to the outputs and outcomes, you are making a number of **assumptions** and it can be useful to list these to understand where you may come across challenges in reaching your outputs and outcomes. For example, for existing crisis alternative services to expand their opening times, there needs to

Full logic model for crisis alternatives

This section will provide details on the full logic model for crisis alternatives, which incorporates the worked example from the previous section as well as other types of activities and their resulting outputs and outcomes. We focus here on the aspects of the logic model that are specific to crisis alternatives, as the information that is similar across multiple logic models was discussed in section 3.2 and summarised in Box 11.).

Activities

The activities have been organised into four categories, covering:

- **Alterations to existing services** (e.g. earlier opening times for crisis café).
- **New services to provide crisis alternatives** (e.g. street triage to provide phone/face-to-face triage, accessible by 111, ambulance and police).
- **Hiring additional staff** (e.g. care support workers).
- **Integrating care teams** (e.g. mental health professionals in ambulance, police and NHS 111 centres for triage).

Expected outputs

There are a number of expected outputs specific to projects for crisis alternatives. These include **more varied, integrated and reactive teams/services, enhanced call handling/triage capacity in crisis, more choice for individuals seeking crisis support, and a broader skill mix amongst staff**.

Expected outcomes

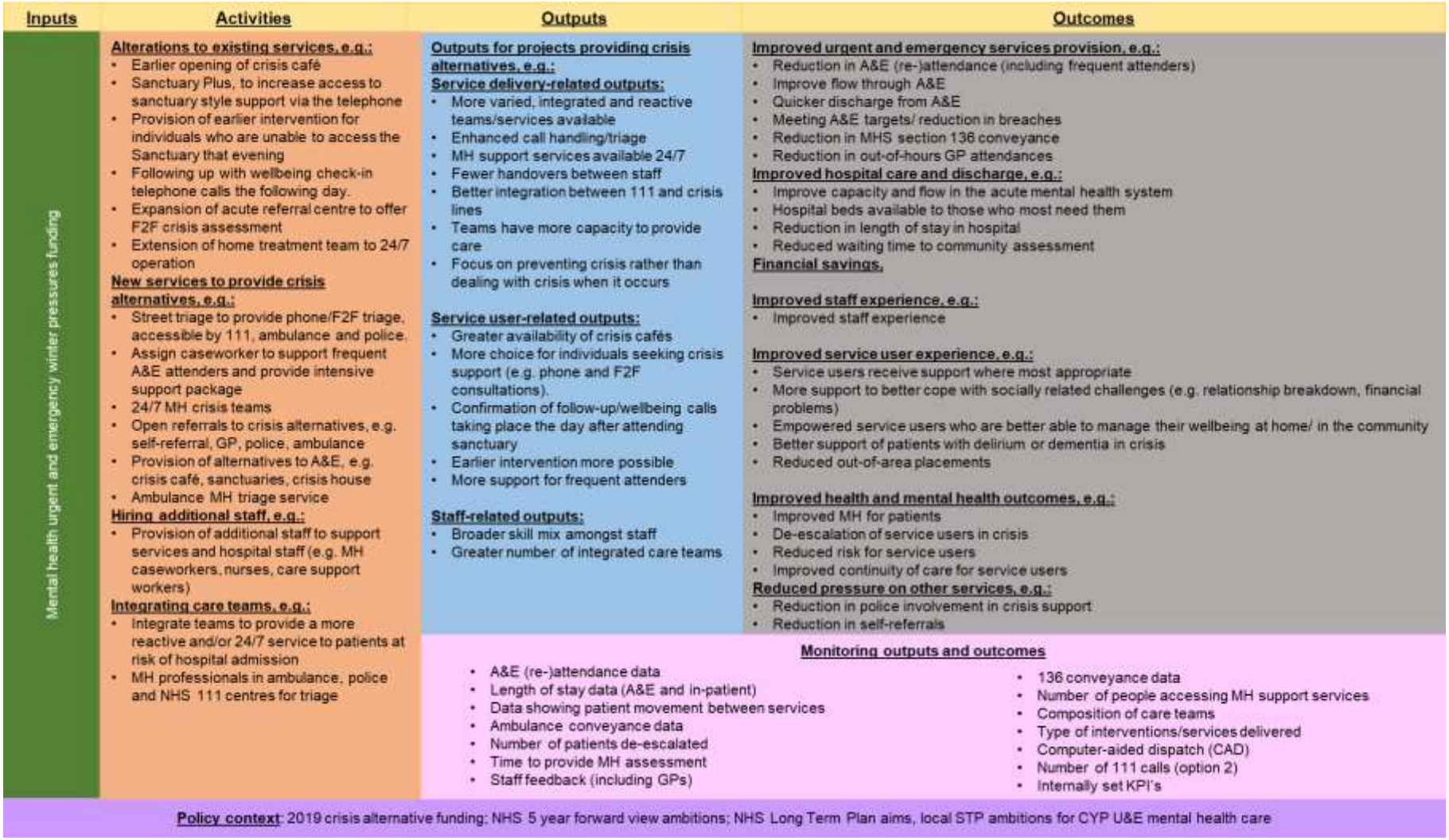
The expected outcomes specific to crisis alternatives include **reduced waiting time for community assessment, service users receiving support where most appropriate, empowered service users who are better able to manage their wellbeing at home/in the community, de-escalation from crisis for more service users, and reduced out-of-area placements**.

Monitoring the expected outputs and outcomes

To monitor the outputs and outcomes of initiatives for crisis alternatives, longer-term mental health outcome measures such as depression and anxiety scales are not appropriate, given the short period of time service users interact with these services. Instead, data such as the **number of de-escalated cases/service users able to go home after receiving support** may be better for monitoring and evaluating the projects in this programme area. In addition, Computer-Aided Dispatch (CAD) data may be used to measure whether there are fewer total cases conveyed for calls triaged through these additional services, as has been used in a service evaluation of a triage pilot intervention for Ambulance Service patients with mental health problems by Yorkshire Ambulance Service (14).

Annex C provides additional detail on types of data that could be used to monitor outputs and outcomes.

Figure 11: Logic model for crisis alternatives



Source: RAND Europe

3.6 Logic model 4: High impact support

High impact support refers to supporting those who have a high impact on the health care system, primarily people who present to A&E frequently. This section will go through the logic model for projects relating to high impact support, focusing on the aspects that are unique to this logic model (as those that are similar to other logic models are discussed in section 3.2. and summarised in Box 11). We will start by providing an example of one pathway through the logic model (**Figure 12**) before going into further detail on the full logic model (**Figure 13**).

Worked example of a pathway of the high impact support logic model

Figure 12 provides the worked example of a potential pathway through the high impact support logic model.

The **activity** of focus is the assignment of a case worker for frequent A&E attenders to signpost them to alternative mental health support services and to liaise with these services if required.

The **outputs** of this could be the identifying and contacting of frequent A&E attenders and an increase in the number of referrals to other mental health support services (both are service delivery-related). A service user-related output may be increased awareness of alternatives to A&E for mental health support for frequent attenders and/or ensuring frequent attenders have a crisis plan put in place.

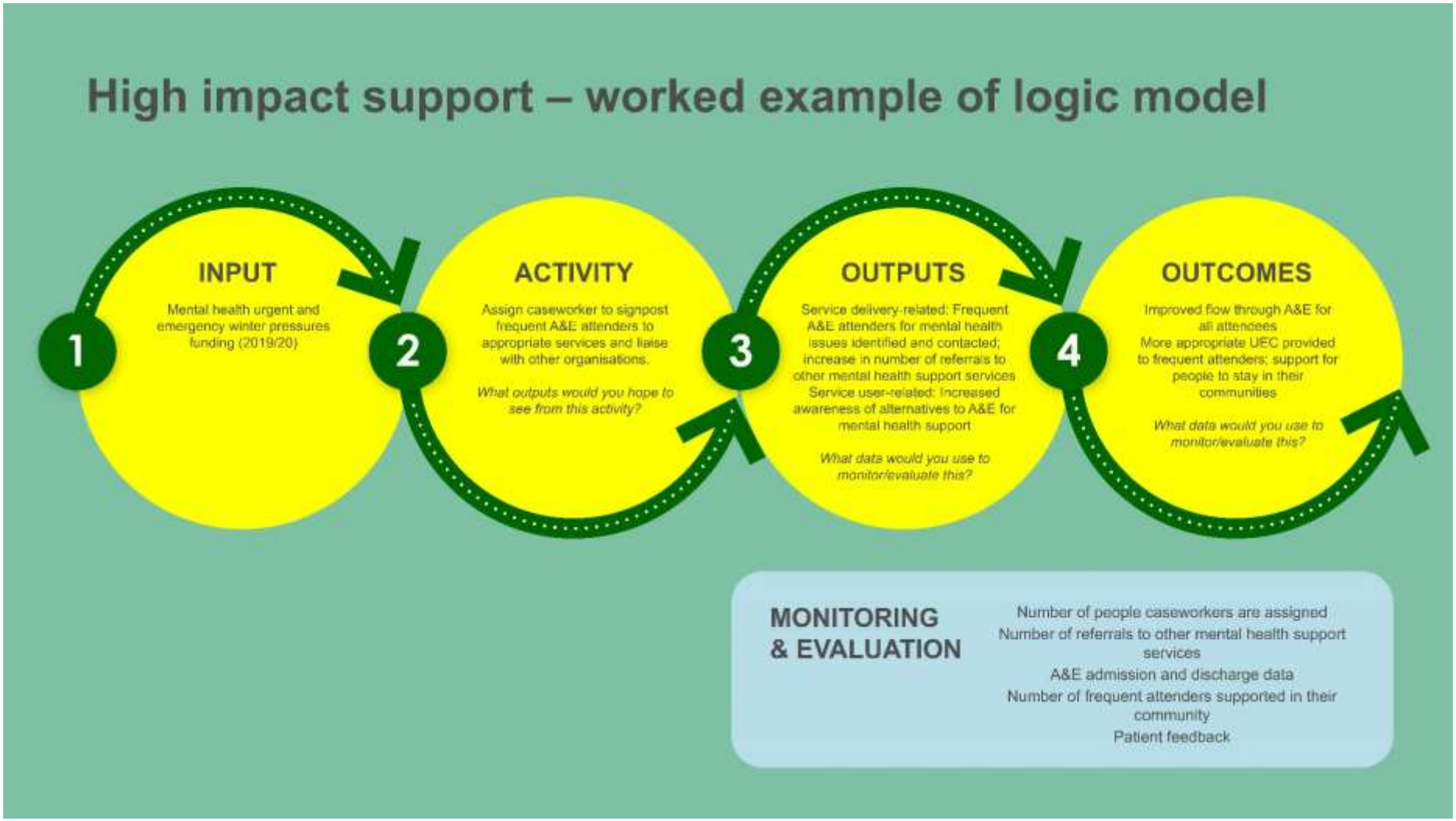
The expected **outcomes** of this type of initiative could be improved flow through A&E for all patients attending A&E, more appropriate urgent and emergency care provided to frequent attenders and support for frequent attenders to stay in their communities.

A range of types of data could be used to **monitor** these example outputs and outcomes. For example, the number of service users assigned to case workers, referrals to other mental health support services and frequent attenders supported in their community. In addition, A&E admission and discharge data, as well as service user feedback, could be explored.

As with the previous logic models, there are a number of **assumptions** that underly the flow from activities to outcomes. These include:

- Staff are available to be trained as case workers.
- Appropriate organisations exist and have the capacity to take on referrals.
- Service users attend alternative organisations for support.
- The alternative organisations provide the type of support the service user requires.

Figure 12: Worked example of a pathway within the high impact support logic model



Source: RAND Europe

BOX 15 – WHAT TO CONSIDER WHEN DEVELOPING YOUR LOGIC MODEL FOR HIGH IMPACT SUPPORT

When designing a logic model, it is often useful to work from the right- to the left-hand side (from outcomes to activity, as the input (i.e. available resource) is often pre-determined):

1. Think about your **vision (outcome)** for the project. **What do you ultimately want to achieve, within the resources you have available**? It may be useful to think about the mental health needs of the frequent A&E attendees in your area and where the pressures are in the system. For example, is more appropriate urgent and emergency mental health support needed for frequent attenders?
2. Working back from this vision, think about **what needs to be put in place to reach the outcome (i.e. the outputs)**. For example, do the frequent A&E attenders need to be identified, or awareness increased about the alternatives to A&E for mental health support?
3. To achieve these outputs, you can then move to thinking about the **activities**. **What projects could you put in place for these outputs to occur**, to ultimately lead to your desired outcome (within your available resources)? For example, could case workers be assigned to frequent A&E attenders, or could improved support be offered for navigating alternative services?
4. Once you have thought about your outcome, output and activities, it is then useful to consider how you might **monitor and evaluate the project** to see if it leads to the outputs/outcome you are looking for. For example, monitoring the number of people with assigned case workers or obtaining feedback from frequent A&E attenders.
5. After you have developed your logic model using the steps above, the final steps are to consider the wider context in which you are implementing your project and the assumptions you hold.
    a. While there is often little you can do to change the **wider context** in which your project is being implemented, it is helpful to consider how these external factors may influence your outputs and outcomes. For example, is there a new policy or programme being implemented that will direct additional resources to high impact support in your area, or are there wider mental health priorities in your area?
    b. In linking your activity to the outputs and outcomes, you are making a number of **assumptions**, and it can be useful to list these to understand where you may come across challenges in reaching your outputs and outcomes. For example, to assign caseworkers to frequent A&E attenders, there needs to be staff with the time

Full logic model for high impact support

This section will provide details on the full logic model for high impact support, which incorporates the worked example from the previous section as well as other types of activities and their resulting expected outputs and outcomes. We focus here on the aspects of the logic model that are specific to high impact support, as the information that is similar across multiple logic models was discussed in 3.2 (summarised in Box 11).

Activities

In terms of the activities, these have been organised into four categories, covering:

- Provision of **support and interventions for frequent A&E attenders** (e.g. additional support in the community).

- Developing **service user care plans**.

- **Navigating the healthcare system and triage** (e.g. assigned staff member to signpost alternative mental health services and liaise with these on behalf of the service user).

- Improving **staff capabilities** (e.g. offering staff training on dealing with frequent attenders).

Expected outputs

In addition to the expected outputs that are similar across all six logic models (see Section 3.2), there are some outputs specific to providing high impact support. These include **identifying who the frequent attenders are within A&E departments and being able to contact them, increased awareness of alternatives to A&E for frequent attenders, and an increase in the number of staff trained specifically to support frequent attenders**.

Expected outcomes

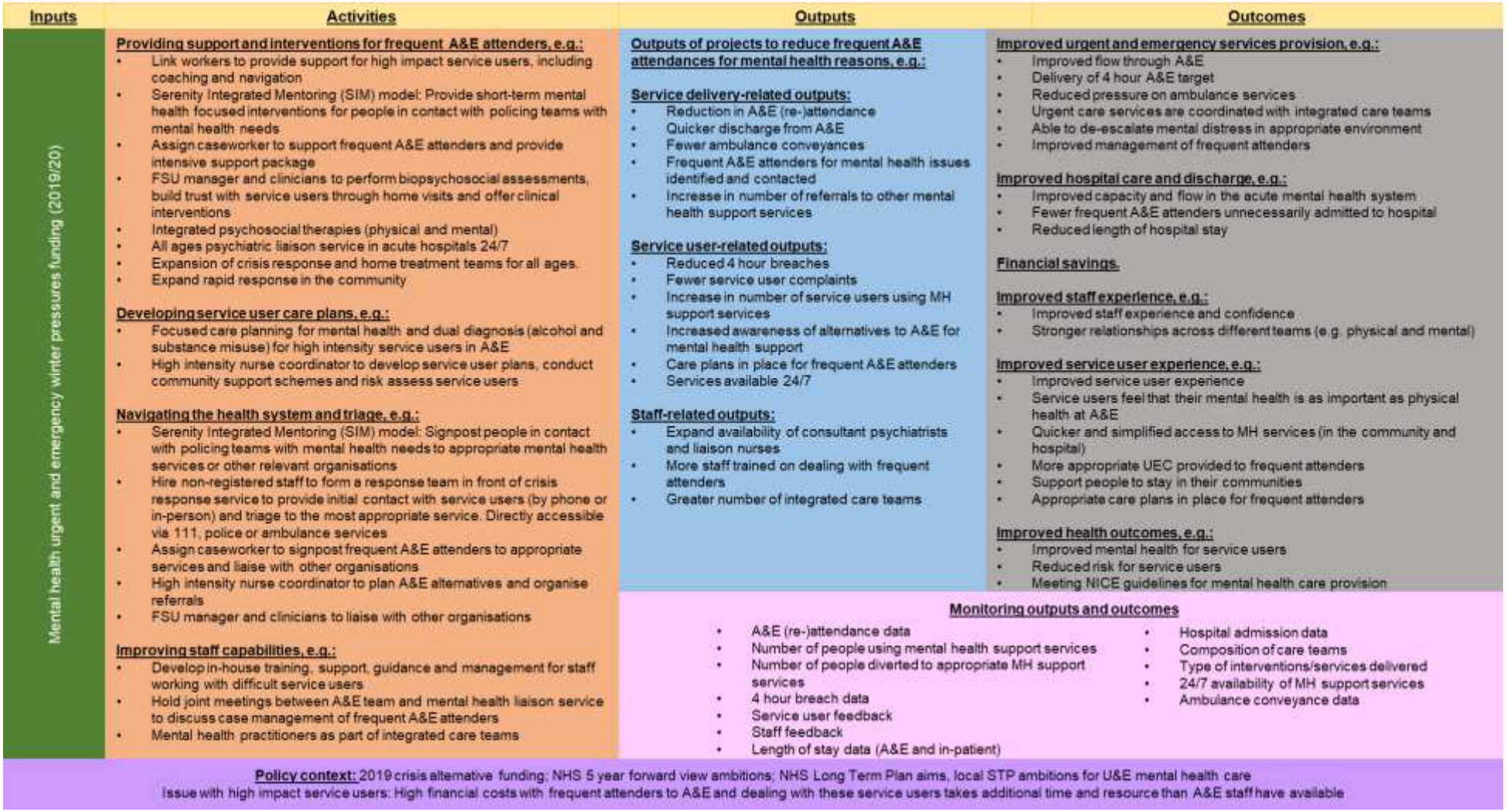
Possible expected outcomes specific to high impact support include **having urgent care services coordinated with integrated care teams and improving the management of frequent attenders**. **Financial savings** have also been linked to some initiatives aiming to divert frequent attenders away from A&E. For the improved staff and service user experience groups of possible outcomes, those specific to high impact support include **service users feeling as though their mental health is as important as their physical health when attending A&E and having appropriate care plans in place** (for both the short and long term).

Monitoring the expected outputs and outcomes

Data are available from **NHS Digital** that can be used to monitor re-attendance to A&E over a seven-day period (15). As frequent attenders are likely to be known to A&E staff, **qualitative data** can be collected on whether these service users are attending A&E less frequently and if staff think they are obtaining more appropriate care.

Annex C provides additional detail on types of data that could be used to monitor outputs and outcomes.

Figure 13: High impact support logic model



Source: RAND Europe

3.7 Logic model 5: Older adults

This section will provide details on the full logic model for older adults, which incorporates the worked example from the previous section as well as other types of activities and their resulting expected outputs and outcomes. We focus here on the aspects of the logic model that are specific to older adults, as those that are similar to other logic models are discussed in section 3.2 and summarised in Box 11. We will start by providing an example of one pathway through the logic model (**Figure 14**) before going into further detail on the full logic model (**Figure 15**).

Worked example of a pathway for older adults

Figure 14 shows a worked example of a pathway for older adults.

The **activity** of focus is linking and working with admission avoidance teams, particularly targeting care homes and providing intensive support to the homes and patients most likely to be admitted.

The **outputs** from this could be an increase in the number of trained staff to be part of admission avoidance teams, an increase in the number of service users receiving assessment (social, physical and psychological) and treatment from admission avoidance teams.

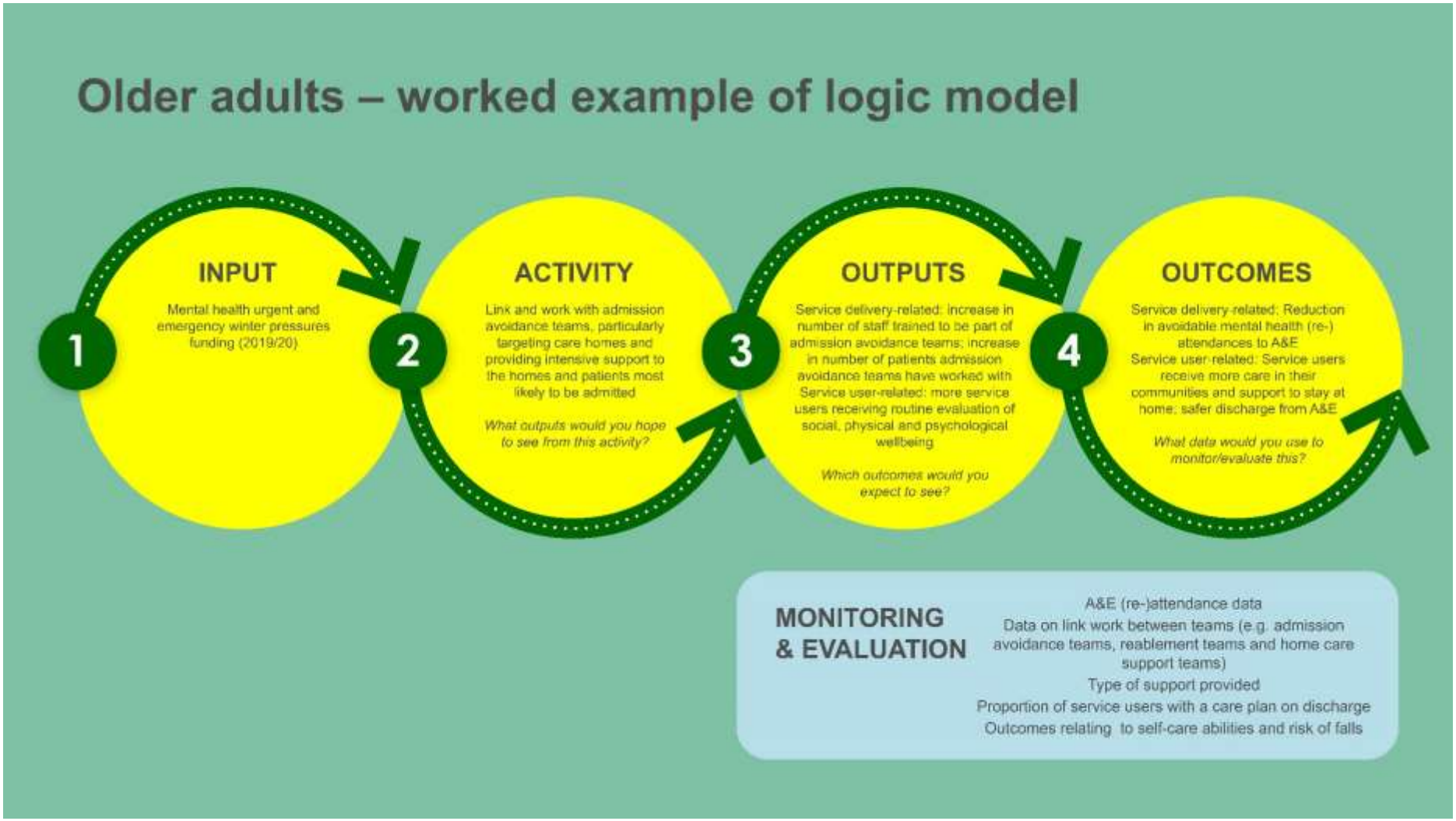
The possible expected **outcomes** of this type of project could be a reduction in (re-)attendances due to service users having a safer discharge back home and service users receiving more care in their communities.

Progress for this activity could be **monitored** through the collection of data on the integration between different support teams for older adults, the types of support provided (including referrals to specialist community services), the proportion of service users with a care plan on discharge, outcomes relating to self-care abilities and risk of falls, and A&E (re-)attendance in older adults.

As with previous logic models, there are a number of **assumptions** that underly the flow from activities to outcomes. Example of these include:

- Systems are in place and are working for the integration of admission avoidance teams in the pathway of older adults attending urgent and emergency care.
- Staff engage with and receive appropriate training.
- The additional support received by service users addresses their needs appropriately to reduce the need for potentially avoidable admissions.

Figure 14: Worked example of older adults' logic model



Source: RAND Europe

BOX 16 – WHAT TO CONSIDER WHEN DEVELOPING YOUR LOGIC MODEL FOR OLDER ADULTS

When designing a logic model, it is often useful to work from the right- to the left-hand side (from outcomes to activity, as the input (i.e. available resource) is often pre-determined):

1. Think about your **vision (outcome)** for the project. **What do you ultimately want to achieve, within the resources you have available**? It may be useful to think about the mental health needs of older adults in your area and where the pressures are in the system. For example, is more appropriate urgent and emergency mental health support needed for patients with dementia?
2. Working back from this vision, think about **what needs to be put in place to reach the outcome (i.e. the outputs)**. For example, are additional staff needed in admission avoidance teams, or is more mental health support needed in care homes?
3. To achieve these outputs, you can then move to thinking about the **activities**. **What projects could you put in place for these outputs to occur**, to ultimately lead to your desired outcome (within your available resources)? For example, could processes be put in place to link hospital and care home teams, or to offer additional peer support in the community?
4. Once you have thought about your outcome, output and activities, it is then useful to consider how you might **monitor and evaluate the project** to see if it leads to the outputs/outcome you are looking for. For example, monitoring the number of hospital admissions or number of patients discharged with a care plan.
5. After you have developed your logic model using the steps above, the final steps are to consider the wider context in which you are implementing your project and the assumptions you hold.
    a. While there is often little you can do to change the **wider context** in which your project is being implemented, it is helpful to consider how these external factors may influence your outputs and outcomes. For example, is there a new policy or programme being implemented that will direct additional resources to older adults in your area, or are there wider mental health priorities in your area?
    b. In linking your activity to the outputs and outcomes, you are making a number of **assumptions** and it can be useful to list these to understand where you may come across challenges in reaching your outputs and outcomes. For example, to provide additional community support, there

Full logic model for older adults

This section will provide details on the full logic model for older adults, which incorporates the worked example from the previous section as well as other types of activities and their resulting expected outputs and outcomes. We focus here on the aspects of the logic model that are specific to older adults, as the information that is similar across multiple logic models was discussed in 3.2 (summarised in Box 11).

Activities

The activities have been organised into three categories, covering:

- Recruitment of **additional staff** (e.g. nurse/paramedic to support mental health staff with the mental and physical health needs of older adults).
- **Stronger links between teams and services** (e.g. link with admission avoidance team).
- **Additional services, specific for older adults** (e.g. peer support with community team for older adults).

Expected outputs

There are a number of expected outputs specific to the provision of urgent and emergency services for older adults. These include the **provision of support by a dedicated nurse or paramedic, contacts with admission avoidance teams** (e.g. at the point of and following discharge), **routine evaluation of service users' social, physical and psychological wellbeing, necessary adaptations to social care plans and better integration between care teams and community services.**

Expected outcomes

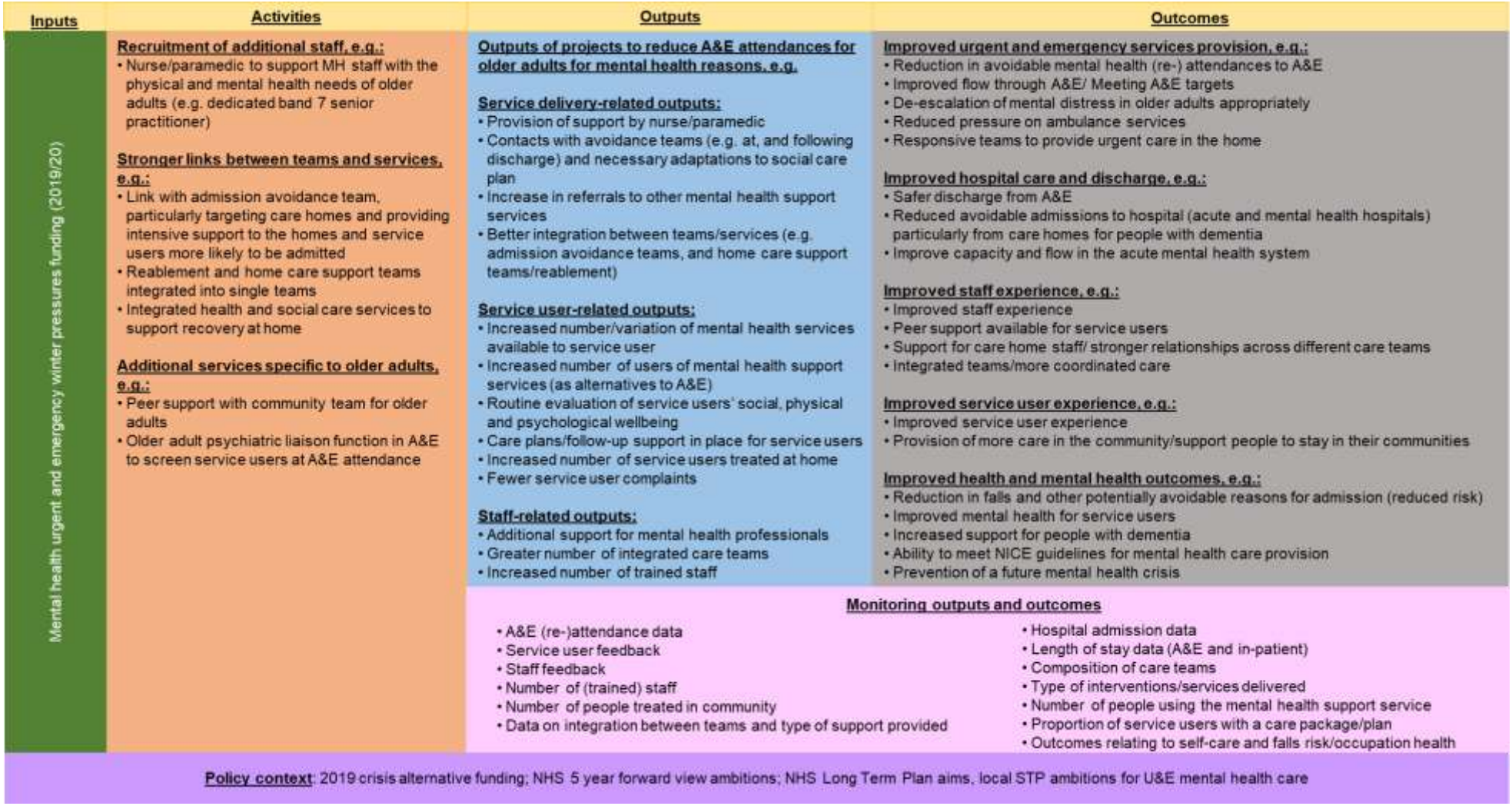
The possible expected outcomes specific to older adults include **the ability to de-escalate mental distress in older adults attending A&E appropriately, responsive teams that provide urgent care in the home, a reduction in (re-)admissions to hospital and A&E** particularly from care homes for people with dementia (due to safer discharge), **a reduction in falls** or other potentially avoidable reasons for admission in older adults due to the **provision of more support in the community.**

Monitoring the expected outputs and outcomes

To monitor the expected outputs and outcomes of initiatives for older adults in urgent and emergency care, data could be collected on the **integration between teams** (e.g. admission avoidance teams, re-ablement teams and home care support teams), **the type of support provided/community services referred to, the proportion of service users with a care plan at discharge, and outcomes related to self-care abilities and risk of falls/occupational support in place.**

Annex C provides additional detail on types of data that could be used to monitor outputs and outcomes.

Figure 15: Older adults logic model



Source: RAND Europe

3.8 Logic model 6: Drug and alcohol misuse

This section will provide details on the full logic model for drug and alcohol misuse, which incorporates the worked example from the previous section as well as other types of activities and their resulting expected outputs and outcomes. We focus here on the aspects of the logic model that are specific to older adults, as those that are similar to other logic models are discussed in section 3.2 and summarised in Box 11. We will start by providing an example of one pathway through the logic model (**Figure 16**) before going into further detail on the full logic model (**Figure 17**).

Worked example of a pathway through the drug and alcohol misuse logic model

Figure 16 outlines an example of one pathway through the logic model for drug and alcohol misuse.

Here, the **activity** of focus is the introduction of a specialist drug and alcohol service in psychiatric liaison.

Examples of the **outputs** that could be expected to arise from this include an increased number of interventions delivered and A&E policies being in place specifically for managing those presenting at A&E who are intoxicated (both service delivery-related outputs). In addition, there may be a greater number of service users receiving mental health interventions (which is a service user-related output).

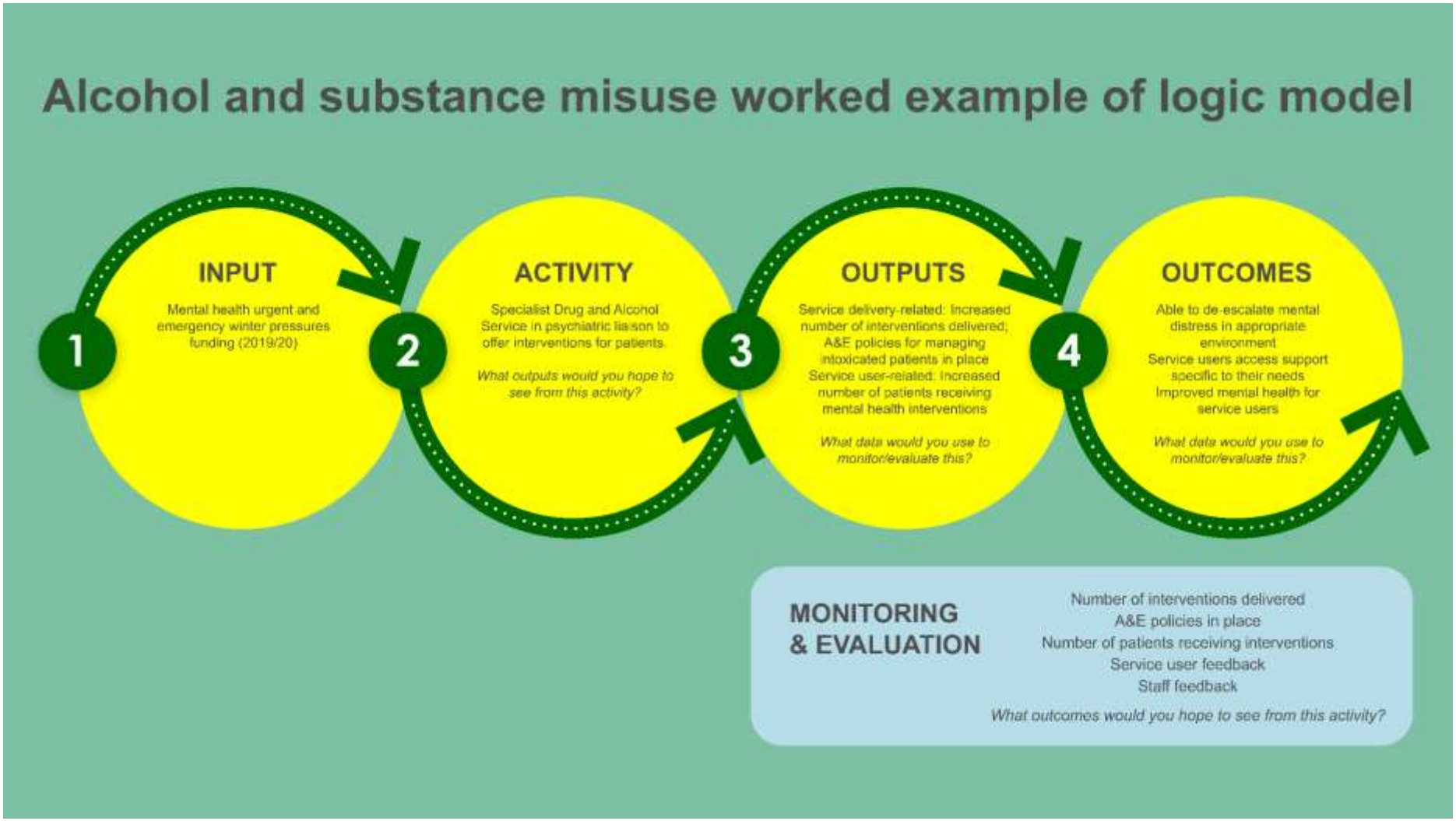
The possible expected **outcomes** that then might be expected to occur are the ability to support service users in a more appropriate environment, service users access support specific to their needs, and improved mental health for the service users.

There are a number of different ways these outputs and outcomes could be **monitored**. For the outputs, this includes the number of users of the new service, the number of interventions delivered and whether appropriate A&E policies are in place. For the outcomes, this includes service user feedback (including mental health assessments) and staff feedback.

There are a number of **assumptions** that underpin this worked example for drug and alcohol misuse. For example:

- Potential service users and staff are aware of the new service
- Service users are referred to the new specialist service
- Staff are available and adequately trained to offer the service
- The service is appropriate for the user's needs.

Figure 16: Worked example of a pathway within the drug and alcohol misuse logic model



Source: RAND Europe

BOX 17 – WHAT TO CONSIDER WHEN DEVELOPING YOUR LOGIC MODEL FOR DRUG AND ALCOHOL MISUSE

When designing a logic model, it is often useful to work from the right- to the left-hand side (from outcomes to activity, as the input (i.e. available resource) is often pre-determined):

1. Think about your **vision (outcome)** for the project. **What do you ultimately want to achieve, within the resources you have available**? It may be useful to think about the mental health needs of those with drug and alcohol misuse challenges in your area and where the pressures are in the system. For example, is more rehabilitation/detox support needed for those with drug and alcohol misuse challenges who present at A&E in mental health crisis?
2. Working back from this vision, think about **what needs to be put in place to reach the outcome (i.e. the outputs)**. For example, are detox policies needed in A&E to support service users or increased integration of physical and mental health teams?
3. To achieve these outputs, you can then move to thinking about the **activities**. **What projects could you put in place for these outputs to occur**, to ultimately lead to your desired outcome (within your available resources)? For example, could a liaison team specific to supporting those with drug and alcohol challenges be introduced in A&E?
4. Once you have thought about your outcome, output and activities, it is then useful to consider how you might **monitor and evaluate the project** to see if it leads to the outputs/outcome you are looking for. For example, monitoring whether detox policies are in place or obtaining staff feedback.
5. After you have developed your logic model using the steps above, the final steps are to consider the wider context in which you are implementing your project and the assumptions you hold.
    a. While there is often little you can do to change the **wider context** in which your project is being implemented, it is helpful to consider how these external factors may influence your outputs and outcomes. For example, is there a new policy or programme being implemented that will direct additional resources to drug and alcohol misuse in your area, or are there wider mental health priorities in your area?
    b. In linking your activity to the outputs and outcomes, you are making a number of **assumptions** and it can be useful to list these to understand where you may come across challenges in reaching your outputs and outcomes. For example, to provide additional mental health liaison services in A&E, there needs to be staff with the time available and the appropriate

Full logic model for drug and alcohol misuse

This section will provide details on the full logic model for drug and alcohol misuse, which incorporates the worked example from the previous section as well as other types of activities and their resulting expected outputs and outcomes. We focus here on the aspects of the logic model that are specific to drug and alcohol misuse, as the information that is similar across multiple logic models was discussed in section 3.2 (summarised in Box 11).

Activities

The activities relating to supporting service users with drug/alcohol misuse challenges have been grouped into five categories:

- **Acute mental health care specifically for service users with drug and alcohol issues** (e.g. specialist drug and alcohol services in psychiatric liaison).
- **Rehabilitation care** specifically for service users with drug and alcohol issues.
- **Improving care planning** for service users with drug and alcohol issues.
- **Offering staff training.**
- **Integrating care teams** (e.g. physical health, mental health and drug and alcohol staff).

Expected outputs

There are a number of expected outputs specific to supporting service users with drug and/or alcohol misuse issues, in addition to the outputs that are similar across all six logic models. These include whether an **A&E department has policies in place for appropriately managing individuals presenting at A&E with drug or alcohol intoxication** (a service delivery-related output). For service-user related outputs, this includes the **provision of both alcohol/drug detox support alongside therapeutic care**, as well as **providing ongoing support to aid in rehabilitation, recovery and social inclusion.** In addition, users are able to **access mental health services that are specific to their specialist needs.**

Expected outcomes

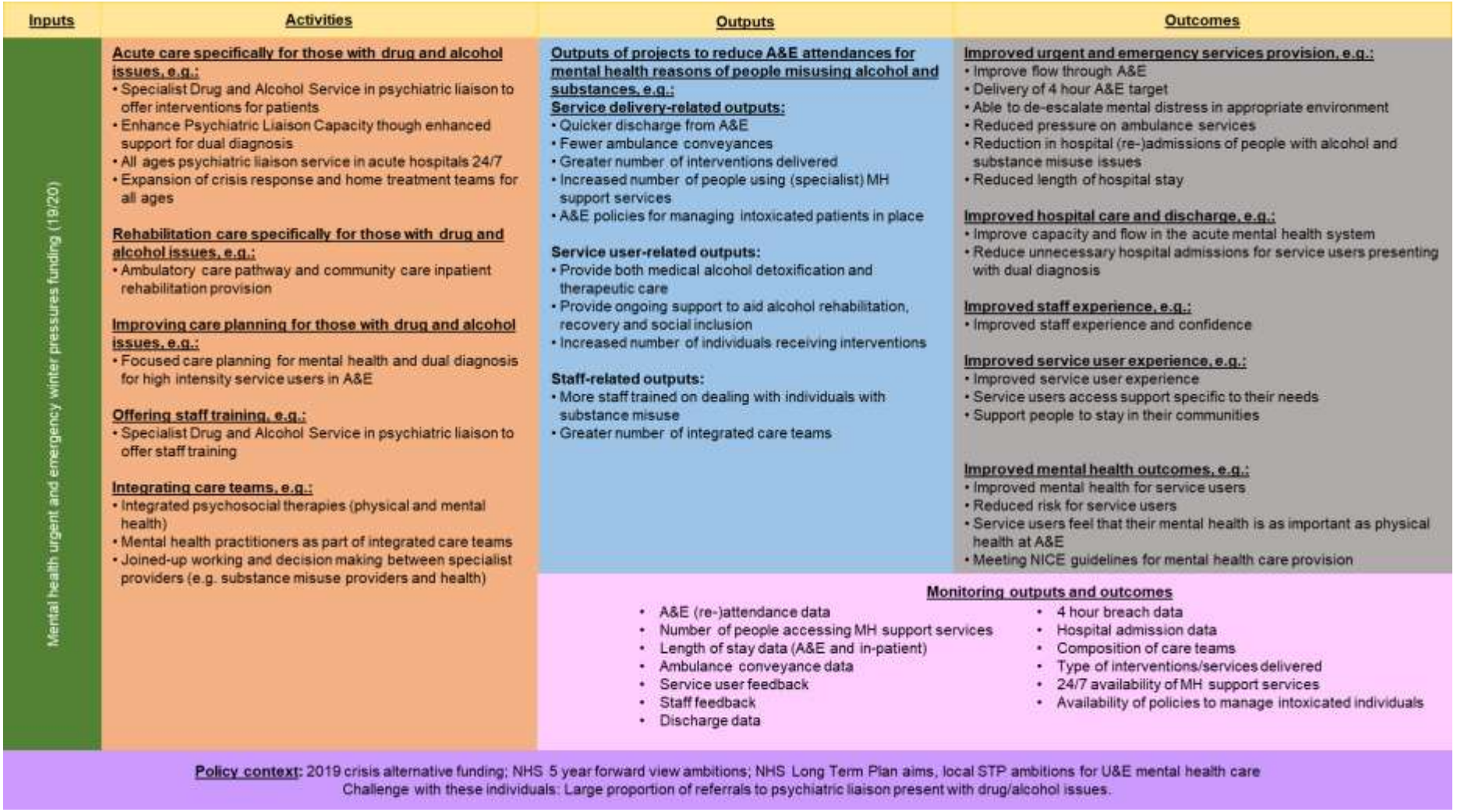
For the possible expected outcomes, those specific to service users with alcohol and/or drug misuse challenges include reducing **unnecessary hospital admission and ensuring that service users feel that their mental health is as important as physical health at A&E.**

Monitoring the expected outputs and outcomes

For monitoring outputs and outcomes, **whether A&E departments have alcohol and/or drug policies** in place could be explored.

Annex C 0 provides additional detail on types of data that could be used to monitor outputs and outcomes.

Figure 17: Drug and alcohol misuse logic model



Source: RAND Europe

Postscript

This guide has been prepared to help ICS/STPs with determining spending priorities within mental health urgent and emergency care. It describes a pragmatic and proportionate process for achieving that and explains how logic models may be developed and used to support the prioritisation process. For more detail, we commend the references listed on the following pages and the list of resources in Annex E.

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Annex A. Further detail on the methodology

The logic models for these six programmes were developed by collating evidence collected across a number of sources. This includes:

- Interviews with representatives of ICS/STPs in the East of England and NHS England and Improvement.
- A review of documents provided by the steering group on the winter pressures funding 2019/20 and the wider literature on logic models relevant to urgent and emergency mental health care.
- Three workshops with representatives of ICS/STPs in the East of England.

The six programme areas to focus on were decided on in consultation with the Eastern AHSN and NHSE&I (Eastern region), namely: children and young people; mental health liaison; crisis alternatives; high impact support; older adults; and drug and alcohol misuse. These six areas were chosen as they featured most commonly in 19/20 mental health winter pressures plans.

The interviews were conducted with representatives of ICS/STPs in the East of England and with NHS England and Improvement. In total, 14 interviews were conducted. Of these, two were with representatives from NHS England and Improvement (involving a total of three individuals) and aimed to allow a better understanding of the urgent and emergency mental health winter pressures funding for 2019/20, including the processes, timelines and expectations. The other 12 interviews were conducted with representatives from ICS/STPs in the East of England, with at least one interview being conducted from each of the six ICS/STPs. These individuals were recommended to interview by a point of contact within each ICS/STP, nominated by a steering group member. The aim of these interviews was to understand the processes of prioritisation used by the six STP/ICSs in the East of England when they decide where to spend mental health urgent and emergency care winter pressures funding. The interviews were held via Microsoft Teams and lasted up to one hour. They were audio-recorded with consent from the interviewee.

Three workshops were held throughout the course of this project, all with representatives from the East of England ICS/STPs. The first was focused on the prioritisation process. It aimed to provide attendees with an overview of the interim findings of the project and to discuss the draft version of the prioritisation process diagram. The other two workshops were focused on the logic models. After initial drafts of the logic models were developed, they were presented, discussed at two logic model workshops (three logic models discussed at each workshop), held with the steering group and representatives from ICS/STPs in the East of England to provide feedback and further recommendations for improving the models.

Box A1 – Note on the development of the activities section of the logic models

For the activities section of the logic models specifically, these activities have been pulled together from a range of sources, including: information on what each of the six ICS/STPs in the East of England implemented, examples of activities developed from the same type of funding elsewhere in England, and ideas from the workshop participants on other initiatives that could be implemented to fill a current gap in services. Therefore, the activities shown include both what has been done and examples of what else might be done.

Annex B. Checklist for designing, reporting and assessing MCDA studies

Table B1: Checklist for designing, reporting and assessing MCDA studies in health care

MCDA step	Recommendation
1. Defining the decision problem	a. Develop a clear description of the decision problem
	b. Validate and report the decision problem
2. Selecting and structuring criteria	a. Report and justify the methods used to identify criteria
	b. Report and justify the criteria definitions
	c. Validate and report the criteria
3. Measuring performance	a. Report and justify the sources used to measure performance
	b. Validate and report the performance metrics
4. Scoring alternatives	a. Report and justify the methods used for scoring
	b. Validate and report scores
5. Weighting criteria	a. Report and justify the methods used for weighting
	b. Validate and report weights
6. Calculating aggregate scores	a. Report and justify the aggregation function used
	b. Validate and report results of the aggregation
7. Dealing with uncertainty	a. Report sources of uncertainty
	b. Report and justify the uncertainty analysis
8. Reporting and examining findings	a. Report the MCDA method and findings
	b. Examine the MCDA findings

Source: Adapted by the authors from Marsh et al. (2016) (4)

Annex C. Data sources for monitoring expected outputs and outcomes

C.1 Finding the right type of data for a project

This aim of this section is to provide a high-level overview of the types of data that *could* be used to monitor expected outputs and outcomes with the aim of helping people to decide which ones are or *are not* useful for them. We consider the following types of data and provide specific examples – including available national data and references to them – drawn primarily from the outputs and outcomes shared across the logic models described in the main text (**Table C1**):

1. Project data, including patient-reported outcome measures
2. Local administrative data
3. National administrative data.

Table C1: Example types of data and potential sources (project level, local administrative data, national administrative data) for monitoring expected outputs and outcomes across multiple logic models

	Example	Examples of data types that can be used to measure expected outputs and outcomes	Project	Local admin.	National
Output	Greater number of users of a service	Number of users of a service	X	X	
	Increased number of different mental health services available	The number of different mental health services available	X	X	
	Greater number of mental health services/interventions delivered	The number of mental health services/interventions delivered	X	X	
	Making mental health support services available in the community 24/7	Availability of mental health services 24/7	X	X	
	Increased number of staff attending training	The number of staff attending training The number of training sessions delivered	X		

	Example	Examples of data types that can be used to measure expected outputs and outcomes	Project	Local admin.	National
Outcome	More appropriate response to service users in mental health crisis	Service user and/or carer feedback	X		
	More varied composition/skillset of care teams	Staff feedback	X		
	Reduced pressure on urgent and emergency services	Ambulance conveyance data A&E (re)attendance data A&E waiting time data		X	X
	Reduced length of in-patient stay	Hospital length of stay data Hospital admission data		X	X

There is no single source of data that could be used to monitor all possible outputs and outcomes identified for the mental health urgent and emergency care winter pressures funding priority areas. The data collected and used must be tailored to the activities, outputs and outcomes defined by the logic model for each project. Decisions about which data to be used will also be informed by:

- The feasibility of data collection in terms of logistics and financial costs.
- Time and labour required to collect data.
- Skills required to process or analyse data and their availability within the team,
- The quality of the data available (e.g. if completion rates too low or data entered incorrectly).
- The timeframe in which data are available (i.e. the time lag between when the data are recorded and when they are available for use, and whether the information is recent enough to be relevant).

In the following sections we provide a brief overview of the different sources of data: (i) project data; (ii) local administrative data; (iii) national administrative data. We discuss the sort of information that could be obtained from each source and the advantages and disadvantages of obtaining data from each source. For the national administrative data,

we provide examples of data collections made available by NHS Digital and Public Health England that may be relevant to East of England priority programme areas, and for which user-friendly ways of accessing the data have been developed (e.g. interactive Excel spreadsheets or webpages), providing information on what these collections contain and ways to access them. The examples provided here are not exhaustive and are intended to provide an illustration of how different types and sources of data could be used.

C.2 Project data

Project data are collected in the course of implementing a project, such as the number of staff who attended a training programme, rather than information recorded as part of the standard provision of healthcare (see Sections C.3 and C.4 for the latter). As such, it may be more likely to be generated and used in the monitoring and evaluation of a project that is in place, rather than informing the prioritisation or selection process. However, if roll-out of an intervention is being considered following an initial pilot or feasibility study, then such data may be available for use in prioritisation.

Data collected could be as simple as recording the number of people who use a service, or the number of hours or days a week a service is available. It could involve conducting focus groups or a short survey of staff and/or service users affected by the project, either while it is in operation or at its conclusion. However, many of the projects included in the East of England winter pressures funding, focus on supporting service users in crisis and it may be challenging to collect data from service users in this context (even when using patient-reported outcome measures – see below). An alternative may be to try and collect data from carers or to ask staff to provide their perspective on changes to service user experience, or to focus on process measures.

The advantages of collecting your own data are that: (i) the information collected will be tailored to the needs of your specific project and enable the measurement and monitoring of all expected outputs and outcomes as required; (ii) data will be obtained for the timeframe relevant to the project; (iii) information may be collated and analysed in a simple and straightforward way (e.g. summarised in an Excel spreadsheet using tables and bar charts). The main disadvantages are that: (i) data collection places an additional burden on staff and may therefore not be completed routinely and thus provide poor quality data; (ii) as noted above, it may be difficult to collect data directly related to service user experience for some projects; (iii) it may also be challenging to collect data if some of the outputs or outcomes of a project are intended to have an impact on wider services (e.g. ambulance conveyances, NHS 111 calls), in which case local or national administrative data may be more useful.

Patient-reported outcome measures

A systematic review was conducted in 2020 to identify a list of patient-reported outcome measures (PROMs) for adults and older adults relevant to mental health (16). This review identified PROM tools covering a range of areas related to mental health including:

- Mental health and psychosocial functioning
- Disability and functional impairment
- Symptoms and severity

- Psychological distress
- Needs assessment (e.g. accommodation, food, self-care)
- Quality of life/recovery
- Risk.

It also identifies healthcare provider outcome measures including:

- Shared decision making
- Clinicians' attitudes and training
- Satisfaction with services.

The review also highlights barriers to the implementation of these measures and their limitations. A similar 2019 review (11) focused on adolescent rather than adult mental health and examined self-report measures of general mental health and wellbeing.

C.3 Local administrative data

Depending on the medical records system for your organisation and the data that are relevant to your project, it may be feasible to access and use administrative data collected at the local level (i.e. Trust, ICS/STP). The advantages to using these data are: (i) they should be available at the geographical level that is relevant to your project; (ii) they should be more rapidly accessible thus providing the information needed in the right timeframe for the project; (iii) if the data needed are already collected locally, this will provide information to support prioritisation and also help with monitoring expected outputs and outcomes by providing a comparator for the project (from the period before it was implemented). For example, Trust-level data from the Datixweb, an online patient safety reporting system that captures violence against staff, was used to examine whether implementing a smoke-free policy was associated with a change in physical violence in psychiatric inpatient settings (17).

The disadvantages to using these data are that: (i) they may not contain information directly relevant to the outputs and outcomes of a project; (ii) there may not be any existing summaries of these data available and thus technical support may be needed to extract and summarise relevant data; (iii) internal ethical or governance approvals may be needed before data can be accessed.

C.4 National administrative data

Administrative datasets consist of information that is routinely captured by care providers and shared with a national body, such as NHS Digital or Public Health England, for aggregation, analysis and publication. In this section, we highlight data sources related to the East of England priority programme areas that could potentially be useful based on the clinical area(s) covered, and whether data are available at a potentially relevant regional level. We have focused on national data sources for which there is currently a user-friendly, preferably web-based graphical interface, tool available that allows individuals to explore and filter the data without requiring any statistical or programming skills.

The advantages of using these data are that: (i) they are readily available and some of them at zero cost to the data user; (ii) they enable comparison of data across regions and against the national average. However, there are a number of disadvantages to these data that may limit their usefulness for individual projects: (i) they may not be timely enough; (ii) they may be presented for too large an area. However, even if not directly useful for monitoring the output or outcome of a single project, these data may provide useful information for identifying unmet needs or recent trends within the local population that can support prioritisation decisions.

More detailed data are usually available from the relevant national organisation (e.g. NHS Digital) on request, but access to these data may be subject to ethical and information governance approvals, there may be costs involved in obtaining the data, and analysing it may require specialised statistical knowledge, which may mean it is not feasible to undertake this for most projects. Accessing national, individual-level data is not covered within this guide. In some areas, it may be possible to access support with this via the local Office of Data & Analytics (e.g. in Suffolk: https://www.healthysuffolk.org.uk/soda).

A&E monthly quality indicators

Data included

NHS Digital generates A&E quality indicators for all providers on a monthly basis. This used to be extracted from Hospital Episode Statistics (HES) but now comes from the Emergency Care Data Set (ECDS). The five indicators are:

1. Left department before treatment was completed: Count and percentage of attendances where patient left before being seen, by month.

2. Time to initial assessment: Median and 95th percentile of total minutes between arrival time and assessment time for ambulance cases by month.

3. Time to treatment: Median and 95th percentile of total minutes between arrival time and time seen for treatment by month.

4. Total Time in A&E: Median and 95th percentile of total minutes in A&E by month.

5. Unplanned reattendances: Count and percentage of attendances where patient returned within 7 days of previous attendance, by month.

Access to data

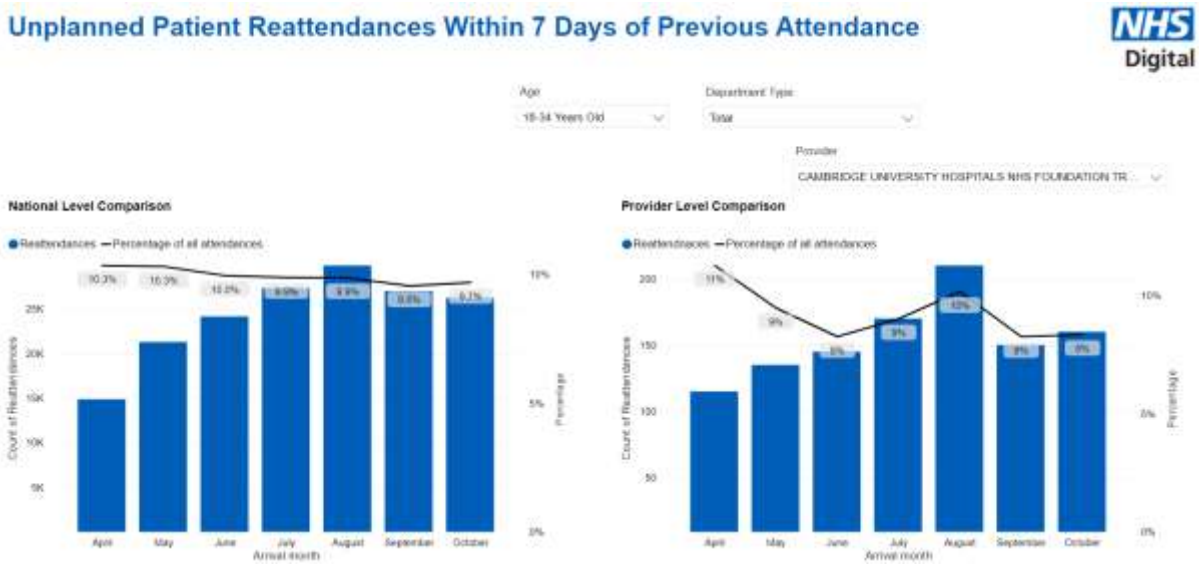
There is an approximately three-month lag in publishing these data. These data can be accessed in Excel spreadsheet format but there is also an online interactive tool that reports these statistics by provider for the previous six months, benchmarked against the national averages (https://digital.nhs.uk/data-and-information/publications/statistical/accident-and-emergency-quality-indicators) (15). This can be filtered by age; however, it cannot be filtered by any information relating to the reason for attendance, so cannot identify attendances specifically related to mental health (see

Figure C1 and **Figure C2**).

Figure C1: Example of interactive NHS Digital reporting tool for A&E data – national comparison for all patients

Source: NHS Digital Interactive A&E CQI Report tool (date accessed: 18/01/2021)

Figure C2: Example of interactive NHS Digital reporting tool for A&E data – national comparison for specific age group (18–34 years old)



Source: NHS Digital Interactive A&E CQI Report tool (date accessed: 18/01/2021)

There is also an interactive dashboard for broader information from HES (https://digital.nhs.uk/data-and-information/publications/statistical/hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data) (18), reported at CCG level, but this provides limited scope for exploring data related to mental health at CCG level.

Demand following emergency admission

Data included

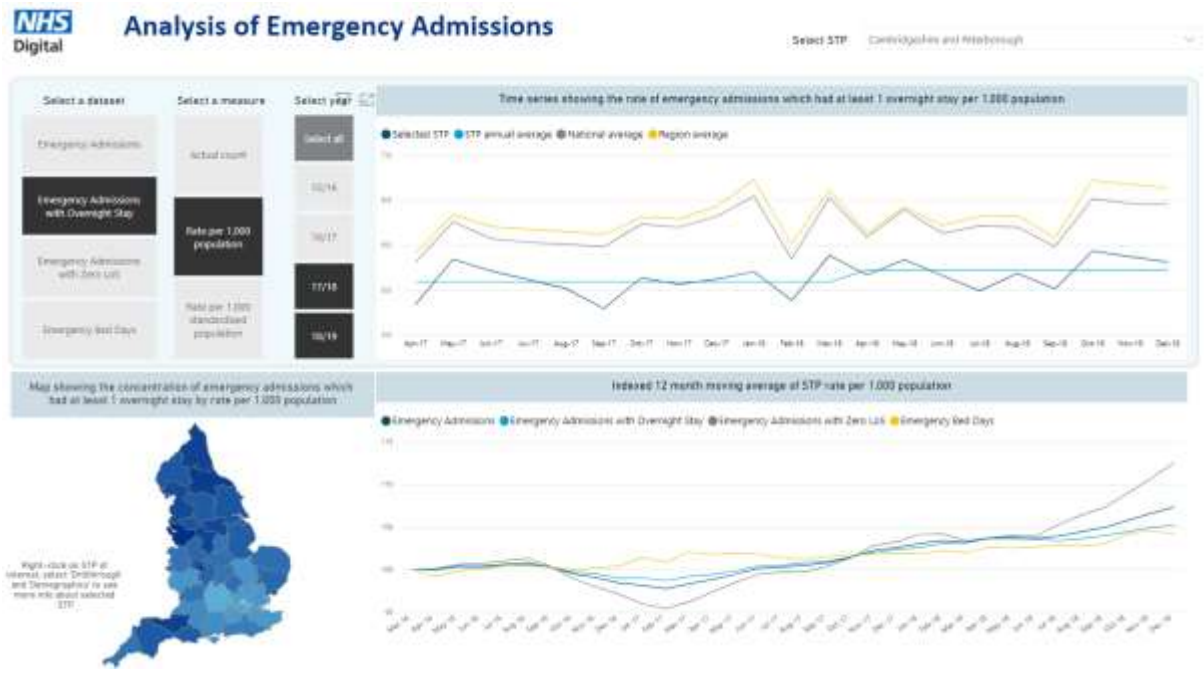
This NHS Digital data set contains high-level information on emergency admissions at ICS/STP level (https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/innovative-uses-of-data/demand-on-healthcare/demand-following-emergency-admission) (19). It contains information on:

- Emergency admissions
- Emergency admissions with an overnight stay
- Emergency admissions with zero length of stay
- Emergency bed days.

Access to data

Data are presented yearly with a one-year lag on data availability. However, information is summarised in an online graphical dashboard (see **Figure C3**) and can be explored by age group and gender.

Figure C3: Example of STP-level data display from the NHS Digital emergency admissions data dashboard



Source: NHS Digital emergency admissions data dashboard (date accessed: 18/01/2021)

Ambulance Quality Indicators

Data included

This data set, collated by NHS Digital, contains data on system indicators and clinical outcomes for all the Ambulance Services in England (https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/) (20). It contains information on:

- Number of transports to an emergency department per month.
- Number of transports to a non-emergency department per month.
- Number of face-to-face incidents with no transporting per month.
- Number of Mental Health Act Section 136 incidents and conveyances per month.

Access to data

It is updated monthly (i.e. one-month lag on data availability), with data summarised as user-friendly Excel spreadsheets that can be downloaded – the geographical area or Ambulance Service of interest can easily be selected within the spreadsheet (see **Figure C4**).

Figure C4: Example of Ambulance Quality Indicator data for the East of England Ambulance Service available via NHS Digital

Section 136 **Ambulance Systems Indicators[1, 2]**

East of England Ambulance Service		Incident count	Transported incidents	Transported incidents	Section 136 response times		
					Total (hours)	Mean (min:sec)	90th centile (hour: min:sec)[1]
RYC	Data item:	A106	A110	A110	A107	A108	A109
2019-20	April	145	129	89%	64	26:33	53:18
	May	154	142	92%	74	28:44	50:56
	June	140	129	92%	73	31:14	1:01:45
	July	163	144	88%	95	35:03	1:18:27
	August	158	144	91%	64	24:19	51:34
	September	145	132	91%	66	27:09	54:13
	October	158	132	84%	90	34:20	1:10:30
	November	156	126	81%	90	34:33	1:08:51
	December	144	117	81%	89	37:11	1:10:46
	January	188	151	80%	91	29:02	1:04:19
	February	136	111	82%	73	32:08	1:04:28
	March	141	114	81%	72	30:40	56:10
2020-21	April	115	101	88%	46	23:51	45:27
	May	166	138	83%	44	15:47	33:15
	June	187	154	82%	59	19:05	40:20
	July	223	200	90%	74	19:55	38:39
	August	210	181	86%	95	27:09	54:53
	September	222	186	84%	93	25:05	48:37
	October	169	144	85%	68	24:03	52:06
	November	9	7	78%	3	19:57	53:20
	December	17	16	94%	5	18:47	42:01
	January	-	-	-	-	-	-

Source: NHS Digital Ambulance Quality Indicators (date accessed: 18/01/2021)

Mental Health Services Data Set (MHSDS)

Data included

This brings together information captured on clinical systems as part of patient care (https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set) (21). It covers:

- Adult and older adult mental health
- Children and young people's mental health
- Learning disabilities or autism spectrum disorders.

The MHSDS not only covers services provided in hospitals but also outpatient clinics and in the community, where the majority of people in contact with these services are treated. The MHSDS includes a wide variety of information such as: (i) contacts/attendances with crisis resolution services or home treatment teams; (ii) new emergency/urgent referrals to crisis care teams (by age group); (iii) number of people subject to compulsory treatment orders and detention under the Mental Health Act; (iv) number of people with a crisis plan in place; (v) waiting times for treatment via the Early Intervention in Psychosis pathway.

Access to data

Data are reported monthly by provider, with an approximately two-month lag (https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics) (22), but they are only available in Excel spreadsheets that require substantial manipulation to summarise the outcomes reported by provider. Additionally, each spreadsheet only provides data for a one-month reporting period, so multiple spreadsheets would need to be downloaded and aggregated to examine changes over time.

National Drug Treatment Monitoring System (NDTMS)

Data included

The NDTMS data set is managed by Public Health England and provides information on the incidence and prevalence of drug treatment in England. It covers both alcohol and other drug treatment services, young people's substance misuse treatment services, and substance misuse treatment in secure settings. Monthly statistics are provided on:

- The number of clients in treatment
- Number of completed treatment spells without re-presentation
- Percentage of all clients completing and not re-presenting.

This is split by opiate users, non-opiate users and alcohol users (all 18 and over). Annual statistics provide more detailed information on a range of information including:

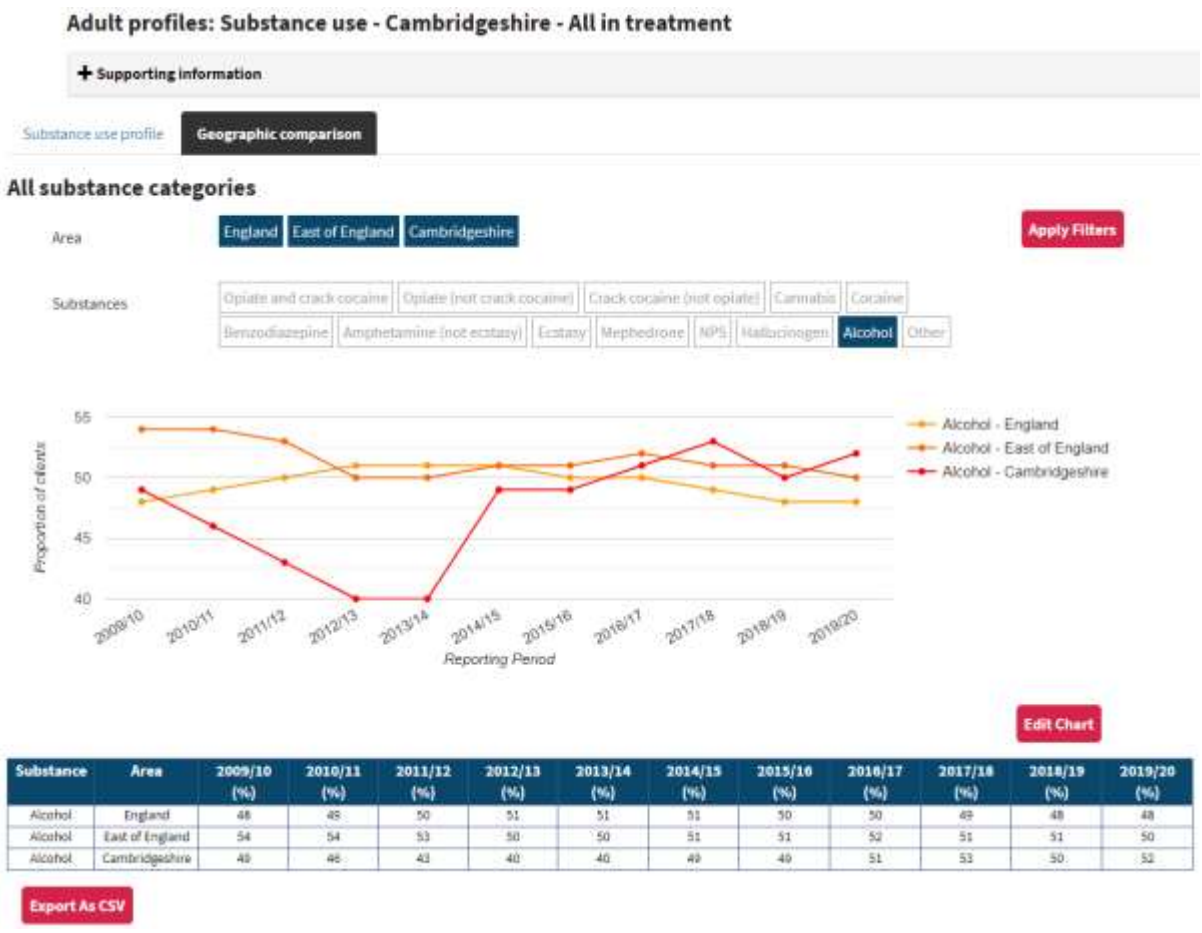
- Number of clients in treatment
- Prevalence and unmet treatment need

- Client characteristics including sociodemographics and type of substance
- Access to services (including referral source)
- Treatment outcomes.

Access to data

All statistical reports and data, including monthly provisional figures, are available from the NDTMS website: https://www.ndtms.net/ (23), although there is an approximately six-month lag in data being published. Monthly figures are available in table format at Local Authority level for a 12-month period. Annual statistics can be accessed via an interactive web-based tool called ViewIt (https://www.ndtms.net/ViewIt/Adult) (24). Data can be displayed for different client subgroups (e.g. by type of substance or sociodemographic characteristics), and to compare a particular Local Authority with a geographic area and the country as a whole (see **Figure C5**).

Figure C5: Example of geographical comparison for annual drug and alcohol treatment statistics provided by the National Drug Treatment Monitoring System ViewIt tool



Substance	Area	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Alcohol	England	48	48	50	51	51	51	50	50	49	48	48
Alcohol	East of England	54	54	53	50	50	51	51	52	51	51	50
Alcohol	Cambridgeshire	48	46	43	40	40	49	49	51	53	50	52

Source: National Drug Treatment Monitoring System ViewIt interface (date accessed: 18/01/2021)

Public Health England Fingertips

Data included

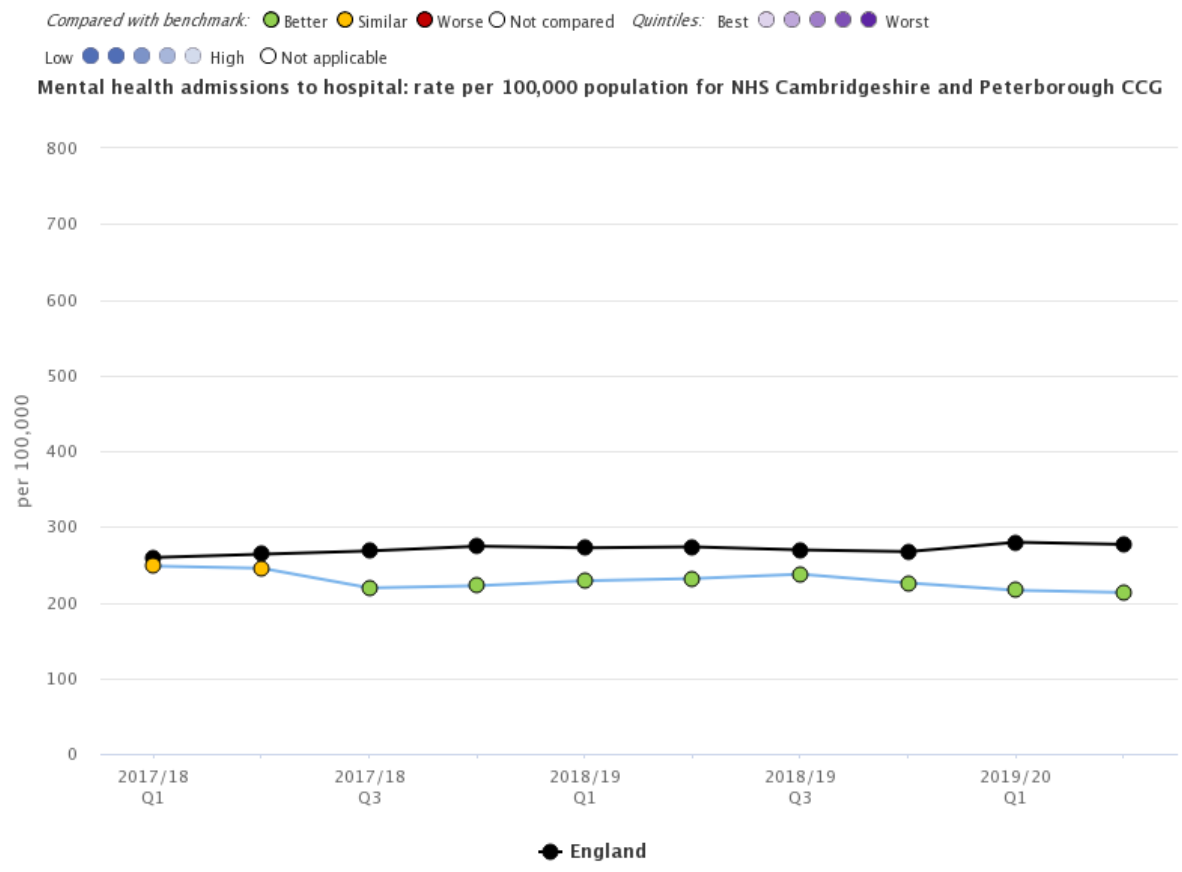
The Public Health England Fingertips data resource aggregates data from multiple sources and provides a user-friendly web-based tool that allows people to explore a range of different measures at different geographical levels. The mental health-related profiles are listed here https://fingertips.phe.org.uk/profile-group/mental-health (25); there is too much information to list all outcomes in this guide.

Access to data

The major limitation of this resource is that most data are only presented annually, or quarterly at best, amounting to a substantial lag in publication. Additionally, the different measures are not all aggregated in the same way (e.g. CCG, Local Authority), as that is dependent on how the data were collected originally. Nevertheless, the data can be used to examine trends in an outcome over time (**Figure C6**) and compare outcomes across regions (

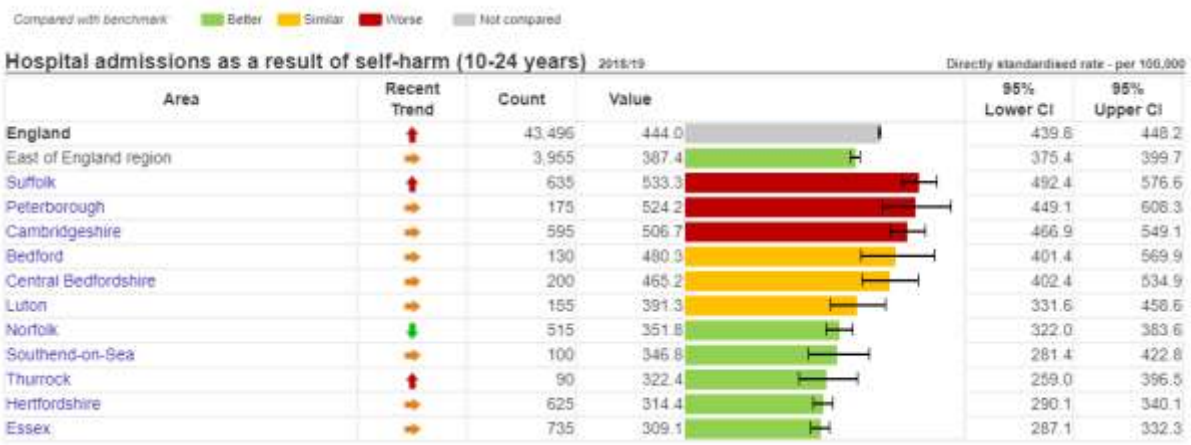
Figure C7).

Figure C6: Example of examining change in an outcome measure over time using the Public Health England Fingertips resource



Source: Public Health England Fingertips resource (date accessed: 18/01/2021)

Figure C7: Example of comparing an outcome measure between regions using the Public Health England Fingertips resource



Compared with benchmark: Better | Similar | Worse | Not compared

Hospital admissions as a result of self-harm (10-24 years) 2018/19

Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	43,496	444.0	439.6	448.2
East of England region	→	3,955	387.4	375.4	399.7
Suffolk	↑	635	533.3	492.4	576.6
Peterborough	→	175	524.2	449.1	606.3
Cambridgeshire	→	595	506.7	466.9	549.1
Bedford	→	130	480.3	401.4	569.9
Central Bedfordshire	→	200	465.2	402.4	534.9
Luton	→	155	391.3	331.6	458.6
Norfolk	↓	515	351.8	322.0	383.6
Southend-on-Sea	→	100	346.8	281.4	422.8
Thurrock	↑	90	322.4	259.0	396.5
Hertfordshire	→	625	314.4	290.1	340.1
Essex	→	735	309.1	287.1	332.3

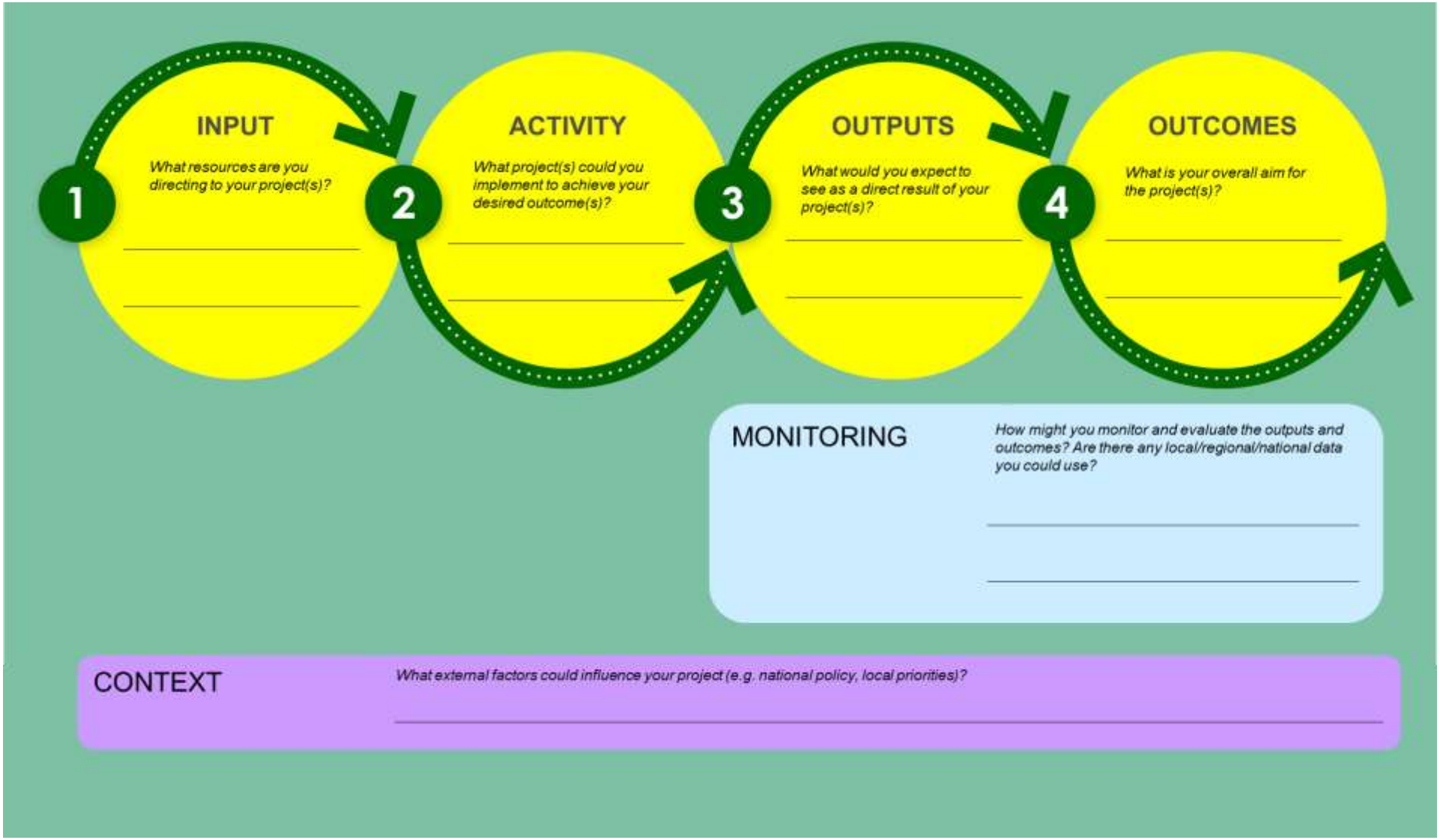
Source: Public Health England Fingertips resource (date accessed: 18/01/2021)

Data sources outside the healthcare sector

Administrative data summaries are created for many areas beyond healthcare, but to use these data in the context of monitoring the expected outputs or outcomes of a project, access to individual-level data would likely be required. This involves applying for ethical and/or information governance approval, which may be too time-consuming or expensive for most projects to consider.

The **National Pupil Database** is one such data source that is particularly relevant to the East of England priority programme area on Children and Young People. This data source contains information for all school children in England on educational attainment, demographics, absence and exclusion, and whether they are in need or looked after. The Department for Education has created an online tool for exploring the information the database contains (https://find-npd-data.education.gov.uk/) (26), but an application of the department to obtain a data extract is then necessary.

Annex D. Logic model worksheet



Annex E. Useful resources

Here, we provide a list of resources you may find helpful when thinking about prioritising your resources and/or monitoring and evaluating your projects:

- **Prioritisation of resources** – the Public Health England webpage provides clear, concise and useful material that may be helpful to other areas, including mental health urgent and emergency care. Some local examples follow, plus the HM Treasury guidance on appraisal of options:

    a. Public Health England. Overview of the prioritisation framework. 2019. https://www.gov.uk/government/publications/the-prioritisation-framework-making-the-most-of-your-budget/overview-of-the-prioritisation-framework

    b. NHS East and North Hertfordshire CCG. Commissioning prioritisation and quality impact assessment. 2019. https://www.enhertsccg.nhs.uk/sites/default/files/documents/Apr2017/Prioritisation-Framework-March-2017-FINAL-v1.6.pdf

    c. NHS West Suffolk CCG. Clinical prioritisation process. https://www.westsuffolkccg.nhs.uk/wp-content/uploads/2013/01/Clinical-Prioritisation-Process1.pdf

    d. NHS Birmingham and Solihull CCG. Policy for the prioritisation of healthcare resources. 2019. https://www.birminghamandsolihullccg.nhs.uk/about-us/publications/policies/2511-prioritisation-of-healthcare-resources-policy/file

    e. HM Treasury. 2020. The Green Book: appraisal and evaluation in central government. https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent

- **Logic model development**:

    a. 0 of this guide provides a blank template of a logic model to help your planning.

    b. Public Health England. Introduction to logic models. 2018. https://www.gov.uk/government/publications/evaluation-in-health-and-well-being-overview/introduction-to-logic-models

    c. HM Treasury. 2020. The Magenta Book. https://www.gov.uk/government/publications/the-magenta-book

    d. Better Evaluation. Using logic models and theories of change better in evaluation. 2017. https://www.betterevaluation.org/en/blog/Using-logic-models-and-theories-of-change-better-in-evaluation