NHS

GIRFT
GETTING IT RIGHT FIRST TIME

Children and Young People's Mental Health Services

GIRFT Programme National Specialty Report

By Dr Guy Northover
GIRFT Clinical Lead for Children and Young People's Mental Health Services

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GIRFT is part of an aligned set of programmes within NHS England and NHS Improvement

Contents

Foreword from Professor Tim Briggs and Professor Tim Kendall

We are delighted to recommend this Getting It Right First Time review of Children and Young People's Mental Health Services, led by Dr Guy Northover.

This report comes at a time when ensuring children and young people have access to effective and efficient mental health services is more important than ever, due to the experiences of living through the COVID-19 pandemic.

The pandemic has been challenging for children, young people and young adults' mental health. More than a quarter of young people and young adults reported disrupted sleep during the pandemic and one in ten young people and young adults reported they often or always felt lonely. 54% of 11-16 year olds with probable mental health problems said lockdown had made their lives worse.[1]

There was an approximate 50% increase in probable mental health conditions in 5-16 year olds across all sex and ethnic groups from 2017 to 2020 and almost a doubling of the number of children requiring urgent treatment for eating disorders.[2] Anecdotally, the complexity and severity of presentations has been increasing. This adds further significance to the recommendations in this report, giving many of them a greater sense of urgency.

The actions in this report, such as the development of more efficient alternatives to admission, joint working, reducing the need for long admissions for young people and the use of digital assessments, can help the NHS as it faces the substantial challenge of coping with this increase in demand for mental health care in the context of COVID-19.

The recommendations in this report are based on the virtual visits Dr Northover made to mental health trusts and provider collaboratives across England, in addition to other data collections and audits. Implementing these recommendations will help children and young people gain equitable access to timely and effective mental health care and treatment before their need becomes an emergency.

The recommendations in the report are also vital to ensure that children and young people are not stranded in the wrong part of the pathway, but instead have an easy route in and an easy route out of mental health services when they need them.

There is also a need for more consistent data and data reporting in the service, especially on outcome measures. Without this, efforts to improve services and provide patients with suitable care when they need it can be hampered, so it is our hope that this report will lead to more routine analysis and reporting of outcome data to drive further quality improvements.

It has been encouraging to hear about the enthusiasm and innovation Dr Northover has seen as he met with colleagues on virtual deep-dive visits. There were many examples of excellent practice, some of which are included as case studies in this report. These are testament to the hard work and dedication of everyone working in the specialty.

That dedication is vital to the GIRFT programme, which can only succeed with the backing of clinicians, commissioners, managers and everyone involved in delivering care.

The GIRFT programme in partnership with NHS England and NHS Improvement will continue to provide support and impetus for all those involved in children and young people's mental health, to work shoulder to shoulder and continue making a real difference to young lives.

Professor Tim Briggs *CBE*

GIRFT programme Chair and National Director of Clinical Improvement for the NHS

Professor Tim Briggs is Consultant Orthopaedic Surgeon at the Royal National Orthopaedic Hospital NHS Trust, where he is also Director of Strategy and External Affairs. He led the first review of orthopaedic surgery that became the pilot for the GIRFT programme, which he now chairs. Professor Briggs is also National Director of Clinical Improvement for the NHS.

Professor Tim Kendall

National Clinical Director for Mental Health for the NHS

Professor Tim Kendall is National Clinical Director for Mental Health for the NHS. He is also Director of the National Collaborating Centre at Royal College of Psychiatrists and University College London (UCL) where he is visiting professor. He is a consultant psychiatrist for homeless people in Sheffield.

[1] *Newlove-Delgado, McManus, Sadler, Thandi, Vizard, Cartwright (2021) "Child mental health in England before and during the COVID-19 lockdown" The Lancet, available via: https://www.thelancet.com/action/showPdf?pii=S2215-0366%2820%2930570-8*

[2] *Ibid.*

Introduction from Dr Guy Northover

Children and Young People's Mental Health Services (CYPMHS) is the fastest growing area of healthcare across the country with resulting increases in resources. There are a multitude of national drivers and programmes to ensure this resource is targeted, valued and effective. Significant changes in the commissioning arrangements are taking place through the NHS-led provider collaborative programme.

The Getting It Right First Time (GIRFT) report looks to support and enhance these national programmes, while allowing a clearer focus in identifying unwarranted variation or improvement requirements in unexpected or unexplained areas. I am honoured to be in a position where, through careful analysis of data and many clinically-led conversations, we can influence how resources can be used to provide best outcomes not only for Children and Young People (CYP), but also reduce their future needs for adult mental health services.

Benchmarking has been taken seriously by CYP services for many years, with fantastic engagement with the NHS Benchmarking Network (NHSBN), and the more recent crisis audit. However, the GIRFT review has been an opportunity to bring all the data together into one place and present it in the narrative of a whole pathway. There is vast variation within CYP services, in part due to the number of commissioners within the field and the differing priorities in different areas of the country. There is certainly no clear best or worst model, but the Five Year Forward View for Mental Health dashboard shows that there is wide variation in Clinical Commissioning Group (CCG) spend and access to community services. The focus on urgent care services can therefore not exclude the non-urgent services, and this was made abundantly clear at the deep-dive visits. It is of great satisfaction that the independent health (IH) sector data is being compared alongside the NHS provided data. The IH sector is not only an equal partner in the GIRFT work but has also been invaluable at deep-dive visits in linking the whole pathway and contributing insightful and, at times, challenging points to the conversations.

In 2019, data from the mental health dashboard showed almost 40% of the total CYPMHS budget was spent on the approximately 4,000 young people admitted to an inpatient unit – the total number of CYP using mental health services. Additionally, the average cost of one admission would support almost 100 young people within the community for one year. Despite this imbalance in spend, for too long an admission into an adolescent inpatient unit has been driven by a lack of appropriate community services rather than the belief that it is the best-known treatment. We know from deep-dive visits that too frequently young people have gone into crisis while awaiting support in the community. Pressures have existed within CYP services for many years and though this is starting to be addressed more recently, the impact of COVID-19 is driving further pressures and worries. However, the dedication and drive of all the clinicians and managers that I have met to improve the care that they can provide to CYP has been outstanding. The data presented has been met with enthusiasm to identify where they can further improve quality, often with ideas generated among the attendees before the deep dive had finished.

Clinically-led technological and service innovation is crucial for demand to be met and most effective when completed as part of a Quality Improvement (QI) initiative. Certainly, the COVID-19 pandemic showed that rapid innovation can be implemented to the clear benefit of patients and staff. However, availability of resource will ultimately be a limiting factor on what can be achieved. Additionally, the current situation of overburdened staff, services operating at above capacity and increased non-clinical demands will not lead to safe, effective, caring, or responsive services.

This report is focused on CYPMHS. However, it is important to note that in addition to the general admission units reviewed within this report, there are additionally six children's units (for under 13 year olds). Where provider level data has not been provided to us with disaggregation of the children's units, this data remains in the data pack. This has very limited impact and involved two of the six units in half a dozen metrics. As such, while the recommendations are of a nature to be of benefit to the children's units, no assessment can be made of what a positive value is for children's units in any of the metrics. This must be taken into consideration particularly for length of stay where children's units are likely to have higher lengths of stay and segregation where 'time out' for a young child is both highly appropriate and recorded as segregation.

The NHS Long Term Plan (LTP) sets out the priorities for CYPMHS and this includes expanding timely and age-appropriate mental health crisis services that 'will improve the experience of children and young people and reduce pressures on accident and emergency (A&E) departments, paediatric wards and ambulance services'. We acknowledge the ambition of the NHS Long Term Plan throughout these guidelines.

Dr Guy Northover

GIRFT Clinical Lead for Children and Young People's Mental Health Services

Guy Northover is a child and adolescent psychiatrist in Berkshire Healthcare NHS Foundation Trust where he is also the Trust Lead Clinical Director and Chief Clinical Information Officer.

He is finance officer for the faculty of child and adolescent psychiatry and the faculty Quality Improvement lead. Guy chairs the data group of the National Tier4 Clinical Reference Group.

Statement of support

The Royal College of Psychiatrists

The Royal College of Psychiatrists very much endorses the work of the Getting it Right First Time Programme (GIRFT) as it offers a real opportunity to improve the care of and outcomes for those who need to use mental health services.

This report on Children and Young People (CYP) is particularly timely as we know the impact that the pandemic has had on this group has been significant. The findings and recommendations it makes are ones that chime with the needs of children and young people and the mental health services that they access.

Within the large number of recommendations it makes, we particularly welcome its focus around three key areas:

- reductions needed in the use of restraint within the CYP inpatient population;
- use of the NHS-led provider collaboratives to drive down the need for long in-patient stays because alternative provision is not available;
- models of inpatient care based on the therapeutic model and outcomes, not a cost per bed day approach.

The College looks forward to working with those at a national and local level to implement the recommendations in this report. Children and young people need to be given the support they require to secure the best start in life and from a mental health perspective, this report provides an excellent way forward in doing this.

Dr Adrian James

President, The Royal College of Psychiatrists

Executive summary

One in six (16%) children aged five to 16 years were identified as having a 'probable mental disorder', a rise from one in ten in 2004 and one in nine in 2017.[3] Self-harm is more common among young people than any other age group, with 25% of women and 9.7% of men aged 16-24 reporting that they have self-harmed.[4] Whilst this report focuses on the under-18 population this remains a significant statistic. Given these statistics it is fortunate that there is increased resource and support for children and young people's mental health. Yet resource alone will not be enough, and this report identifies the improvements that must be made to drive efficiency and effectiveness in this vital area of healthcare.

Managing crises in the community

The importance of ensuring young people receive the right treatment close to home and making sure that their family, social and educational networks do not break down is abundantly clear. While inpatient care remains an important factor of urgent care and crisis treatment, the role of services aimed at avoiding crises, home treatment teams and alternatives to admission services are an effective and efficient way of providing care.[5, 6, 7, 8] The cost of one inpatient care episode equates to provision of care to about 100 children and young people within the community. Despite this, within community services there remain gaps in training and resource to manage these young people, with admission often required because of a lack of community provision, rather than inpatient care being considered the best option.

Joined up pathways

Crises care for CYP mental health is complex, often involving multiple different providers and commissioners across both health and social care. While there are often good reasons for this complexity it should not impact on the care young people receive. However, all too often the crisis care is siloed with young people feeling that they are moving from team to team, repeating their distressing stories, and experiencing changes to previously agreed care plans. This complexity has been recognised nationally and has begun to be addressed through the NHS-led provider collaborative initiatives. However, focusing on the young person's journey, seamlessly stepping up or stepping down care, and making sure that the young person is receiving the right care at each step, must remain at the heart of improvements.

Children and young people's specialist inpatient services

We were fortunate in being able to extend the Getting it Right First Time Programme (GIRFT) data collection to forensic and learning disability inpatient units. However, unsurprisingly, the issues that arose were similar in nature to those within the general adolescent units (GAU). A clear message around the importance of the quality and safety of the inpatient units has arisen; in all settings young people are exposed to restrictive intervention which risk re-traumatisation, decreased therapeutic engagement, and subsequent increased time in service.

Holistic approach

CYP's mental health is a collaborative effort and many key roles are played by partners, including children's social care, acute hospitals and paediatric services, education, police and other emergency services, the voluntary, community and social enterprise sector, and not forgetting the young people, their families and carers, and community support. While inclusion of these partners is outside the scope of this report, their contribution and roles are vital.

[3] *NHS Digital (2020) Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up*

[4] *McManus, S., Bebbington, P. Jenkins, R. Brugha, T. (2014) Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014. NHS Digital. https://webarchive.nationalarchives.gov.uk/20180328140249/http://digital.nhs.uk/catalogue/PUB21748*

[5] *Sadler, K., Vizard, T., Ford, T., Goodman, A., Goodman, R., McManus, S. (2018) The mental health of children and young people in England 2017: trends and characteristics. Health and Social Care Information Centre. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017*

[6] *Bould, H., Mars, B., Moran, P., Biddle, L., Gunnell, D. (2019) Rising suicide rates among adolescents in England and Wales. Lancet, 394:116-7. doi:10.1016/S0140-6736(19)31102-X pmid:31227370.*

[7] *NHS England and NHS Improvement (2021) CYP-ED waiting times time-series. NHS England and NHS Improvement. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/02/CYP-ED-Waiting-Times-Timeseries-Q3-2020-21.xls*

[8] *Ougrin, D., Corrigall, R., Stahl, D. et al. (2020) Supported discharge service versus inpatient care evaluation (SITE): a randomised controlled trial comparing effectiveness of an intensive community care service versus inpatient treatment as usual for adolescents with severe psychiatric disorders: self-harm, functional impairment, and educational and clinical outcomes. European Child and Adolescent Psychiatry. https://link.springer.com/article/10.1007/s00787-020-01617-1*

Co-design

Co-design and service user participation has a strong history within children and young people's mental health services, and where services are demonstrably of high quality there is often clear co-design of these services. Listening to the voice of young people, they are clear that while an admission may be unavoidable, and on occasions preferable, services must be seamless and community focused. It is crucial that, in taking forward the recommendations in this report, young people and their families are included in the design of the service improvements and developments.

Our findings

Data and quality improvement

- A major overarching difficulty we faced in conducting our analysis was inconsistency in data quality and reporting, including the extremely limited use of outcome measures. This is a major factor behind unwarranted variation across mental health services.
- Viewing data as averages does not allow the complexities behind the variation to be understood. Effective segmentation of data (moving away from a single 'average' metric) along with a clear clinical interpretation, will drive Quality Improvement (QI).
- Despite an enthusiasm to improve services, few providers could demonstrate mature and robust QI programmes or a clear understanding of how their collected data is driving improvement. This does appear to be changing with the implementation of NHS-led provider collaboratives, however data should both drive national understanding and local QI.

Lack of a clear inpatient model

- There is wide variation in the cost per bed day of inpatient beds, wide variation in staffing numbers and wide variation in length of stay (LoS). Much of this variation is unexplainable, however the variation was such that it was not possible to identify a preferred inpatient model.
- General admission inpatient LoS was 60 days or above for 39% of admissions with significant variation between the units. While whole system flow had a role to play, this variation was also a reflection of the different inpatient clinical models. While longer admissions are at times the most effective and efficient treatment for a young person, too often we heard that discharges were delayed or of young people deteriorating because of their experiences on the unit.
- There rarely appeared to be clear admission expectations, benefits or expected discharge dates and criteria for admitted young people.
- Retention and recruitment within the adolescent inpatient units is a challenge. NHS Benchmarking Network (NHSBN) data highlighted vacancy rates within adolescent inpatient units at the time of data collection were at a mean of 19%, which is higher than the national average for mental health services (14.3%). Within this figure, there is vast variation with one service reporting almost 70% vacancy rates and four services reporting no vacancies. The data clearly identified that the better the staffing levels the shorter the LoS.
- Autism and neurodiversity were identified as a major factor on young people's LoS and outcome. However, the minority of units were able to implement reasonable adjustments to the environment or therapeutic support for these young people. Additionally, poor diagnosis and outcome reporting makes it a challenge to identify the extent of the problem.

Restraint and restrictive interventions

- The restraint of young people is, on average, 5.7 times more likely to occur than restraint of an adult admitted to the same trust. Furthermore, the data shows that those trusts that restrain more adults restrain proportionally more young people.
- The restraint and restrictive intervention data quality flowing to the Mental Health Minimum Data Set (MHSDS) was also poor, with worse data flowing from the more secure inpatient units. While this has started to be addressed, it remains crucial to admitted CYP that this data is available at a national level.

Community crisis model

- There was significant variation within crisis models in terms of hours of service, interventions offered and staffing levels. However, the associated poor data collections made comparison between the models difficult.
- The highest performing providers were all able to demonstrate a joined-up crisis pathway, with robust processes to ensure multiagency assessments prior to admissions, with determination of the aims of the admission, what would be offered and what outcomes would be necessary for discharge back to the community.
- 78% of young people will have accessed support via A&E or a paediatric ward in the six months prior to admission to an adolescent psychiatric inpatient unit. This highlights the importance of ensuring acute hospitals are effective parts of the crisis pathway and allow the start of interventions which may then avoid an admission to a mental health unit.
- Too often we heard that young people were admitted to an inpatient unit because of a lack of an effective community alternative rather than because it was felt to be the best intervention for a young person.

Intensive community support services

- The crisis and urgent care pathway begins by providing the right intervention to avoid the crisis in the first instance. We found no relationship between Clinical Commissioning Group (CCG) spend on community CYP mental health services and subsequent number of young people admitted to an inpatient unit.
- There is evidence in both adult and young person research to suggest that the provision of effective intensive community support services, such as early intervention in psychosis services, eating disorder services, personality disorder services and neuro-disability services, lead to better outcomes for young people. However, there remains inconsistent quality and breadth of provision of these services across the country.

Recommendations

Clear inpatient models

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1. There must be a clear strategy and plan on reducing the proportion of young people remaining on the inpatient unit for more than 60 days. The plan must include: • promotion and development of effective alternatives to an inpatient admission, including provision through social care and education; • rapid and appropriate access to therapeutic support on the inpatient unit; • the ability to ensure a rapid discharge from hospital with ongoing intensive support in a community setting.	**a** Commissioners and providers including lead providers within a collaborative must develop alternatives to admission for young people who are likely to escalate behaviours on admission and can be managed in the community. This must be a jointly owned plan with all commissioners working together.	NHS and IH providers, commissioners, and Lead Provider/s of an NHS-led provider collaborative.	Each provider to have clear clinical outcomes driving principles behind discharge.	For progress within 3-6 months of publication.
	b Commissioners and providers must enable multiagency working, in particular with social care and education to enable ongoing community support in a social/educational environment that will foster engagement with the community therapeutic process.	NHS and IH providers, commissioners, and Lead Provider/s of an NHS-led provider collaborative.	Each provider and lead provider/s of an NHS-led provider collaborative to have a clear strategy as described in the action.	For progress within 3-6 months of publication.
	c Clinicians and commissioners must develop locally agreed clinical outcomes to use as the guiding principle behind discharge. These outcomes must link to the Impact Framework.	NHS and IH providers, commissioners, and Lead Provider/s of an NHS-led provider collaborative.	Developed multiagency pathways to support the treatment of complex young people in the community.	For progress within 12 -18 months of publication.
	d Commissioners including lead providers within a collaborative must promote a guiding principle of discharge being linked to agreed clinical outcomes rather than an arbitrary LoS.	NHS and IH providers, commissioners, and Lead Provider/s of an NHS-led provider collaborative.	Developed multiagency pathways to support the treatment of complex young people in the community.	For progress within 12 -18 months of publication.
	e Commissioners and lead provider/s of an NHS-led provider collaborative to monitor LoS using stratification of LoS rather than average LoS.	NHS and IH providers, commissioners, and lead provider/s of an NHS-led provider collaborative	Decreased percentage of patients discharged from a LoS greater than 60 days.	For progression within 12 months of publication.
	f Commissioners and lead provider/s of an NHS-led provider collaborative to monitor readmission rates.	NHS and IH providers, commissioners, and lead provider/s of an NHS-led provider collaborative	Decreased readmission rates.	For progression within 12 months of publication.

Clear inpatient models (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
2. Clear therapeutic models must be present on each unit, concordant with available NICE guidance, for the most common reasons for admissions. The model requires identified clinical interventions including frequency, intensity and expected outcomes. These models should be accurately staffed and link to the funding model for the unit.	**a** Each provider to review the service offer requirements of the service specification.	NHS and IH providers.	Clear therapeutic models, which are concordant with available NICE guidance, within each inpatient unit.	For progress within 12 months of publication.
	b Each provider to assess care provision against published NICE guidance on depression in CYP (NG134), the recommendations on referral in crisis and challenging behaviour in NICE's guideline on psychosis and schizophrenia in CYP (CG155), and the recommendations on inpatient and day patient treatment in NICE's guideline on eating disorders: recognition and treatment (NG69).	NHS and IH providers.	Developed outcomes-based service specification.	For progress within 18 months of publication.
3. A blended model of commissioning for inpatient units should be considered and commissioned based on the provision of therapeutic models and outcomes, not a cost per bed day model.	**a** To develop an outcomes-based service specification linking to the resourcing of the unit.	Service specification to be developed by the national Tier 4 Clinical Reference Group.	Clear outcomes-based service specifications for all child and adolescent unit types.	For progress within 18-24 months of publication.
	b Linking to rrecommendation 17. The service specification should include requirement on data collection for diagnosis, reason for admission, interventions offered and patient reported outcome measures.	Commissioners including lead providers to implement service specification.	Improved consistency of the therapeutic model within inpatient units	For progress within 18-24 months of publication.

Clear inpatient models (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
4. There must be a focus on avoiding escalation in presentation and behaviour of young people in GAU to prevent avoidable admissions to PICU. All PICU admissions should be subject to careful collective review to identify if any opportunities to avoid the PICU admission were missed.	**a** For each trust/IH provider to identify a profile of young people requiring PICU admissions.	Trust/IH provider.	Improved management of escalating behaviours on GAUs.	For progress within 18 months of publication.
	b For each trust/IH provider to identify the most common reasons for escalation to PICU.	Trust/IH provider.	Decreased admission of young people at risk of escalation of behaviours on admission	For progress within 18 months of publication.
	c Each trust/IH provider to implement plans to reduce reasons for escalation to PICU.	Trust/IH provider.	Decreased use of PICU beds.	For progress within 18 months of publication.
	d Each trust/IH provider to ensure effective staff training is in place.	Trust/IH provider.		For progress within 18 months of publication.
	e Each trust/IH provider to ensure an appropriate environment is provided.	Trust/IH provider.		For progress within 18 months of publication.

Restrictive interventions and the use of the Mental Health Act

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
5. All provider organisations must focus on reducing the incidence of restraint, prone restraint, and seclusion and should: • Ensure levels of restraint in the CYP inpatient population are no higher than in the adult inpatient population. • Have a clear plan in place to reduce incidents of restraint and seclusion. Improvement activity should be based on benchmarking with peers aiming for milestones year on year to achieve a position in the top decile.	**a** All NHS and IH providers must have a clear QI plan in place to address restraint and seclusion with an aim to reduce incidents of restraint by at least 10% year on year. The plan must include an aim to improve data collection on restraint episodes.	All NHS and IH providers.	• Demonstrable decrease in restraint and seclusion. • Increase in the quality of reporting of restraint episodes.	For progress within 6 months of publication.
6. When requiring a Mental Health Act assessment, CYP must be assessed by clinicians with the right skills in a child appropriate environment.	**a** Improve the national offer on support and training on reducing restrictive practices in CYP inpatient services. Ensure that there is an appropriate therapeutic environment to support the development of psychological formulation and de-escalation interventions.	HEE/NHS England and NHS Improvement. All NHS and IH providers.	All CYP inpatient staff have accessed high quality CYP focused reducing restrictive practice training.	For progress within 18-24 months of publication.
7. Commissioners, including lead providers within a collaborative, must ensure that there are effective protocols in place so that when a social need, rather than medical, is present there is a clear and understood pathway to follow which operates both in and out of hours.	**a** Commissioners and providers must develop a clear, commissioned, multiagency pathway.	Commissioners, providers.	• Decreased inappropriate admissions to CYP inpatient units. • Decreased LoS within the Place of Safety/ Section 136 suites.	For progress within 18 months of publication.

Community and crisis services

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
8. The crisis and urgent care pathways, including inpatient admissions, must be seamless with consistent treatment plans, objectives, and care coordination. In most circumstances, this will require the community care coordinator remaining as the main point of contact and driver of care regardless of the crisis, urgent care or inpatient setting the patient is within. There must be a robust preadmission assessment process including input from the inpatient unit, crisis services, community team and when necessary the local authority. The aim of the assessment process should be to avoid admissions if at all possible.	**a** Providers to review the CRAFT model and implement a similar model of community engagement of young people within the crisis pathway.	Providers.	Increased percentage of young people reporting satisfied or very satisfied on patient reported satisfaction questionnaires.	For progress within 12 months of publication.
	b To review the contracting arrangement for crisis services and community services to allow the implementation of the new model.	Commissioners including lead providers within a collaborative.	Using stratified data, reduced proportion of young people admitted for longer than 60 days.	For progress within 12 months of publication.
	c Provision of training for community staff to ensure staff are skilled to implement new model.	Providers.	Decreased number of inappropriate admissions as defined by the lead provider within the collaborative.	For progress within 12 months of publication.
	d Providers to review the learning from CETRs within their trust and ensure that any learning is implemented.	Providers.		For progress within 12 months of publication.
9. Commissioners must ensure that young people are admitted within their natural clinical flow, recognising that there may be patient choice or specific clinical needs to admit outside. This should be in line with the national CYPMH Competency Framework.	**a** Commissioners including lead providers within a collaborative to undertake bed modelling with the use of an appropriate modelling tool.	Commissioners and lead provider/s of an NHS-led provider collaborative.	95% of young people admitted within their natural clinical flow.	For progress within 12 months of publication.

Community and crisis services (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
10. There must be an effective and sufficiently resourced CYP urgent & emergency mental health pathway based on local needs and with effective data collection to drive QI. The pathway, as indicated in the Long Term Plan, will operate 24 hours a day, seven days a week. It will combine crisis assessment, brief response, and intensive home treatment functions.	**a** To drive continued investment, including re-investment into: • An urgent and emergency response. To ensure the urgent and emergency mental health pathway combines crisis assessment, brief response and intensive home treatment functions. • Linking to recommendation 11, ensuring that there are effective processes and policies linking the urgent and emergency services to the intensive community intervention services.	Commissioners of the urgent care pathways	• All CYP experiencing a mental health crisis will be able to access age-appropriate crisis care 24 hours a day, seven days a week. • Increase in proportion of young people in a crisis receiving crisis care. • Decreased proportion of young people in a crisis requiring admission to a paediatric ward or mental health inpatient unit.	For progress within 18 months of publication.
11. Individual providers and commissioners must ensure there are evidence-based crisis avoidance, specialist intensive community support teams to provide treatment to high-risk young people with the aim of avoiding them entering a crisis.	**a** Invest in evidence-based crisis avoidance, specialist intensive community support teams. These teams must be multiagency in nature.	Commissioners and providers.	Increased access to specialist intensive community support teams nationally.	For progress within 24 months of publication.
	b There must be ongoing evaluation and sharing of best practice as services are developed at a local and national level.	Providers and through national NHS-led provider collaborative forums.	A reduction in the number of young people, who are known to services, requiring crisis support.	For progress within 24 months of publication.
	c Providers must enable effective coding of these services and ensure the flow of data from these teams to the MHSDS.	Providers and through national NHS-led provider collaborative forums.		For progress within 24 months of publication.
12. The urgent and crisis care pathways, including those for eating disorders and neurodevelopmental disorders, must work across physical and mental health organisations in a seamless and effective way with a recognition that best outcomes are not always achieved in a mental health setting.	**a** The role of A&E and paediatric wards to be clearly identified, through commissioned arrangements, within the urgent and crisis care pathway.	Commissioners including lead providers within a collaborative.	Decreased number of young people admitted to adolescent psychiatric inpatient unit from A&E or paediatric ward.	For progress within 12 months of publication.
	b Where specialist paediatric input is required, such as within the eating disorder pathways, there is identified and commissioned paediatrician input.	Commissioners including lead providers within a collaborative.	Increased staff satisfaction in managing young people with mental health needs within an acute hospital setting.	For progress within 12 months of publication.
	c For A&E and paediatric staff to access appropriate training such as the training developed by Healthy London Partnership.	Providers and commissioners including lead providers within a collaborative.	Increased staff satisfaction in managing young people with mental health needs within an acute hospital setting.	For progress within 12 months of publication.

Workforce

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
13. Recruitment and retention of skilled staff must be a focus for all inpatient units. Data on staffing levels, vacancy rates, turnover and agency use for all urgent care and inpatient services should be collected at NHS-led provider collaborative level to support sharing of best practice and enable the challenges to be addressed as a systems issue. It is clear that there is a direct relationship between shorter LoS and more staff.	**a** A clear unit-level recruitment and retention programme needs to be in place that links with trust programmes.	NHS and IH providers.	Improved recruitment and retention at a local and national level.	For progress within 6 months of publication.
	b Consider national collection of routine workforce data for all CYP inpatient and community services.	NHS England and NHS Improvement and HEE.	Improved recruitment and retention at a local and national level.	For progress within 6 months of publication.
	c Sharing of best practice through NHS-led provider collaborative events.	NHS and IH providers and lead provider/s of an NHS-led provider collaborative.	Improved recruitment and retention at a local and national level.	For progress within one year of publication.
14. Trusts, commissioners and lead provider/s of an NHS-led provider collaborative should, taking into consideration national training initiatives, develop a local workforce strategy to support delivery of the Long Term Plan with a focus on staff skills and competencies rather than professions.	**a** Development of a local workforce strategy shared across the NHS-led provider collaboratives. The workforce strategy should identify the gaps in national training and fill these with local training offers.	NHS and IH providers, commissioners, and lead provider/s of an NHS-led provider collaborative.	Improved recruitment and retention at a local and national level.	For progress within two months of publication.

Support for children and young people with autism and/or learning disabilities

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
15. The additional needs and reasonable adjustments for young people with autism and/or learning disabilities, who are experiencing a mental health crisis, must be identified and managed in all settings.	Services must ensure that:			
	a There is effective and high-quality training for staff in autism.	NHS and IH providers.	Decreased length of time in contact with service for young people with a comorbid autism and/or learning disability.	For progress within 12 months of publication.
	b As already indicated within the Department of Health Building Notes, outpatient and inpatient environments are adaptable to the sensory needs of young people with autism.	NHS and IH providers.	Decreased number of admissions of young people with a comorbid autism and/or learning disability.	For progress within 12 months of publication.
	c Inpatient units' crisis services and intensive community support services ensure the availability of specialist assessments and care for young people with an autism spectrum condition diagnosis or suspected autism spectrum condition.	NHS and IH providers.	Increased percentage of young people reporting satisfied or very satisfied on patient reported satisfaction questionnaires.	For progress within 12 months of publication.
	d Effective digital solutions to promote communication are made available.	NHS and IH providers.		For progress within 12 months of publication.

Technology, data quality, outcomes and use of data

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
16. All adolescent inpatient units and crisis services must improve the use of QI programmes to drive high quality care.	**a** For QNIC to strengthen the role of QI within their standards.	QNIC	All adolescent inpatient units meeting QNIC standards relating to QI.	For progress within 12 months of publication.
	b All providers to meet the QNIC standards for QI.	NHS and IH providers	All adolescent inpatient units meeting QNIC standards relating to QI.	For progress within 12 months of publication.
	c Consider the development of a national improvement collaborative on a topic that is a shared quality concern across adolescent inpatient units.	National Tier 4 Clinical Reference. Provider collaborative	All adolescent inpatient units to have an active QI project.	For progress within 12 months of publication.
	d To identify a national forum for adolescent inpatient units which can host QI resources, successes, and learning.	Specialised Commissioning team.	All adolescent inpatient units to have an active QI project.	For progress within 12 months of publication.
17. All NHS commissioned services must have effective data collection processes to understand the reason for acceptance into a service, interventions offered and outcome of interventions. This data must be flowed to the MHSDS.	**a** Local data collection of reason for admission, intervention offered to be implemented.	Inpatient and crisis service providers through use of SNOMED-CT codes.	Improved data collection into MHSDS.	For progress within 12 months of publication.
	b This data must be collected and analysed at an NHS-led provider collaborative level.	Commissioners and lead provider/s of an NHS-led provider collaborative.	Best practice shared at NHS-led provider collaborative clinical forum. Monitored through Model Mental Health as a key metric.	For progress within 12 months of publication.
18. A national approach to a definition of diagnosis/reason for admission should be developed through the CYPMH policy team/Specialised Commissioning team/NHS digital and adopted by all services.	**a** Paired outcome measures must be implemented within all services.	NHS England and NHS Improvement.	Increased number of young people with a recorded diagnosis on MHSDS.	For progress within 12 months of publication.
	b Development of nationally accepted SNOMED-CT codes.	Inpatient and crisis service providers.	Increased number of young people with a recorded diagnosis on MHSDS.	For progress within 12 months of publication.
	c Implementation and use of diagnosis SNOMED-CT codes.	Inpatient and crisis service providers.	Increased number of young people with a recorded diagnosis on MHSDS. Increased number of young people with a recorded diagnosis on MHSDS.	For progress within 12 months of publication. For progress within 12 months of publication.

Technology, data quality, outcomes and use of data (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
19. Trusts and IH providers to be encouraged to invest in IT infrastructure for adolescent inpatient units. All inpatient patient-focused meetings must have the option of videoconference access.	**a** To ensure that their digital strategies include a specific focus on adolescent inpatient unit infrastructure.	Trusts and IH providers.	Improvement in NHS digital maturity scores for each organisation.	For progress within 12 months of publication.
	b To ensure each adolescent inpatient unit has a clinically- led initiative to increase videoconference access for carers, patients and the wider community team. Implementation monitored at NHS-led provider collaborative operational level.	Lead Provider/s of an NHS-led provider collaborative to hold oversight of implementation and set targets to be achieved. Individual trusts and IH providers to develop and implement initiatives.	Increased percentage of activity undertaken through videoconferencing.	For progress within 12 months of publication.

Governance and advocacy

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
20. There must be effective governance and advocacy systems in place in all CYP mental health inpatient units to ensure that young people are able to speak up should they be exposed to inappropriate practices.	**a** Individual inpatient adolescent units to ensure governance and advocacy systems are in place.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.
	b Ensure that systems are co-designed with young people.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.
	c Patient experience measure included in routine collection.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.
	d Young people able to contribute to service design evaluation and audit.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.
	e Ensure that there are processes in place, so the patient voice is clear within care planning.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.

Governance and advocacy (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
20. There must be effective governance and advocacy systems in place in all CYP mental health inpatient units to ensure that young people are able to speak up should they be exposed to inappropriate practices.	**f** Reasonable adjustments should be put in place to ensure children and young people with LDA access advocacy proactively.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.
21. Reduce litigation costs by application of the GIRFT programme's five-point plan.	**a** Clinicians and trust management to assess their litigation claims covered under Clinical Negligence Scheme for Trust (CNST) notified to the trust over the last five years.	Clinicians and trusts management.	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	For progress within six months of publication.
	b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via *CNST.Helpline@resolution.nhs.uk*	Clinicians and trusts management.	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	Upon completion of **a**
	c Once claims have been verified clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trusts panel firm should be able to provide support.	Clinicians and trusts management.	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	Upon completion of **b**

Governance and advocacy (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
21. Reduce litigation costs by application of the GIRFT programme's five-point plan.	**d** Claims should be triangulated with learning themes from complaints, inquests, and SI/ PSI and where a claim has not already been reviewed as SI/PSI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all staff in a structured format at departmental/directorate meetings (including MDT meetings, and morbidity and mortality meetings where appropriate.	Clinicians and trusts management.	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	Upon completion of **c**
	e GIRFT clinical leads and regional teams to share with trusts examples of good practice where it would be of benefit.	GIRFT clinical leads	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	For continual action throughout GIRFT programme.

Children and Young People's Mental Health Services today

Children and Young People's Mental Health Services (CYPMHS) is the newer term for Children and Adolescent Mental Health Services (CAMHS). Improving CYP mental health is a priority for the NHS, and the whole mental health sector, to ensure appropriate support is available when and where CYP need it.

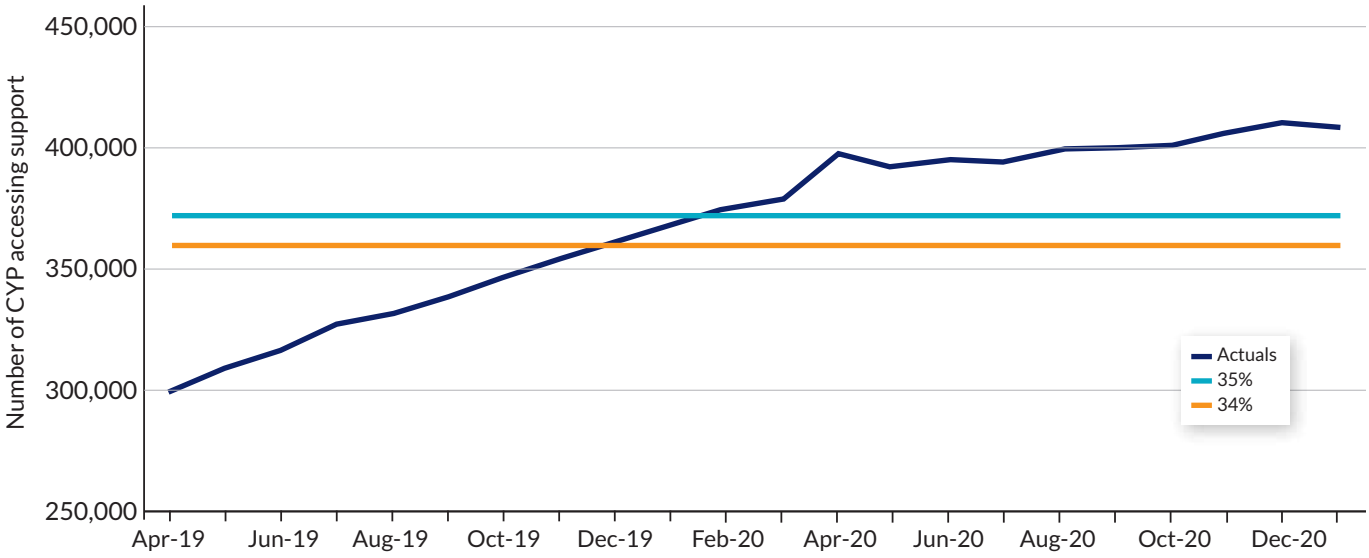
NHSBN noted in its most recent report that CYPMHS is arguably the fastest growing major health speciality, with significant progress since 2015 where access was estimated to be 25%, and new services (for example, crisis and intensive home treatment) were established. In 2019/20, almost 560,000 CYP received at least one contact from NHS funded services, with 391,940 with two or more contacts. The Five Year Forward View (FYFV) target of 35% access against prevalence for two contacts or more by 2021 was met and exceeded with 36.8% access.[9] Spend by the NHS has risen year on year, with approximately £961m spend in 2016-17 rising to £1,280m in 2019-20.

Although this progress in terms of funding, access, and type of service available shows a positive focus by commissioners and service providers, NHS England and NHS Improvement recognises there is still significant unmet need which hinders the prospects and life chances of some of the most vulnerable people in our society. GIRFT understands that services, providers and commissioners have further to go to improve timely access to best evidence-based, high quality, compassionate support and care. In 2018/19, when the data for this report was collected, the target was for 32% of CYP with a diagnosable mental health disorder to be able to access an appropriate NHS-funded service. While nationally 36.1% of CYP accessed services in 2018/19, there was regional variation in terms of access, waiting times and unmet need that may have led, at times, to crisis presentations and preventable admissions to inpatient care.

In **Figure 1** below, the figures 1.1 and 1.2 shows the steep increase in treatment based on investment via the FYFV and LTP. Specifically:

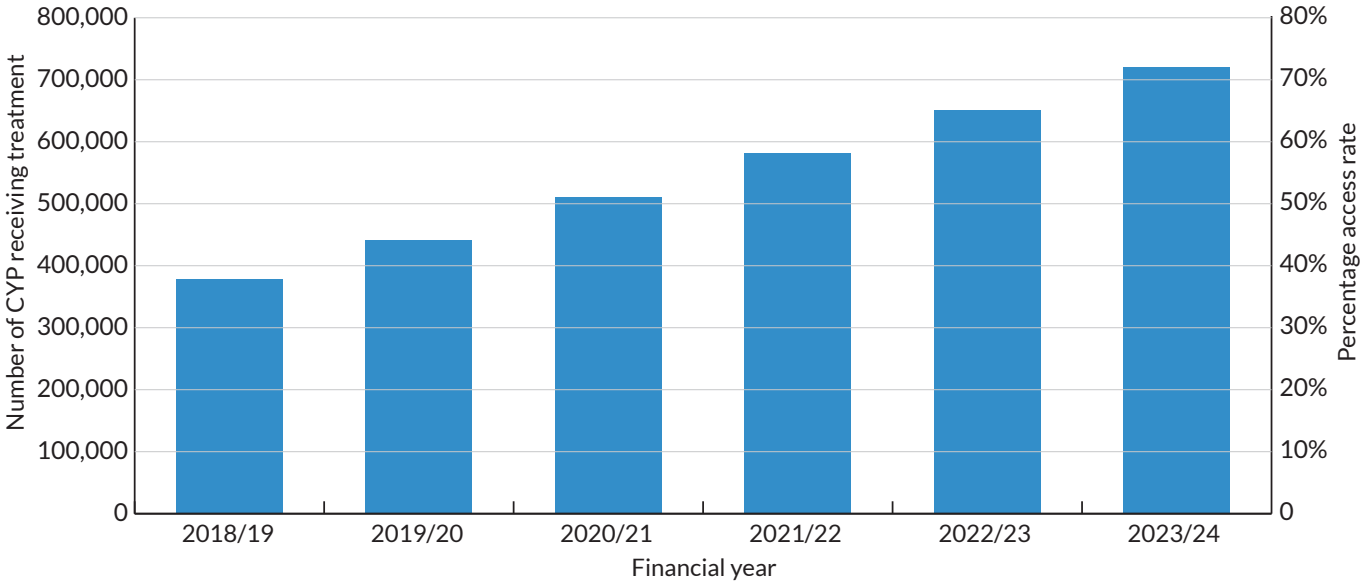
- Figure 1.1 shows increasing numbers of CYP accessing support between April 2019 and December 2020 (the end of the FYFV period).
- Figure 1.2 shows the trajectory for treatment contacts to 2023/24, as part of the LTP.

Figure 1.1: Number of CYP accessing support from April 2019 to January 2021



[9] *NHS Digital (2005) Mental health of children and young people in Great Britain, 2004. NHS Digital. https://webarchive.nationalarchives.gov.uk/20180307185414/http://digital.nhs.uk/catalogue/PUB06116*

Figure 1.2: NHS Long Term Plan trajectory for treatment contacts from 2018/19 to 2023/24



Policy

The NHS Long Term Plan[10] builds on the progress and learning from previous programmes and strategies going back to 2004 including the National Service Framework, Every Child Matters,[11] Choice and Partnership Approach, Targeted Mental Health in Schools, Children and Young People's Improving Access to Psychological Therapies Change programme, Future in Mind,[12] Five Year Forward View for Mental Health[13] and Transforming CYPMH – Green Paper.[14]

The implementation plan for the Five Year Forward View for mental health endorsed the vision set out in Future in Mind and included the following commitments:[15]

- By 2020/21, there will be a significant expansion in access to high-quality mental health care for children and young people. At least 70,000 additional children and young people each year will receive evidence-based treatment – representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions.
- In delivering this expansion within community-based services, CCGs should commission improved access to 24/7 crisis resolution and liaison mental health services which are appropriate for children and young people.
- By 2020/21, in-patient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area (OOA) placements. Inappropriate use of beds in paediatric and adult wards will be eliminated. All general in-patient units for children and young people will move to be commissioned on a 'place-basis' by localities, so that they are integrated into local pathways. As a result, the use of in-patient beds should reduce overall, with more significant reductions possible in certain specialised beds.

The NHS Long Term Plan sets out a series of ambitious commitments that continue and extend the Future in Mind/Five Year Forward View programme to deliver access to high quality evidence-based support from early intervention through to intensive treatment for our most unwell CYP.

[10] *ibid*

[11] *Department of Health (2003) Every Child Matters. Department of Health. https://www.gov.uk/government/publications/every-child-matters*

[12] *NHS England (2015) Future in Mind: Children and Young People's Mental Wellbeing. NHS England. https://www.england.nhs.uk/blog/martin-mcshane-14/*

[13] *NHS England (2014) NHS Five Year Forward View. NHS England. https://www.england.nhs.uk/five-year-forward-view/*

[14] *Department of Health (2017) Transforming children and young people's mental health provision: a green paper. Department of Health. https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper*

[15] *NHS England and NHS Improvement (2016) Implementing the five year forward view for mental health. NHS England and NHS Improvement. https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf*

There are challenges for CYPMHS within the call for wider alignment with services for all CYP and young adults with complex needs, as well as the move towards greater integration within Integrated Care Systems (ICS).[16] However, these challenges also present opportunities for integrated pathways between community and inpatient settings, with the NHS-led provider collaboratives reinvesting savings into community-based earlier interventions, step-up and step-down care, and inpatient admission only when it is necessary.

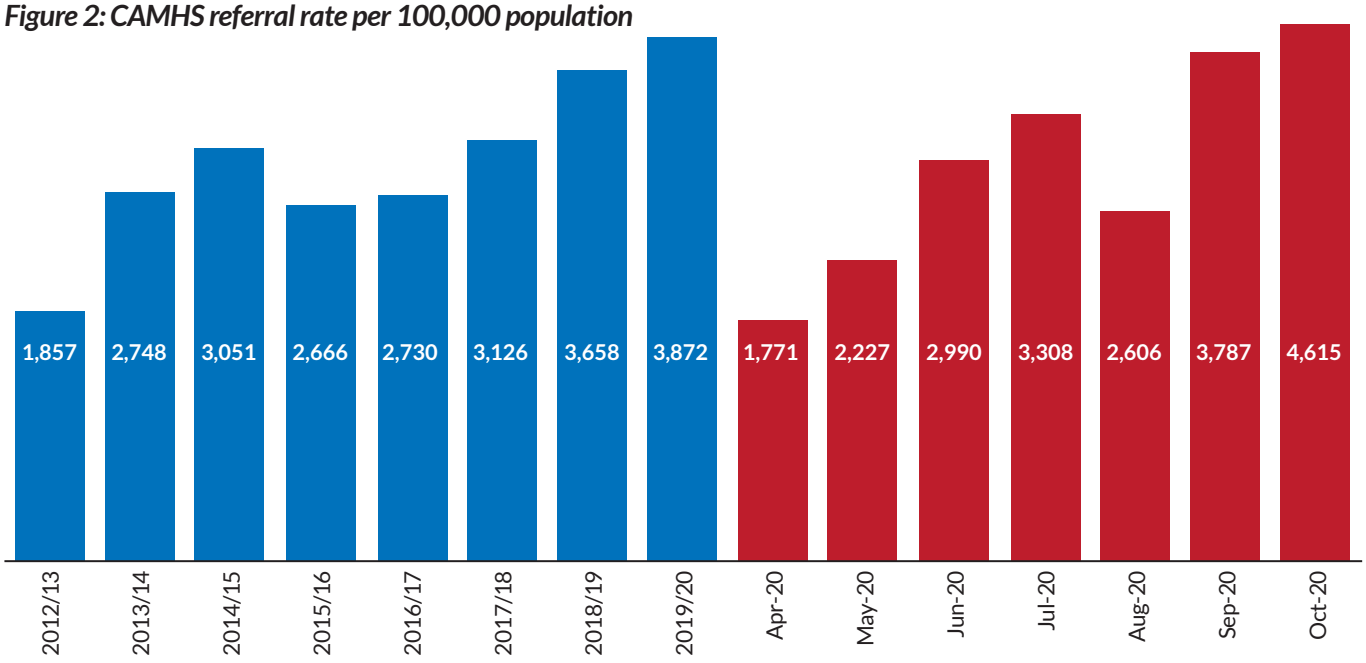
The NHS Long Term Plan commitments that are particularly relevant to the GIRFT programme are:

- To increase the number of young people accessing NHS funded services, so that by 2023/24 an extra 345,000 0-25-year olds will be able to access support.
- Funding for CYPMHS will grow faster than both overall NHS funding and total mental health spending. For the first time, CYPMHS will grow as a proportion of all mental health services, which will themselves also be growing faster than the NHS overall.
- By 2023/24 all appropriate specialised mental health services, and autism and/or learning disability services, will be managed through NHS-led provider collaboratives.
- By 2023/24 there will be 100% coverage of 24/7 age-appropriate crisis care, via NHS 111, including 24/7 mental health crisis provision for children and young people that combines crisis assessment, brief response, and intensive home treatment functions.
- CYP mental health plans align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice.

Increasing demand

The work underway to deliver the NHS Long Term Plan is completed against a backdrop of rising referrals, and rising prevalence because of the pandemic. CYPMH referrals have doubled since 2012-13 and, although the workforce has grown in parallel (see **Figure 3**), the rising complexity and acuity has led to rising average waiting times. In July 2020, NHS Digital undertook a follow-up survey of mental health of children and young people.[17] It found that rates of probable mental disorder in CYP aged 5-16 have increased since 2017 in both boys and girls and across age groups. In 2020, one in six (16.0%) CYP aged 5-16 years were identified as having a probable mental disorder, increasing from one in nine (10.8%) in 2017 (see **Figures 2**).

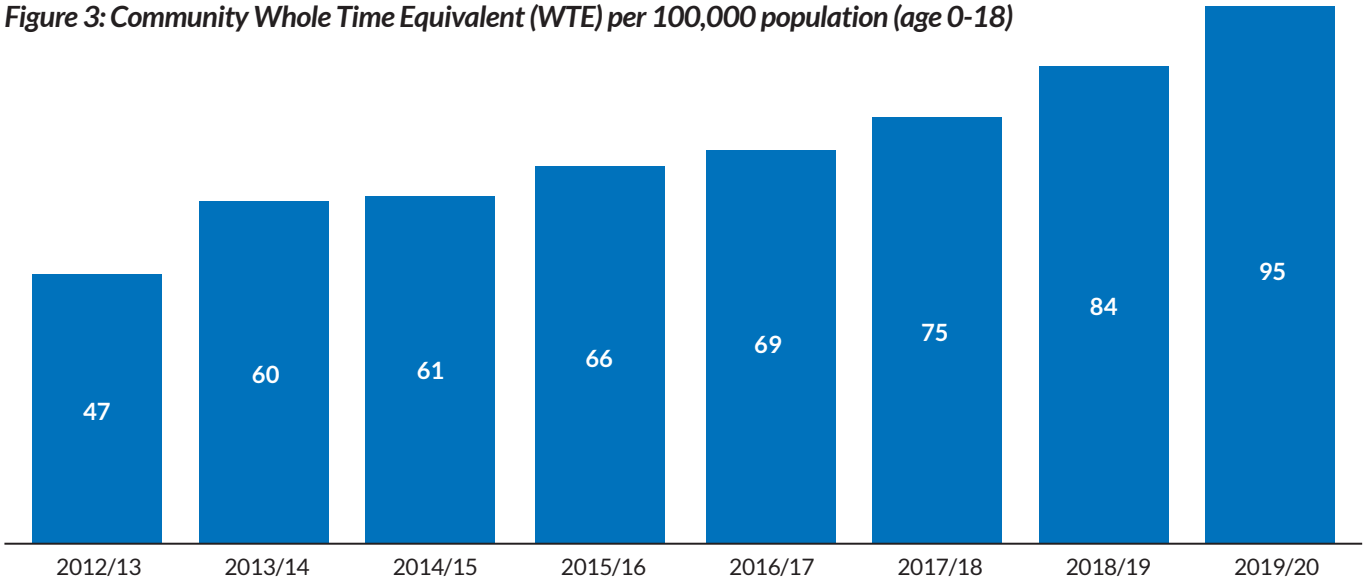
Figure 2: CAMHS referral rate per 100,000 population



[16] *NHS England (2020) Integrating Care Systems. NHS England. https://www.england.nhs.uk/integratedcare/intSchoegrated-care-systems/ https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version*

[17] *ibid*

Figure 3: Community Whole Time Equivalent (WTE) per 100,000 population (age 0-18)



Source: NHS Benchmarking Network 2019/20

Provider collaboratives

The NHS-led provider collaboratives model is based on the New Care Model (NCM) pilots. These pilots trialled new ways of working across mental health NHS trusts within local areas of the specialised commissioned services. The NCM pilot sites, the earliest of which became live in April 2017, provided the specialised mental health services across their geographical footprint with the aim of reducing the number of people who were cared for OOA and creating the services their population needed through re-investment into local community services. By the end of 2019, there were 18 live New Care Model pilot sites, eight of which were CYP pilot sites. The evaluation of the NCMs identified the greatest benefits in CYPMHS.[18]

The NHS Long Term Plan sets out the ambition that all appropriate specialised mental health and autism and/or learning disability services will be delivered through a provider collaborative by 2023/24. Based on the NCM approach, each provider collaborative will be led by a lead provider which will be an NHS organisation. Once live, the lead provider will take on financial and clinical responsibility for the patient population. At the time of writing, three CYP NHS-led provider collaboratives are live having been implemented in October 2020.

For specialised CYP services, the following will be included in the Phase 1 rollout:

- general adolescent and general adolescent learning disability services;
- autism and/or learning disability services - Psychiatric Intensive Care Units (PICU);
- specialist CAMHS eating disorders units;
- CAMHS low secure and CAMHS low secure autism and/or learning disability services.

The following services are included in phase 2 of the programme:

- community forensic CAMHS;
- children's (under 13s) services;
- medium secure units;
- deaf CAMHS.

The national NHS-led provider collaborative programme is working with key stakeholders to determine the most appropriate approach for these phase 2 services - see **Appendix 1** for a list of CYP NHS-led provider collaboratives.

[18] *Niche Health & Social Care Consulting (2019) Evaluation of New Care Models in Mental Health. Niche. https://www.nicheconsult.co.uk/wp-content/uploads/2019/09/New-Care-Models-Evaluation-Full-Report.pdf*

Within CYP mental health services NHS-led provider collaboratives are responsible for the inpatient component of the urgent and crisis care pathway and may in addition commission some alternative to admission services. However, the vast majority of community services are commissioned by CCGs.

NHS-led provider collaboratives will take financial and clinical responsibility for their population that access the services listed, they will not take financial or clinical responsibility for the CCG services but will work closely within the system. The data packs have been developed at an NHS-led provider collaborative level to support the understanding of the complex pathways and not because this is an area with consistent commissioning or overall financial responsibility.

NHS Quality Improvement Taskforce

In autumn 2019, a National Quality Improvement Taskforce was established to improve current specialist CYP inpatient mental health, autism and/or learning disability services in England.

The taskforce seeks to make a rapid set of improvements in care over 18 to 24 months, through to the end of 2021. The primary scope of the Taskforce is to ensure inpatient services deliver safe, high quality care for CYP that is timely, treatment-focused and outcomes-based. It will look at workforce, hospital facilities and inpatient admissions.

The taskforce's independent oversight board is chaired by Anne Longfield OBE, for the Children's Commissioner for England. This will provide independent, expert advice and scrutiny on the work of the taskforce. The delivery group is chaired by John Lawlor OBE, the chief executive of NHS Cumbria, Northumberland, Tyne and Wear, and senior responsible officer for the taskforce. This delivery group, made up of leaders from across the NHS and other key partners, will implement the taskforce objectives.

The clear links between the taskforce objectives and the GIRFT objectives has resulted in close working between the two. Notably the inpatient units of most interest to the taskforce, the secure estate and autism and/or learning disability units, are not in scope in the CYPMH GIRFT work. The GIRFT programme has been able to support the taskforce through developing a data pack using the GIRFT principles. While this data is not included within this report, each provider of secure or learning disability units have had an individualised pack and the opportunity to attend presentations of the data along with a clinical interpretation.

The scope of this report

This review focuses on CYP under the age of 18. While the report covers 0-18 years old and includes two child inpatient units admitting young people under the age of 12, the main focus, drive and recommendations are aimed towards the over-13 age group. GIRFT did not specifically collect data on the children's units, which often operate a different clinical model and will have significantly different reasons for longer LoS and different indicators of good outcomes. The aim of the review is to improve the quality and effectiveness of the care young people receive while an inpatient in an adolescent mental health unit, and to decrease the likelihood that a young person requires an admission in the first place.

While local authority (LA) commissioned or provided services and voluntary organisations are not specifically excluded, and representatives are encouraged to attend deep-dive visits, data collection from these services has only been available to us if their data was reported through the MHSDS, or other mental health data collection systems. This can result in an incomplete picture in some circumstances.

The scope also includes the presentation and support young people receive when within the acute hospital A&E department or paediatric ward. However, it is focused on the CYP mental health intervention at these points of care.

Out of scope of this report, but covered within the Quality Taskforce GIRFT project, are low and medium secure forensic units and learning disability units. However, throughout this report, reference to these units is often made as they remain part of the crisis and urgent care pathway. While recognising the importance of transition from CYP services to adult services, challenges in this area impact the adult crisis and inpatient services rather than CYP services. As such, these challenges are addressed within the GIRFT Mental Health Adult Crisis and Acute Care national report.[19]

Audience and purpose

This report is for all mental health and acute provider trusts, with special consideration to the NHS-led provider collaboratives, the clinicians and clinical leaders in Child and Adolescent Mental Health, as well as trust executives, operational staff, chief clinical information officers, and data analysts. The aim is to support the provision of high quality, CYP crisis, urgent and inpatient care within their natural clinical flow. It will enable service development to be based on local need, using real-time data, and employing a continuous QI approach. The report should be used by commissioners including, ICS's CCG's, LA, and NHS England and NHS Improvement, as well as aiming to provide benefits for young people, their families, and carers. NHS England and NHS Improvement programme teams include the CYPMH Policy Team (responsible for policy to ensure best evidence and fiscally optimal service models are in place), the CYPMH Specialised Commissioning Team, and the Quality Taskforce.

The report is also for the Royal College of Psychiatrists (RCPsych), The Royal College of Nursing, the College Centre for Quality Improvement (CCQI) and other professional staff bodies (such as The British Psychological Society and NHS Confederation) representing all providers of healthcare; the Care Quality Commission (CQC) to inspect against national standards; service user organisations such as Rethink and Young MIND; Health Education England (HEE) for education and training of CYP staff; and, the Department of Health and Social Care (DHSC) and Department for Education (DfE) and Ministry of Justice (MoJ)

The purpose of this report is to use national data to highlight the main challenges and the extent of them in the provision of mental health services for CYP requiring inpatient, crisis or specialist intensive community support. The report also focuses on the state of CYP crisis and urgent care services across England which provide the care for this group of people at certain key times. The report highlights areas where there is good local and NHS-led provider collaborative practice for others to learn from and incorporate into their own CYP crisis and urgent care systems, as well as highlighting unwarranted variation, to make clear action plans to improve within set timelines. Given this, we ask that systems - including providers, commissioners, provider collaborative and LAs - use the report's recommendations to help achieve LTP ambitions, alongside existing contractual requirements, and otherwise design improvements to address unwarranted variation.

[19] *GIRFT Mental Health Adult Crisis and Acute Care national report https://future.nhs.uk/connect.ti/GIRFTNational/view?objectID=30318096*

Methodology

Our analysis is based on the GIRFT programme model, with the aim of identifying unwarranted variation in practice and outcomes. We used nationally available data sources to help benchmark trusts and sent a questionnaire to all NHS providers. With the national metrics agreed, the data analysis team generated individual reports for each NHS trust participating in the programme. These reports, or data packs, compared the trust's performance with the national data, enabling the trust to see how its activity levels, commissioning decisions, costs and patient outcomes compare to those of its peers.

The individual data packs were not designed for wider publication but rather to give the trusts and NHS-led provider collaboratives an insight into their own area of practice. They were issued to the trust in advance of a scheduled meeting between the GIRFT clinical lead and staff at the NHS trust. At the meeting, known as a deep-dive visit, the clinical lead discussed the individual data packs, with a focus on the areas where the data indicates variation between national norms and trust performance. Our deep-dive visits provided an opportunity to review data with clinical staff and representatives from trust leadership and management teams.

The data pack for CYPMHS included metrics from national datasets such as the NHSBN, MHSDS, and NHS England and NHS Improvement specialised commissioning (Specialised Mental Health Patient Level Data Set Specification). Some of the themes explored in the national report have emerged from conversations with trusts as part of the deep-dive visits. We also conducted an analysis of observation notes created after each deep-dive visit to identify and provide an evidence base for these themes.

Where the data highlighted the trust not meeting targets, this was explored in more detail to identify the reasons. Where appropriate, the trust drew upon the expertise of their senior clinicians as they discussed specific challenges they faced and considered potential changes to practice. These individuals' extensive local knowledge provided a fuller context and explanation. Conversely, where the data indicated the trust was outperforming its peers, the clinical lead sought to understand if this was appropriate practice, identify what the trust was doing differently and how its approach, if appropriate, could be adopted by others to improve performance across the NHS.

The initial plan was to follow the standard GIRFT approach and undertake a face-to-face deep-dive visit for each provider. However, as the importance of the NHS-led provider collaboratives grew, we focused on a longer NHS-led provider collaborative visit with the option for the individual providers having a subsequent provider level deep-dive visit on the same or next day. We started undertaking visits in August 2020. At the time of writing this report, we have undertaken 11 out of 16 provider collaborative visits, including providers from both the NHS and independent sector.

Conducting virtual deep-dive visits via Microsoft Teams has been a great success with 30-50 well-engaged people being present on the calls from across different trusts, CCGs, LAs and independent providers. The deep-dive visits have also been exceptionally well supported by the NHS England and NHS Improvement CYPMH team. Each visit had representation from the national team who provided invaluable insights into the NHS-led provider collaborative data and where it may be varying from best practice.

During the consultations, we discussed variations in the data and how each trust stands in relation to their peers, both within the NHS-led provider collaborative and nationally. These discussions have informed our findings and recommendations. Our recommendations and actions should be considered alongside all trust and NHS-led provider collaborative level actions provided on deep-dive visits, as well as any ongoing work by the Royal Colleges and other professional bodies, NICE, NHS specialised commissioning, NHS England and NHS Improvement (including the NHS Long Term Plan), and other bodies working to improve care for young people affected by mental health conditions.

Data quality and metrics

The data sources selected and the metrics for each area of practice were developed in partnership with the GIRFT programme clinical lead for CYPMHS and in consultation with key stakeholders, including pilot site colleagues, NHS England and NHS Improvement policy team, NHS Specialised Commissioning, and the Tier 4 National Clinical Reference Group. It was ensured that the data was relevant to this field of practice. The data was collected for the 2018/19 financial year.

One overarching difficulty we faced, consistent with the GIRFT Mental Health Crisis and Acute Care report, was inconsistency in data quality and reporting, as well as limited use of outcome measures. This lack of data is a major factor behind unwarranted variation across mental health services. Throughout the project, we identified challenges with data and poor data flow to the MHSDS leading to gaps, such that comparison to the yearly NHSBN data collection was often difficult.

There has been a significant national improvement over the past two years in the recording of data for CYPMH. This has happened as the number of mental health providers submitting to the MHSDS has approximately trebled. This suggests that data collected today would be of a higher quality and in some circumstances more useful than when we did the initial data collection. An example of this is the collection of Mental Health Act data which, at the point of data collection, we were unable to obtain in a usable format. However, it is now possible to identify and use this data more effectively. There is a drive to improve data quality through service specifications, commissioning arrangements and the development of an impact framework.

Data sources

In addition to the GIRFT questionnaire data, we have used the MHSDS to help benchmark trusts in a national context where possible and used specialised commissioning data within inpatient benchmarking. However, broader issues with quality and completeness of MHSDS data mean that we have relied on the NHSBN to fill the gaps. We have also drawn data from a range of other sources, including Hospital Episode Statistics (HES) and Crisis Audit.

A specific shortened NHSBN data collection tool was developed for the independent health (IH) sector and combined with the GIRFT supplementary questionnaire. The majority of the IH sector has not been part of the benchmarking network, and the extent of the reliance on this data made this additional snapshot data collection essential.

Gaps in our analysis

- Our analysis was limited by what was nationally reported and available to us. Most available data was presented on a trust-level basis which was helpful for comparing trusts but can conceal much variability across individual trust services. This can be of particular issue within CYPMH services given that there can be considerable inter-unit variability within a trust. For example, within CYPMH services, some providers may provide services in two or more separate parts of the country with significantly different models or funding structures.
- The IH sector provides only inpatient care and reports into the MHSDS. Additionally, the sector engaged well with the additional data collection. There are, however, some understandable gaps in the data collection around financial models and specific questions relating to inpatient relationships with trust crisis teams.
- There was a significant lack of nationally reported available data on interventions and outcomes. Most data was top-level process data covering areas such as numbers of contacts, rather than more specific information – for example, the purpose of a contact and what outcomes had been achieved.
- There was unwarranted variation across every metric we examined. The absence of robust, routine data not only hampers attempts to compare and improve services, but it is also a contributory factor behind trusts receiving significant amounts of ad hoc information requests. This adds additional pressure to available capacity.

Deep-dive summary

Throughout our deep-dive visits, we have been struck by the desire and determination from the NHS-led provider collaborative clinical and operational leadership. During deep dives, we found all collaboratives and providers have clear visions to provide the best possible care for children and young people with a recognition of where improvement is needed. While the national data is by no means perfect, the desire to collect and use data for service development and QI was also clear. At all deep-dive visits, the teams sought knowledge on best practice elsewhere in the country and to understand how such practice can be shared moving into the future.

The pressures and challenges of the day-to-day work were apparent, with an acknowledgement that the impact that this has on staff did not appear to stop the enthusiasm to engage with the GIRFT deep dive. Staff voiced frustrations with the apparent lack of recognition of the complexity and risk being held within the urgent care system, and thoughts that there were often limited treatment options outside of an inpatient stay. This led to feelings of an admission being the least worst option. This was most apparent when considering young people with complex social situations where a mental illness may not be the primary driver of the admission.

The complexity of the urgent care pathway was always apparent. There are multiple commissioners of the urgent care pathway, including lead providers within a collaborative, CCGs, specialist commissioning and LA. Even in a single trust, recommendations may only be relevant for one CCG area. The impact of variation in quality and effectiveness may be within an organisation or provider that is not responsible for that variation. For example, NHS-led provider collaborative leads identified that, at times, investing within an underfunded community team while being outside their area of commissioning may result in the best outcomes within the urgent care pathway. NHS-led provider collaborative leads did not articulate an answer to the challenging question of how to invest or save when the area of maximal impact is outside of that collaborative's responsibility.

The engagement of the IH sector has been fantastic, with representation at all the relevant NHS-led provider collaborative visits providing thoughtful insights toward the data. The IH sector has been highly engaged in the subsequent recommendations and are most certainly considering the whole pathway rather than their units only.

Impact of COVID-19

Since the declaration of the COVID-19 pandemic in March 2020, there has been a scale and spread of positive change throughout the system, as well as an enthusiasm for these changes to improve innovative service delivery. For example, there have been accelerated changes with crisis hubs, videoconferencing, and digital assessments. However, as in other areas of the health service, there has been an increase in unmet need caused by the pandemic. We have already started seeing a significant increase in the presentation of some conditions, such as eating disorders, that will not be able to be managed within the current bed base.

There has been widespread upheaval for individuals and health and social care systems. The speed of COVID-19 progression, and the level of change for populations across the globe, is without precedent in living memory. Stark daily infection and mortality figures are indicative of the mounting personal and social cost of the pandemic. As the disease spreads and stringent measures to manage it are put in place, the mental health impacts are starting to become apparent.

Data from the ONS/NHS Digital survey has shown there has been an increase in probable mental health problems in 5–16 year olds in England, with the incidence rising from 10.8% in 2017 to 16.0% in July 2020 across age, gender, and ethnic groups. As in 2017, during the pandemic 27.2% of young women had a probable mental health problem. More than a quarter of children (aged 5–16 years) and young people (aged 17–22) reported disrupted sleep and one in ten (5.4% of children and 13.8% of young people) often or always felt lonely. Both problems were more common in those with probable mental health problems, of whom 18.0% felt fearful of leaving the house because of COVID-19.[20]

A review of likely child suicides in England during the COVID-19 pandemic raised a signal that child suicide deaths may have increased during the first 56 days of lockdown in March to May 2020, but that the risk remained low and the numbers were too small to reach definitive conclusions.[21] It is important to acknowledge the complex reasons underlying cases of likely suicide, and there is no evidence of a simple link between the pandemic and any possible increase.

A YoungMinds survey[22] of over 2,000 young people with a history of mental health needs following the easing of lockdown restrictions showed 80% of respondents agreed that the coronavirus pandemic had made their mental health worse. In addition, 41% said the pandemic had made their mental health 'much worse', up from 32% in the previous survey in March. This was often related to increased feelings of anxiety, isolation, a loss of coping mechanisms or a loss of motivation.

More than 1,000 respondents (i.e. 31%) who were accessing mental health support in the three months leading up to the crisis (including from the NHS, school and university counsellors, private providers, charities, and helplines), said they were no longer able to access support but still required it. In April 2020, almost half of 16-to-24-year olds showed new symptoms of psychological distress. This age group were the most likely to report new symptoms in May 2020. This group have also reported feeling relatively more anxious over the summer months, when adults' reported anxiety was reducing.[23]

Most, if not all, of the adolescent inpatient units were closed to relatives and visitors and the practice of patient overnight leave from the wards was halted due to the accelerating COVID-19 situation. This impact, along with the use of digital technologies, will become apparent as the data over the COVID-19 period is analysed. Bed occupancy within CYPMH inpatient units decreased to around 63% in April 2020. However, June 2020's figure of 71% brings the sector back to previous historical trend levels.[24] CYPMH referrals saw the largest reduction of any mental health service, with 52% fewer referrals received in April 2020 compared to the same period last year. This is likely linked to the closures of schools and colleges, and therefore the reduction in referrals from the education system. During 2018/19, these referrals represented 13% of all referrals into CYPMH. Although referral rates increased during May and June 2020, rates were still 20% below previous levels. During this period, the relative lack of access to primary care and other services, such as Speech and Language Therapy, could be perceived to contribute to the drop in referral volumes.

While a reduction in the number of young people admitted was identified during the height of the crisis, there have subsequently been anecdotal reports of increased complexity and severity of presentations. In addition, the community referrals initially mirrored inpatient referrals but are now back to pre-COVID-19 levels.

[20] *Vizard T, Sadler K, Ford T, et al. Mental Health of Children and Young People in England 2020, Wave 1 follow-up to the 2017 survey. 2020. https://files.digital.nhs.uk/CB/C41981/mhcyp_2020_rep.pdf*

[21] *National Child Mortality Database (2020) Child Suicide Rates during the COVID-19 Pandemic in England: Real-time Surveillance. National Child Mortality Database.*

[22] *Young Minds (2020) Coronavirus: Impact on young people with mental health needs. Young Mind. https://youngminds.org.uk/media/3904/coronavirus-report-summer-2020-final.pdf*

[23] *ibid*

[24] *NHS Benchmarking Network (2020) Covid-19 Monthly Tracker Mental Health, Learning Disability and Autism Services. NHS Benchmarking Network. https://www.nhsbenchmarking.nhs.uk/news/monthly-covid-19-dashboard*

COVID-19 hit between the GIRFT pilot deep-dive visits and visits themselves, resulting in a gap in deep dives. Many changes were implemented due to COVID-19 which were covered by the deep dives but were not seen within the data pack. Undertaking deep-dive visits virtually was a success and initially led to an increase in participation. Chairing the deep-dive visits virtually required a new skill set to ensure everyone was engaged in the session with effective use of participant engagement, use of the comment facility of videoconferencing and a structured agenda. As the second wave of COVID-19 impacted, it understandably became increasingly difficult to engage the executive members of provider organisations in the visit. The fact visits were being completed by videoconference did, however, allow executive staff from the providers to engage with the sections of the visit most relevant to them.

A number of good practice examples and innovations were observed during the COVID-19 response:

Development of crisis hubs away from A&E

Where crisis hubs were developed, positive feedback received from patients and staff related to more rapid assessments, no unnecessary steps prior to seeing a CYPMH specialist, and a decreasing risk of patients being exposed to COVID-19. The challenge of ensuring good links with paediatric wards was met, as was ensuring good links with social care. Additionally, Standard Operating Procedures (SOPS) were in place for young people who could not go home because of safeguarding. Also, the challenge of ensuring staffing levels and safety in a remote location was met. Lastly, all areas were able to establish crisis helplines which will now form part of the local crisis pathway.

Use of digital assessments

Remote assessments and monitoring were widely taken up by crisis teams during COVID-19.

The NHSBN COVID-19 tracker found CYPMH caseloads in June 2020 exceeded previous levels, and around 43% of CYP on caseloads received a clinical contact during the month. Contact rates in June 2020 increased by approximately 8%, which is a positive finding for the CYPMH sector at this time. Levels of activity reflect strong adoption of digital consultations with approximately 20% of all contacts delivered through this medium in June 2020.

Virtual appointments do not work for everybody – there are particular issues for its use with CYP. There are challenges, such as CYP who are often in crisis and have complex social situations with overcrowded accommodation, safeguarding issues in the family home or poverty. Digital assessments are not as effective as face-to-face assessments for safeguarding risks where the home environment or interaction between family members requires assessment, or for confidentiality where the young person's privacy within the family home is not assured. Some young people lack access to technology, are concerned about privacy or simply do not feel safe opening up online. Almost a third of young people lost access to mental health support after lockdown.[25]

A large proportion of mental health support is provided through schools both informally via teachers and formally via school counselling, and this is due to increase further as documented in the Long Term Plan. However, the ability to access this support during the COVID-19 pandemic has been harder hit than the specialised services. This can be seen in the significant reduction in referrals to specialised services during the period of school closure.

While virtual support will continue to play an important role, those face-to-face services which were unable to continue must also be able to offer enough face-to-face appointments to cover all needs. It is key these services reopen quickly where possible.

Videoconferencing by inpatient units for CPAs and discharge meetings

Videoconferencing ensures a decreased risk of the COVID-19 infection and has been preferred by some young people their families and carers. This has led to better engagement by community teams and other agencies and promoted more rapid discharge. However, trusts need a very good level of IT infrastructure to maintain videoconferencing within inpatient units to ensure data safety and reliability. Most trusts do not yet have this. The benefits of videoconferencing in adolescent inpatient units are potentially greater than in other inpatient units given the very large number of agencies that usually attend - for example, school, social care, CYPMHS, families, Youth Offending Services (YOS), drug and alcohol services, and youth workers.

[25] *Children & Young People Now (2020) Third of young people left without mental health support during lockdown, survey finds. https://www.cypnow.co.uk/news/article/third-of-young-people-left-without-mental-health-support-during-lockdown-survey-finds*

CASE STUDY

The use of videoconferencing in CPA and discharge meetings

Throughout the deep dive visits, many providers described their experience of the impact of videoconferencing in the Care Programme Approach (CPA) and discharge meetings. We followed up on some of these examples below:

Northamptonshire Healthcare NHS Foundation Trust

The team at Northamptonshire told us the use of videoconferencing via Microsoft Teams has been very beneficial in terms of parent attendance at CPA meetings, particularly if they do not live in the local area. The team have found family therapy delivered via Microsoft Teams to be really effective, especially in the case where families are separated or again, where they do not live in the local area. Attendance levels for all meetings has increased.

St Andrews Healthcare, Northampton

CYPMH team leaders at St Andrews Northampton polled to gather comments on how working differently due to COVID-19 has impacted them, particularly around videoconferencing and online meetings. The team told us:

- Patient assessments are completed without the need for travel, or extended time out of the day, so they can be done in a more time efficient manner. "Even during isolation due to COVID-19, most staff were able to work from home if needed and could carry out duties".
- Families/carers can have access to ward rounds and other clinical meetings. One individual said "family access to the ward round is excellent and has really boosted communication".
- There is a feeling that there has been better attendance at meetings from external clinicians due to remote access becoming more "normal".
- They have been able to deliver Dialectical Behavioural Therapy (DBT) groups across multiple wards via Microsoft Teams. Despite initially thinking that this would be very challenging, it has turned out to be beneficial in adding different views to the discussion.
- It has meant they have been able to maintain coproduction over the pandemic too. "My experience is that it is much harder as a facilitator, but it has meant more patients can attend as they wouldn't necessarily be able to come off the ward previously".
- There has definitely been more attendance by the external team, specifically for discharge planning meetings.

Although the majority of the group described positive experiences, one team leader said... "my personal view of pre-admission assessments over Teams is that they are really ineffective, and very hard to do to a high standard. I got so much more from looking at the child's records and then sitting with them in a room together, in the old days".

North West London CYPMH NHS-led provider collaborative

When describing their 'CRAFT' meeting model, the clinical lead said . . . "face to face attendance at the CRAFT meetings has always been preferred, as the initial contact helps establish close working relationships between the young person, the parents/carers, the inpatient professionals, and the community network of professionals, including representatives from non-health services. Some meetings were held by teleconference in response to demands on time and travel. The COVID-19 pandemic has rapidly and significantly changed this. With the now readily available remote platforms, virtual face to face meetings are easily set up, and have proved satisfactory. It is already evident that attendance at meetings convened at short notice are better attended (short notice being the essence of a crisis admission), and it has made engagement of colleagues from other agencies more feasible. The ongoing experience and learning will inevitably continue to shape the clinical process going forward".

Lack of clear inpatient model

In 2018, NHSBN identified that approximately 4,500 children and young people were admitted to CYPMH inpatient units per year at an average cost of £77,000 per admission. This makes this group the second most expensive type of bed – see **Table 1** on average cost of mental health beds. Although there will be some CYP who require inpatient treatment for clinical reasons, as NHS-led provider collaboratives have already demonstrated, some of these funds are more effectively used to provide community support. NHSBN data in **Figure 4** shows the mean LoS on a GAU ranging from 111-30 days.

Additionally, there is significant variation in the quality of units with the 2017 CQC review of inpatient services, identifying seven units as inadequate, 32 requiring improvement, 60 as good and two outstanding in the domain of safety.[26]

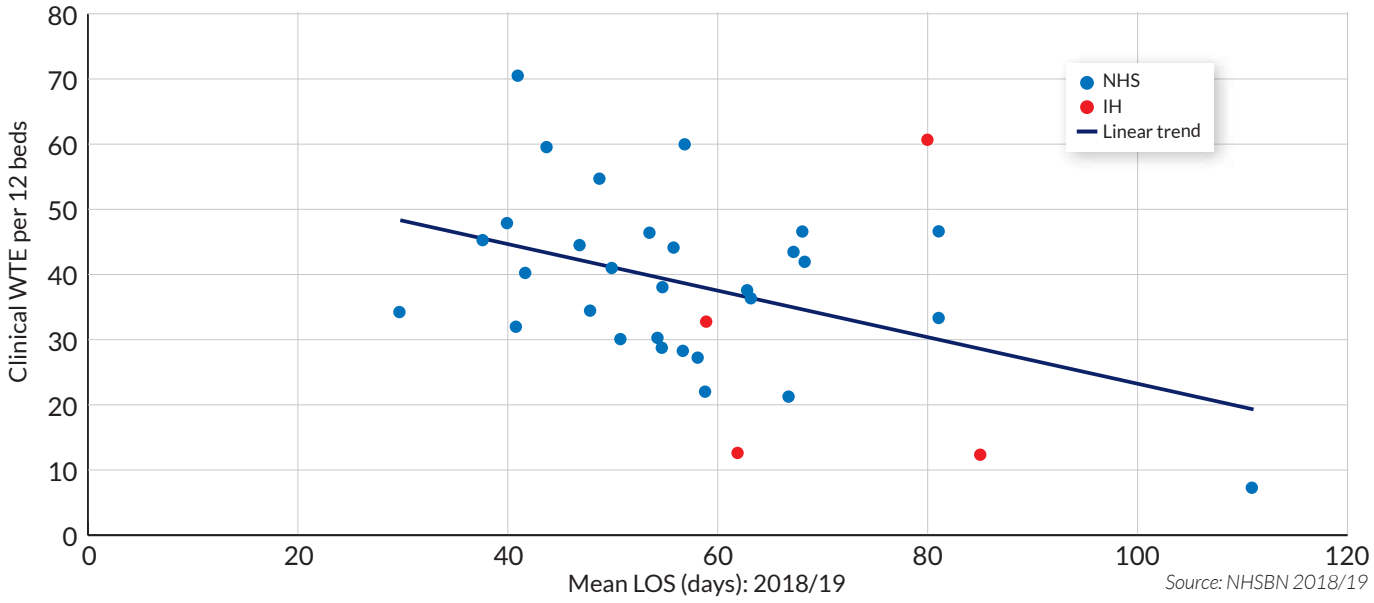
The current position is five are inadequate, ten require improvement; 39 good and one outstanding. 11 are inspected but not rated and one not rated.[27]

Table 1: Average cost of mental health beds

Mental health speciality	Per bed	Per admission	Per bed (rank)	Per admission (rank)
CYP general admission	£233,193	£58,052	2	3
CYP eating disorder	£172,791	£127,855	5	1
Adult acute	£144,837	£13,587	7	7
Older adult acute	£154,000	£38,511	6	5
PICU	£261,331	£42,628	1	4
Eating Disorders	£176,579	£62,603	4	2
Mother and Baby	£225,944	£38,372	3	6

Source: NHSBN 2018/19

Figure 4: General CYPMH mean LoS and clinical staff per 10 beds



Source: NHSBN 2018/19

Note: One outlier removed due to a different service model

[26] *Care Quality Commission (2017) Review of children and young people's mental health services: Phase One supporting documentation: Inspection report analysis. CQC. https://www.cqc.org.uk/sites/default/files/20171027_cypmhphase1_inspectionreportanalysis.pdf*

[27] *Unpublished analysis from CQC reflecting the current position as of 19th March 2021*

Psychiatric Intensive Care Unit beds (PICU)

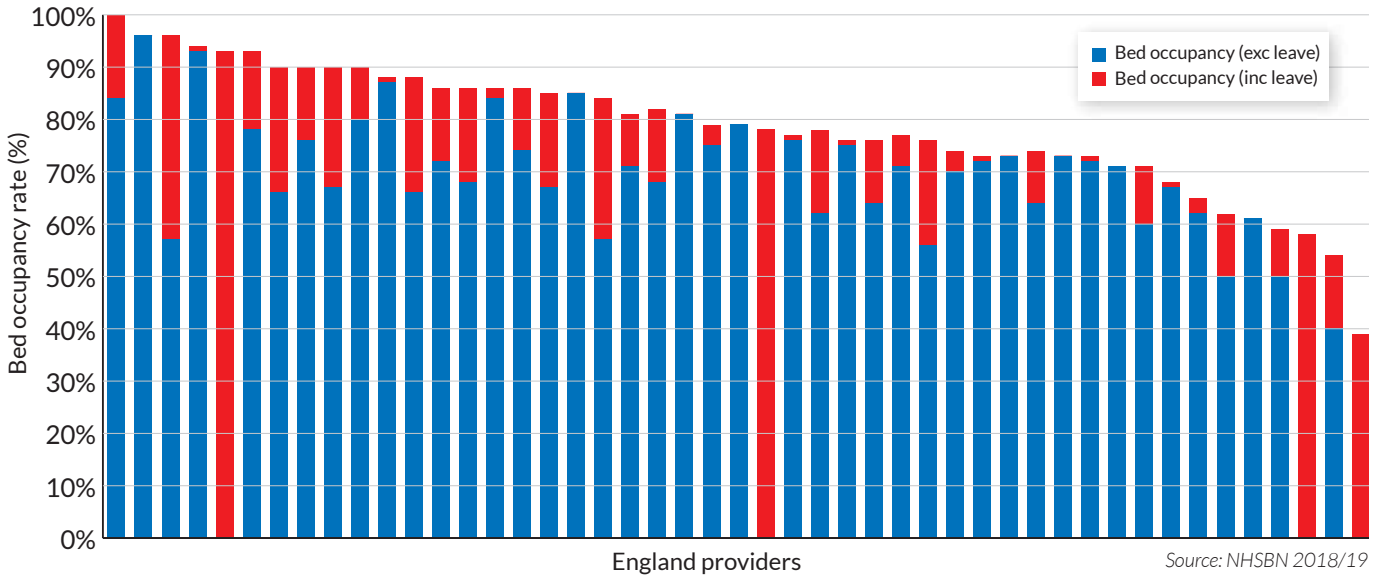
While PICU is used within paediatric terms and mental health terms, within this document we are using PICU to describe Psychiatric Intensive Care Unit beds. To add an additional layer of complexity to the bed estate in CYPMH services, PICU beds are commissioned as separate units. Although the original scope did not include PICU or forensic beds, the additional GIRFT project looking at the secure estate has been referenced in Recommendation 4. It is important to note that during the period of the deep-dive visits, significant concern was raised over the perceived lack of PICU beds, with most NHS-led provider collaboratives reporting multiple young people waiting for PICU beds for multiple days.

There must be a focus on avoiding escalation in presentation and behaviour of young people in GAU to prevent avoidable admissions to PICU. While this is not a recommendation regarding PICU bed numbers, the shift in focus would reduce the requirements for PICU beds through effective staffing, interventions, ensuring right young people are admitted, and stopping avoidable escalations in care requirements.

Length of stay in inpatient units

There is significant variation in the occupancy of units and variation in the LoS. Based on the 2018/19 data available, there is certainly not a lack of inpatient CYMPH beds – although there is an unclear idea of usage. **Figure 5** demonstrates the CYPMH occupancy profile including relatively low occupancy when compared to other specialities. The bed occupancy including leave was 79%, and excluding leave was 71%. The bed occupancy within the IH sector and NHS providers appears to be comparable.

Figure 5: General CYPMH bed occupancy rate 2018/19

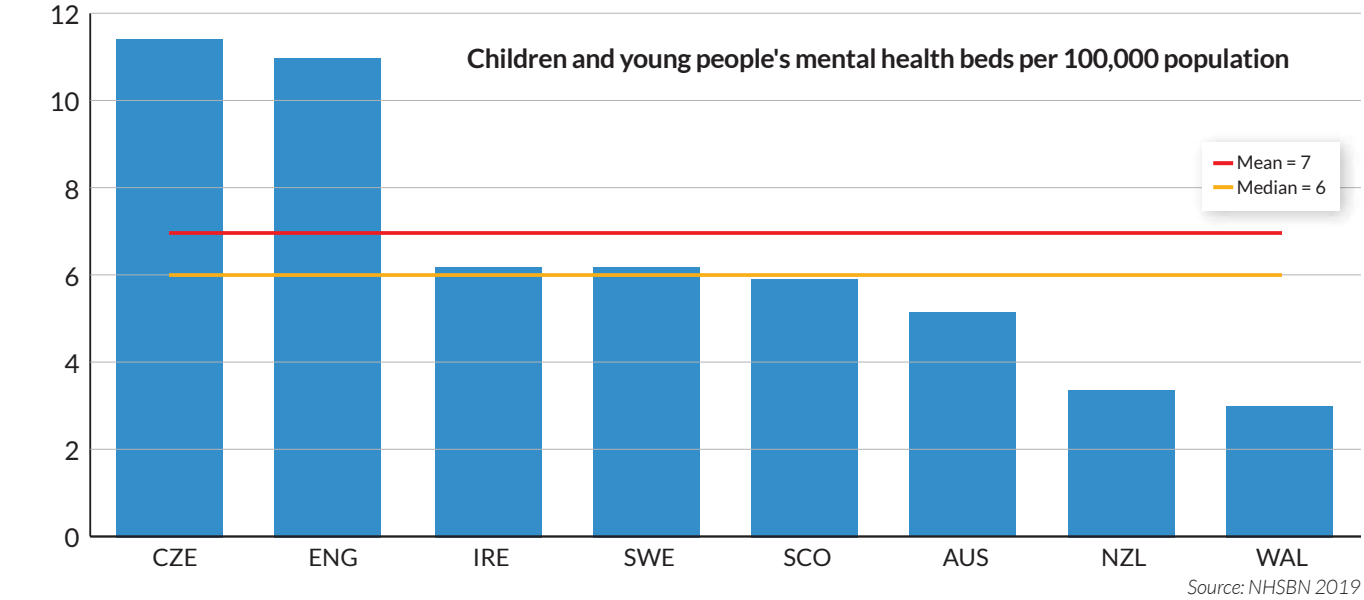


Source: NHSBN 2018/19

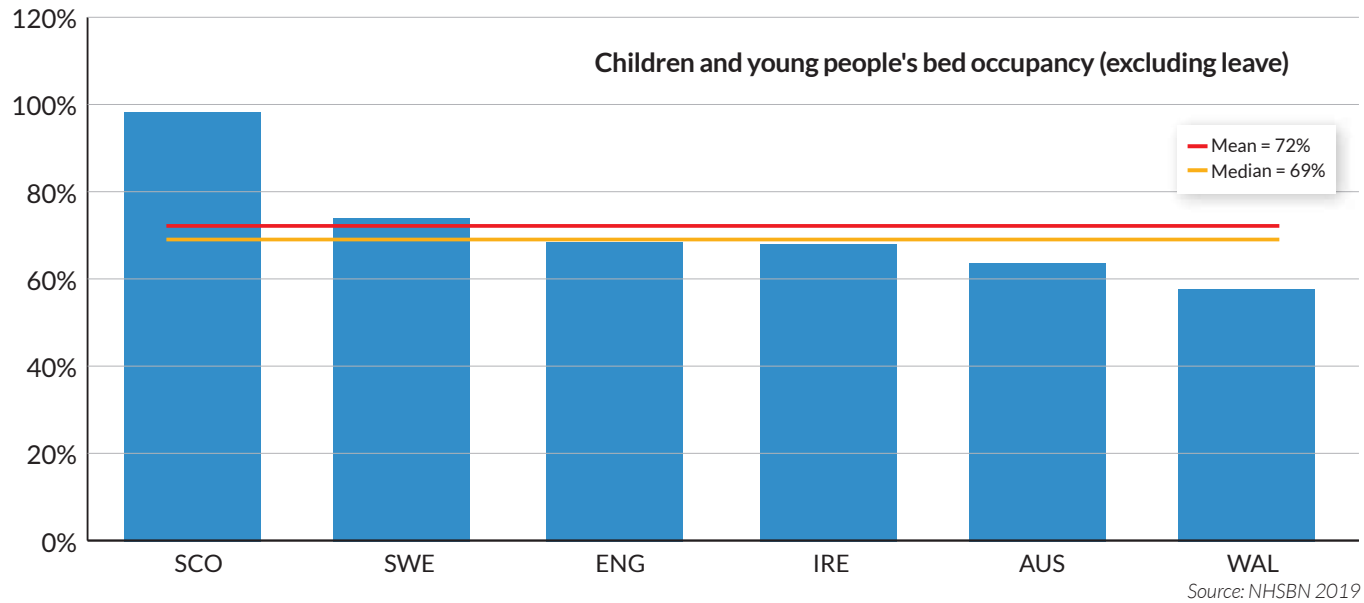
The low levels of bed occupancy are not recognised by units themselves and is likely to be a result of a combination of factors, such as beds often being closed – for example, due to repair or due to patient mix or staffing levels. The national data collection does not consider the impact on the data of a unit opening midway through a financial year, or the closure of units. Bed occupancy is a crude number that can be misinterpreted. While it is clearly dependent on demand, the way bed occupancy is recorded within the national datasets does not allow for the distinction between beds being vacant due to demand or operational reasons (such as closure from safety concerns), or beds/units being opened or closed due to other reasons.

Figure 6 and **Figure 7** shows the international comparison of CYP beds and occupancy, and the international comparison of CYP for LoS, respectively. Across eight countries, the international comparison of beds per 100K population showed a mean of seven and median of six. Across six countries, the international comparison of occupancy (excluding leave) showed a mean of 72% and a median of 69%. The international comparison of LoS (excluding leave) across eight countries, showed a mean of 46 days and a median of 37 days.

Figure 6: International comparison of children and young people's beds and occupancy



Source: NHSBN 2019

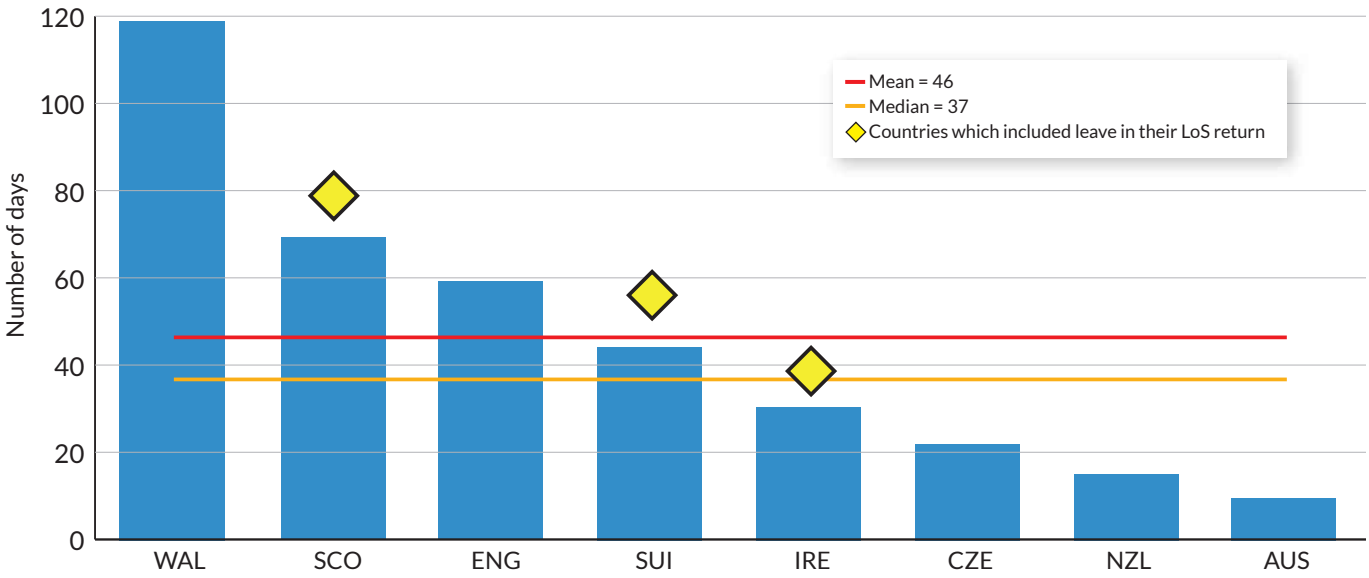


Source: NHSBN 2019

Most commonly, average LoS is used as a metric to determine the efficiency of a unit. However, this is not recommended as different inpatient models can result in significant differences in LoS. For example, Norfolk developed a robust crisis admission service. This resulted in multiple admissions with less than 72 hours. However, this may hide inappropriate LoS for the young people admitted for other reasons. Trusts with highly robust crisis services and minimal inpatient beds will admit fewer young people. It could be assumed that admitting fewer young people will result in the admission of more complex young people, and hence increased LoS. However, the feedback from the deep-dive visits is that this is not the case. For example, at Lincolnshire Partnership Trust, following the closure of their 14-bedded inpatient unit, the number of admissions dropped significantly. Despite this, there was no increase in the LoS of those few young people who were admitted and a decrease in the use of PICU beds. The feedback from the service is that they recognised there there was a cohort of young people who not only did poorly on admission but often showed an exacerbation of their difficulties. However, prior to the closure of the unit, the collaborative fed back that there was not a robust community alternative to support these young people in crisis. It should be noted that the investment in community services has demonstrated the benefit of alternatives to admission for this cohort of young people. As such, an approach to reduce the maximum LoS should not ignore the impact of appropriate community services on this metric.

Therefore, it is recommended that units stratify their data to identify where the improvement should occur. While England is an outlier when it comes to national LoS (based on NHSBN data), it is difficult to compare models across countries. However, the international data does suggest that much shorter LoS are achievable and should be aimed for.

Figure 7: International comparison of children and young people's length of stay

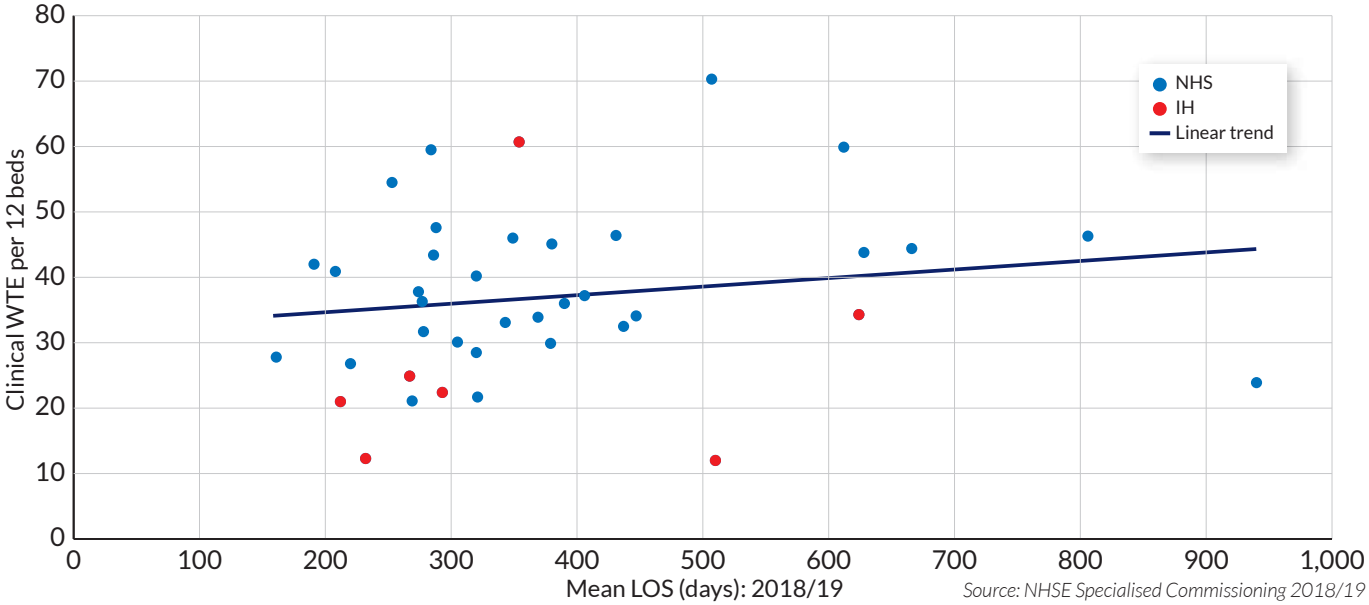


Source: NHSBN 2019

There is little understanding as to why or what is driving this LoS. Understandably there is concern over the variation and very high maximum LoS. **Figure 8** explores the relationship between LoS and clinical staff WTE. The data highlights how the mean LoS increases as staff per bed reduces. Viewed alongside **Figure 4** (page 35) presenting the provider maximum LoS, the trend indicates that, although the average LoS reduces with more clinical staff, that trend is not present with the maximum LoS. This suggests different factors are at play affecting average and maximum LoS.

Our data did not look at delayed transfers of care or the impact of LA decisions on placing hard to place children. This is because the data is not routinely collected at a national level and could not be explored in the depth that is required. From the deep-dive visits, this was identified as an issue in a small but significant number of children.

Figure 8: General CYPMH maximum LoS



Source: NHSE Specialised Commissioning 2018/19

At present it is unusual for a unit to review its LoS data in anything other than as an overall average. There are many different reasons for admission to an adolescent inpatient unit each of which will result in a significantly different LoS. There are also many different reasons for a young person to remain on an inpatient unit longer than is required which again will result in significantly different LoS. By stratifying the LoS data, it is possible for a unit to focus its improvement energies where it is most required, which may be on increasing the number of admissions with a LoS below 30 days or, for example, decreasing the number of admissions, assuming there is no clear crisis admission model, with a LoS below seven days. It is imperative that when monitoring the LoS data that consideration is also given to readmission data to ensure that admissions remain of an appropriate length and quality rather than a focus on a single metric.

Based on the need for a more refined understanding of an appropriate LoS, a requirement for stratification of the data, and a better understanding of the clinical models being used on units, we are not able to make a sweeping recommendation to reduce average LoS. From the data we have, and feedback from deep-dive visits, we can identify that the maximum LoS is too high, with the number of discharges of young people at over 60 days admission at 39%.

Escalation processes for young people with learning disabilities or autism, including referral to a serious care intervenor and/or key working service, are under development and the impact of this should continue to be monitored with consideration of how, if successful, a similar process could be used for all CYP with very long length of stay.

We recommend future investment should be focused on alternatives to admission, promotion of early discharge and ensuring that there are effective models of care to treat the presenting condition. It is important to link LoS to better admission and discharge planning, as well as linking to patient outcomes. There are opportunities within the community - for example, social prescribing and personal health budgets - which should be considered within admission avoidance and discharge planning.[28] The aim is to reduce the proportion of young people with an admission over 60 days. As per the NHS Long Term Plan, this will both provide better outcomes for young people and result in a more rapid improvement in services than the very long process of commissioning and building new inpatient units.

It should be noted that data used here is from 2018/19. There has been an increase in the prevalence of mental illness in children and young people, particularly during the COVID-19 crisis, which may result in increased bed usage. There is a need to manage this surge while recognising the need to reduce beds in the long-term. While capacity modelling will be helpful, the focus should be on LoS management to this surge rather than commissioning new units.

[28] *NHS England and NHS Improvement (2017) Care and Treatment Reviews: Policy and Guidance. NHS England and NHS Improvement. https://www.england.nhs.uk/publication/care-and-treatment-reviews-policy-and-guidance/*

CASE STUDY

'The Cove' GAU inpatient model

Lancashire and South Cumbria NHS Foundation Trust

The Cove, based in Heysham, is a 14-bedded GAU providing inpatient care to young people between the ages of 13 and 18. The mean LoS was one of the lowest in the country (NHSBN 2018/19) and the maximum LoS for discharges was well below the England average (NHS England and NHS Improvement Specialised Commissioning 2018/19). The unit was also a significant positive outlier for bed occupancy rates, throughput and accessibility.

Admission

All young people that are admitted to The Cove receive a CPA within five working days, to determine if continued admission is indicated. Where the answer is 'no', the team work with partner agencies to ensure there is a robust plan to support discharge. If the answer is 'yes', the team formulate and agree on care aims for the remainder of the admission, which will be reviewed within 28 days.

The team at The Cove use a psychological formulation approach for assessment to inform care, intervention, risk management and post discharge planning for young people. This has improved outcomes for young people at the point of discharge, evidenced in the readmission rates to the unit. In the previous 12 months, the team cited five young people had been readmitted to The Cove within 28 days of discharge (6% of all admissions).

Environment

The Cove has been designed in collaboration with young people to ensure it is safe and comfortable. There are notice boards and signage reducing potential 'flash points' and conflict which might lead to an increase in risk taking behaviour and cause a barrier to discharge. There are lounge areas to provide readily accessible quiet space away from the ward, and co-produced wall murals in the ward to provide background images that do not impact on a young person's sensory needs.

Flow and capacity

The team have a weekly meeting to discuss all Tier 4 activity i.e. referrals into the service, young people on waiting lists, young people currently in OOA specialist beds, and young people at The Cove. The aim of the meeting is to review flow and capacity by tracking LoS, and to review estimated dates of discharge, progress, and clinical updates from specialist services. There is a further meeting on a Friday for all North West providers, chaired by the matron at The Cove, which has supported flow of young people across the North West.

Therapeutic models

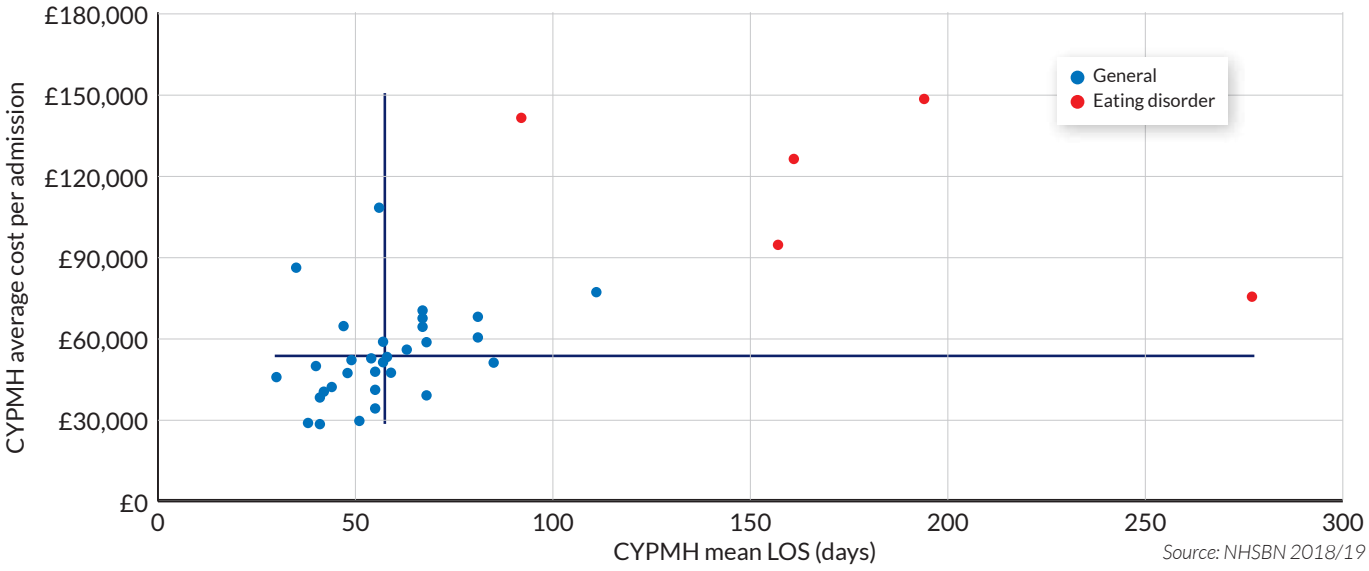
There is no consistency in the staffing levels on the inpatient units - NHS Benchmarking data identifies variation from 21 clinical WTEs per 12 beds to over 80 - and no consistency over the bed day pricing. This variation indicates a significant difference in the operational and clinical model between the units. Some of this variation is driven by multiple commissioners commissioning different parts of the pathway, with some of the variation occurring within single NHS-led provider collaboratives. This would be addressed by integration of services at system level. At present, providers cannot explain the differences in the commissioned model or why their approach may be different to one in a neighbouring provider. It is further apparent that providers are not looking at whole pathway outcomes in the design of the inpatient unit. CYP inpatient beds are the second most expensive mental health beds and that has driven an approach of reducing the cost per bed day, but less thought has gone into understanding why the cost is high or if this is justified.

There is a significant variation between units in the pricing of bed days, ranging between £600 and £1,600 (**Figure 10**), and admission costs days, ranging between £28.5K and £148.5K (**Figure 9**), with no clear association with outcomes or quality of care. There does, however, appear to be an association in most units of increased LoS with decreased cost per bed day. This results in an almost linear relationship between LoS and cost per admission. Given the huge variation in cost per bed day, this association is unexpected and best explained through the shorter admissions associated with more costly bed day prices.

It is notable that we struggled to gain any outcome data other than the proxy measure of LoS. There is a need for outcome measures, such as Patient Reported Outcome Measures (PROMS), to monitor improvement in health. This approach will also enable effective personalisation of care.

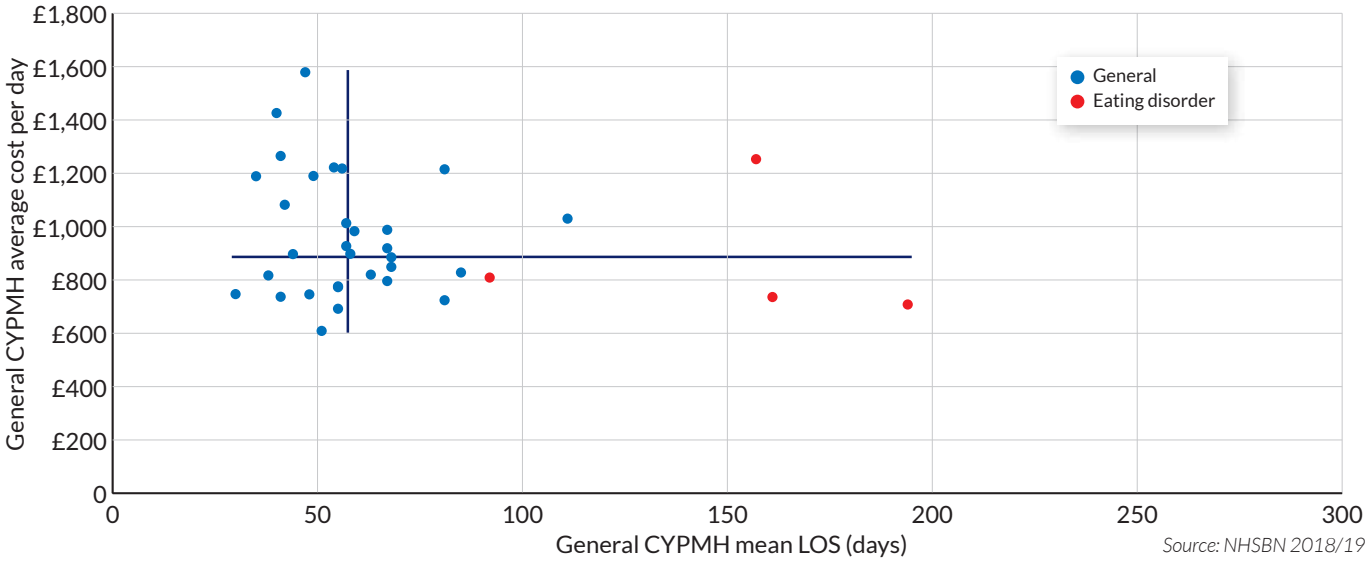
Figures 9 and **10** show the relationship between LoS and admission cost, with **Figure 9** of mean LoS and cost per admission and **Figure 10** of mean LoS and cost per day. It should be noted that 92% (34/37) of providers presented are NHS providers as the majority of the IH providers did not return cost information. Additionally, the LoS outlier was removed due to incomparable service models nationally.

Figure 9: General and eating disorder CYPMH mean LoS and cost per admission



Source: NHSBN 2018/19

Figure 10: General and eating disorder CYPMH mean LoS and cost per day



Source: NHSBN 2018/19

Feedback from units indicates that having a mix of young people with differing presentations and complexities leads to a healthier therapeutic milieu. This drives perceived shorter LoS and staff retention. Within the deep-dive visits, it was not clear whether there was a significant clinical advantage to stand-alone eating disorder units. However, cost per admissions within the stand-alone eating disorder units is considerably higher, while the cost per bed day is considerably lower. It should be noted that NHS England has provided guidance on Community Eating Disorder services which acknowledges the importance of collaboration between these services and inpatient or intensive day care teams, as well as ensuring inpatient admissions are brief in duration and as close as possible to the child or young person's home.[29]

We compared the LoS and cost per admission of GAUs with an associated eating disorder unit in the same trust, alongside GAUs which do not have a separate eating disorder unit. There is no statistical difference between the two types of GAU, with a slight benefit towards those GAU which admit eating disorder patients. This is supported by national evidence, suggesting there is no benefit of admission to a specialist eating disorder unit over admission to a general adolescent unit with specialist community support. There are a number of possible explanations for this, including the stand-alone eating disorder units admitting the more complex challenging eating disorder patients who are more likely to need nasogastric tube feeding, while further research is indicated. However, it is also possible that this is an indication of the importance of a mix of presentations on an inpatient unit. From the deep-dive visits, units that felt they admitted primarily emotional dysregulation and self-harm reported the least staff satisfaction and felt they saw a larger number of young people escalating to PICU beds.

Recommendation 13 has clearly identified the link between low staffing levels and subsequent longer LoS which suggests investment in units should be on staffing levels. It is also notable that the skill mix within inpatient CYPMH units is notably lower than in community services. While this may indicate the need for meaningful activity on the units, as provided by lower banded activity coordinators or health care assistants, it may also indicate a need for a greater spread of experience and expertise amongst staff.

One area that we were unable to explore effectively within the GIRFT deep-dive visits was the use of day beds. This is because the definition of day-case beds is not clear, similarly mentioned in other GIRFT reports.[30, 31]

Some trusts use inpatient beds as step-down beds and describe these as day beds; other trusts have separate day units for specific conditions such as eating disorder patients; and others can admit young people into the inpatient unit on a day basis only to avoid a full admission. These places are also differently commissioned in different areas. Staff from units providing any of these options report clinical and quality benefits. However, we were not able to compare costs, outcomes, or clinical models and, as such, can make no clear recommendations. We do, however, recommend the consideration of a nationally-focused audit on day place provision and service models, commissioned by the specialised commissioning team or as part of the NHSBN benchmarking exercise. Within an NHS-led provider collaborative area, there should be a clear understanding of where such day places fit within the urgent care and crisis pathway, as well as ensure the data collection allows data driven QI and reduction in variation across the NHS-led provider collaborative.

It should be noted that NICE has published a number of guidelines on how inpatient care should be delivered.[32, 33, 34]

Reducing the requirement for PICU beds

Although QI and a continued focus on reducing LoS and improved outcomes should be maintained, other than one unit, there is less variation in the LoS or client mix in the PICU data than in the GAU data. At a national level the national clinical lead for the Low Secure Network has established an effective clinical network between the PICU units with effective standards and quality reviews.

While the data was not collected, it was a common theme at deep-dive visits that many, if not most, admissions to PICU beds result from escalating behaviours on GAUs which, with effective staffing, training and environment, may have been avoided. For example, when the adolescent inpatient unit within Cheshire and Wirral closed, there was a concern that this

[29] *NHS England NHS Improvement (2019) Addendum: Inpatient and intensive day care extension to the community eating disorder guidance. NHS England NHS Improvement. https://www.england.nhs.uk/wp-content/uploads/2019/08/addendum-to-the-cyp-ed-guidance.pdf*

[30] *GIRFT (2021) Endocrinology GIRFT Programme National Specialty Report. GIRFT. https://future.nhs.uk/connect.ti/GIRFTNational/view?objectID=30318096*

[31] *GIRFT (2021) Hospital Dentistry GIRFT Programme National Specialty Report. GIRFT. https://future.nhs.uk/connect.ti/GIRFTNational/view?objectID=30318096*

[32] *NICE (2019) Depression in children and young people: identification and management NG134. NICE. https://www.nice.org.uk/guidance/NG134*

[33] *NICE (2016) Psychosis and schizophrenia in children and young people: recognition and management CG155. NICE. https://www.nice.org.uk/Guidance/CG155*

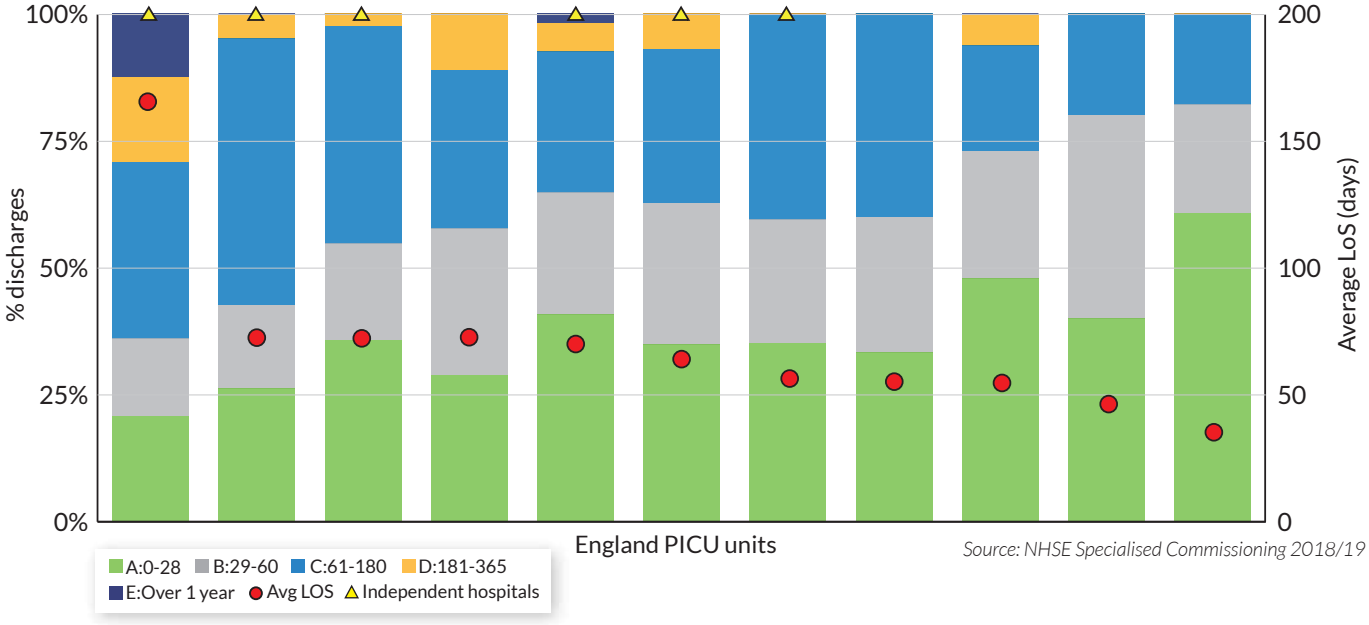
[34] *NICE (2020) Eating disorders: recognition and treatment NG69. NICE. https://www.nice.org.uk/guidance/ng69*

would result in an increase in the presentation of complexity and risk of the young people requiring admission, although fewer admissions which may have led to an subsequent increase in use of PICU beds. However, the trust saw a significant decrease in not just the total number of admissions but also the number of young people requiring a PICU bed. As heard in deep dives, this confirmed to the trust the avoidance of inappropriate admissions onto a GAU. Deep-dive visits also identified the importance of the flexibility of the unit in managing the type of presentation of admissions to maintain a good balance of need. Units which have periods of time with admissions only of severe self-injurious behaviour report more escalations in behaviour than those with a mix of needs. A mix of patient needs can be therapeutically/operationally beneficial.

The final point around PICU use is that, at present, restraint in adolescent inpatient units is over five times higher than that in their adult counterparts (discussed in Recommendation 5). This strongly suggests that training and support in managing challenging behaviour in an adolescent inpatient unit needs addressing in the first instance, rather than an assumption that this can be addressed by building more PICU units.

There is little variation within LoS in PICU. While again LoS is the only proxy outcome measure that we have, there is an association between cost of the unit and LoS, with the costlier units having shorter LoS. This suggests units should focus on providing an efficient service, rather than focusing on providing a cheap cost per bed day service. The PICU data suggests that the focus should be on reducing the number of young people who require PICU beds in the first instance. There is less variation in the LoS in PICU, although individual practices in one unit need addressing. **Figure 11** illustrates the PICU average LoS. One provider appears to have a significantly higher proportion of discharges over 180 days and one year, which has driven the extended LoS for this provider (links to Recommendation 4).

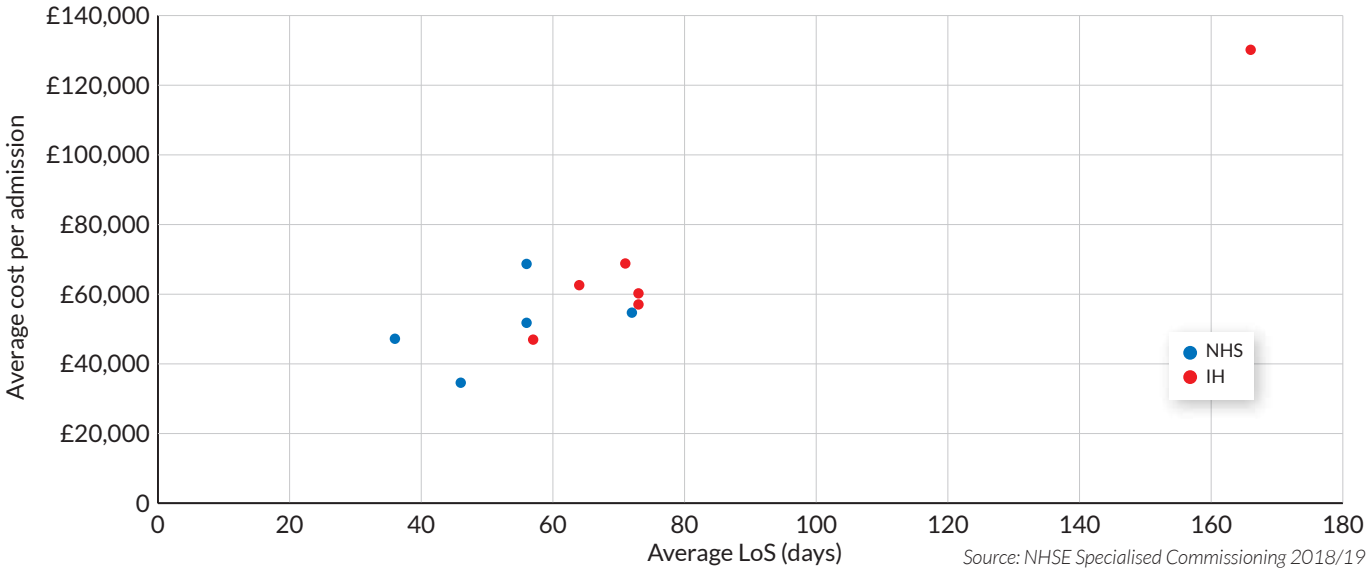
Figure 11: PICU average LoS



Source: NHSE Specialised Commissioning 2018/19

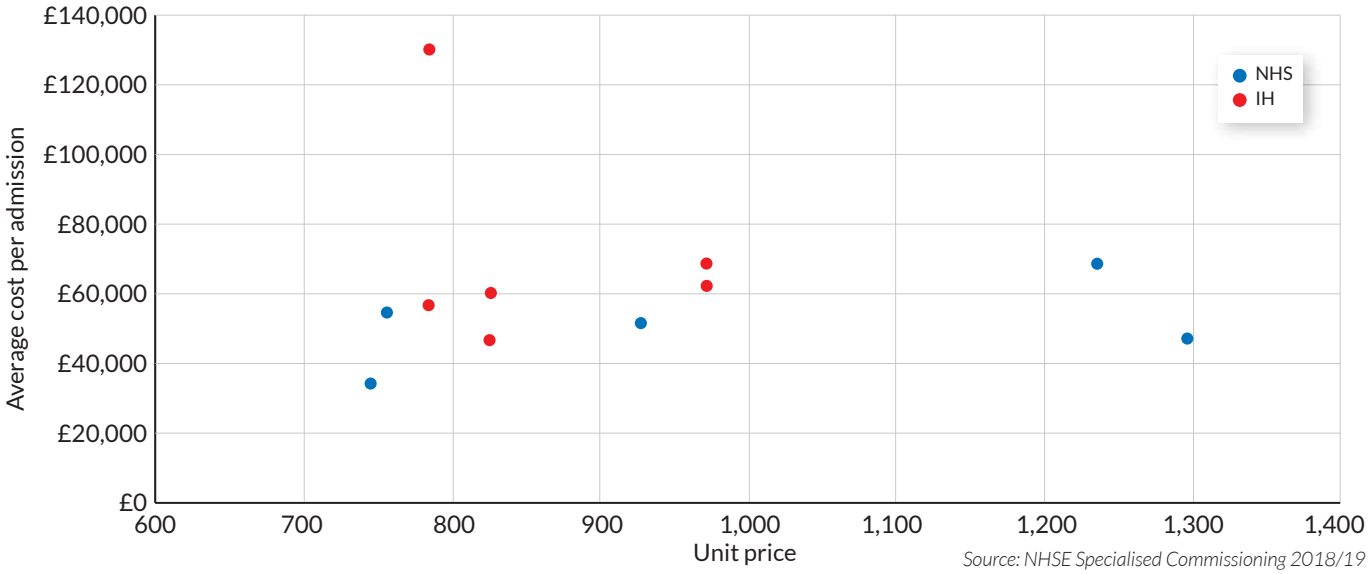
Figure 12 provides the PICU cost per admission and LoS, with **Figure 13** illustrating the PICU cost per admission and unit price. The outlier unit with an increased average cost per admission appears to be driven by the increased LoS rather than the unit price.

Figure 12: PICU - cost per admission and LoS



Source: NHSE Specialised Commissioning 2018/19

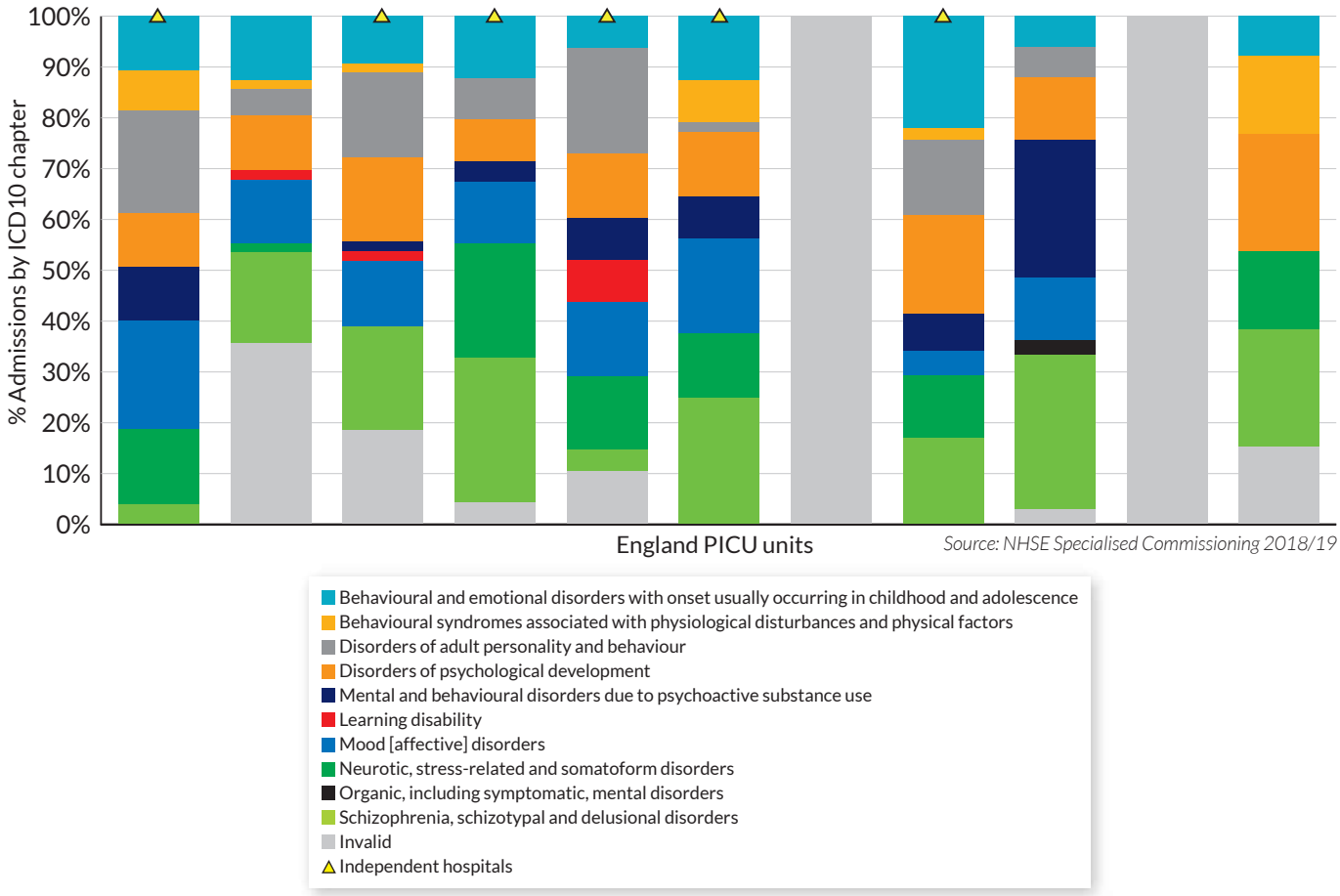
Figure 13: PICU - cost per admission and unit price



Source: NHSE Specialised Commissioning 2018/19

Figure 14 shows the PICU admissions by diagnostic group. There is wide provider variation in the diagnosis profile admitted to PICUs in 2018/19, with 22% of admissions without an ICD10 recorded.

Figure 14: PICU admissions by diagnostic group



Based on deep-dive visits, the main driver to PICU admissions appears to be the admission and onwards management of young people into GAU who may not have benefited from the admission in the first instance. The improvement must therefore occur at the GAU level in terms of recognition and management of challenging behaviours, along with ensuring that there are appropriate environmental factors to minimise the risk of escalation.

Recommendations: Clear inpatient models

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1. There must be a clear strategy and plan on reducing the proportion of young people remaining on the inpatient unit for more than 60 days. The plan must include: • promotion and development of effective alternatives to an inpatient admission, including provision through social care and education; • rapid and appropriate access to therapeutic support on the inpatient unit; • the ability to ensure a rapid discharge from hospital with ongoing intensive support in a community setting.	**a** Commissioners and providers including lead providers within a collaborative must develop alternatives to admission for young people who are likely to escalate behaviours on admission and can be managed in the community. This must be a jointly owned plan with all commissioners working together.	NHS and IH providers, commissioners, and Lead Provider/s of an NHS-led provider collaborative.	Each provider to have clear clinical outcomes driving principles behind discharge.	For progress within 3-6 months of publication.
	b Commissioners and providers must enable multiagency working, in particular with social care and education to enable ongoing community support in a social/educational environment that will foster engagement with the community therapeutic process.	NHS and IH providers, commissioners, and Lead Provider/s of an NHS-led provider collaborative.	Each provider and lead provider/s of an NHS-led provider collaborative to have a clear strategy as described in the action.	For progress within 3-6 months of publication.
	c Clinicians and commissioners must develop locally agreed clinical outcomes to use as the guiding principle behind discharge. These outcomes must link to the Impact Framework.	NHS and IH providers, commissioners, and Lead Provider/s of an NHS-led provider collaborative.	Developed multiagency pathways to support the treatment of complex young people in the community.	For progress within 12 -18 months of publication.
	d Commissioners including lead providers within a collaborative must promote a guiding principle of discharge being linked to agreed clinical outcomes rather than an arbitrary LoS.	NHS and IH providers, commissioners, and Lead Provider/s of an NHS-led provider collaborative.	Developed multiagency pathways to support the treatment of complex young people in the community.	For progress within 12 -18 months of publication.
	e Commissioners and lead provider/s of an NHS-led provider collaborative to monitor LoS using stratification of LoS rather than average LoS.	NHS and IH providers, commissioners, and lead provider/s of an NHS-led provider collaborative	Decreased percentage of patients discharged from a LoS greater than 60 days.	For progression within 12 months of publication.
	f Commissioners and lead provider/s of an NHS-led provider collaborative to monitor readmission rates.	NHS and IH providers, commissioners, and lead provider/s of an NHS-led provider collaborative	Decreased readmission rates.	For progression within 12 months of publication.

Recommendations: Clear inpatient models (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
2. Clear therapeutic models must be present on each unit, concordant with available NICE guidance, for the most common reasons for admissions. The model requires identified clinical interventions including frequency, intensity and expected outcomes. These models should be accurately staffed and link to the funding model for the unit.	**a** Each provider to review the service offer requirements of the service specification.	NHS and IH providers.	Clear therapeutic models, which are concordant with available NICE guidance, within each inpatient unit.	For progress within 12 months of publication.
	b Each provider to assess care provision against published NICE guidance on depression in CYP (NG134), the recommendations on referral in crisis and challenging behaviour in NICE's guideline on psychosis and schizophrenia in CYP (CG155), and the recommendations on inpatient and day patient treatment in NICE's guideline on eating disorders: recognition and treatment (NG69).	NHS and IH providers.	Developed outcomes-based service specification.	For progress within 18 months of publication.
3. A blended model of commissioning for inpatient units should be considered and commissioned based on the provision of therapeutic models and outcomes, not a cost per bed day model.	**a** To develop an outcomes-based service specification linking to the resourcing of the unit.	Service specification to be developed by the national Tier 4 Clinical Reference Group.	Clear outcomes-based service specifications for all child and adolescent unit types.	For progress within 18-24 months of publication.
	b Linking to rrecommendation 17. The service specification should include requirement on data collection for diagnosis, reason for admission, interventions offered and patient reported outcome measures.	Commissioners including lead providers to implement service specification.	Improved consistency of the therapeutic model within inpatient units	For progress within 18-24 months of publication.

Recommendations: Clear inpatient models (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
4. There must be a focus on avoiding escalation in presentation and behaviour of young people in GAU to prevent avoidable admissions to PICU. All PICU admissions should be subject to careful collective review to identify if any opportunities to avoid the PICU admission were missed.	**a** For each trust/IH provider to identify a profile of young people requiring PICU admissions.	Trust/IH provider.	Improved management of escalating behaviours on GAUs.	For progress within 18 months of publication.
	b For each trust/IH provider to identify the most common reasons for escalation to PICU.	Trust/IH provider.	Decreased admission of young people at risk of escalation of behaviours on admission	For progress within 18 months of publication.
	c Each trust/IH provider to implement plans to reduce reasons for escalation to PICU.	Trust/IH provider.	Decreased use of PICU beds.	For progress within 18 months of publication.
	d Each trust/IH provider to ensure effective staff training is in place.	Trust/IH provider.		For progress within 18 months of publication.
	e Each trust/IH provider to ensure an appropriate environment is provided.	Trust/IH provider.		For progress within 18 months of publication.

Restrictive interventions and the use of the mental health act

Incidents of seclusion, restraint and prone restraint remain too high

It is not excusable that the incidence of seclusion, restraint and prone restraint remains high in CYPMHS and is, on average, over five times higher than the adult equivalent. This cannot be explained by acuity and there is a substantial variation across inpatient units.

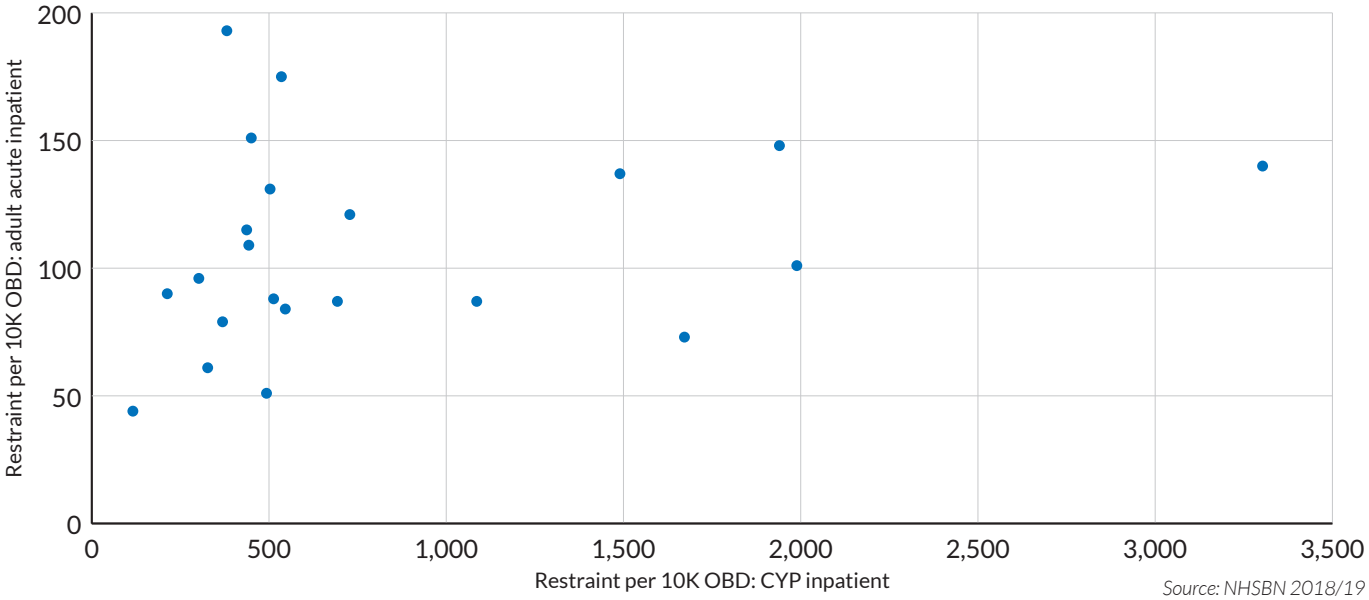
From deep-dive visits, there were multiple explanations for increased restrictive interventions for young people. These include:

- Increased number of young people with emotional dysregulation/personality disorder admitted than within the adult population due to lack of community alternatives.
- Young people remaining on units beyond the time that it is therapeutic.
- Use of restrictive interventions when appropriately or inappropriately nasogastric tube feeding young people.
- Less involvement in trust wide reducing restrictive intervention programmes from CYP units.
- Less expertise on wards due to prevalence of small, isolated units with no High Dependency Unit (HDU)/PICU within same trust.
- Increased staff turnover and vacancy rates.
- Developmental level of CYP means that adult focused de-escalation techniques are not always effective.

Young people admitted to mental health units are often victims of trauma, and the process of restraint can be akin to re-experiencing the historical trauma and can lead to less engagement in therapeutic activities and longer time to recovery.

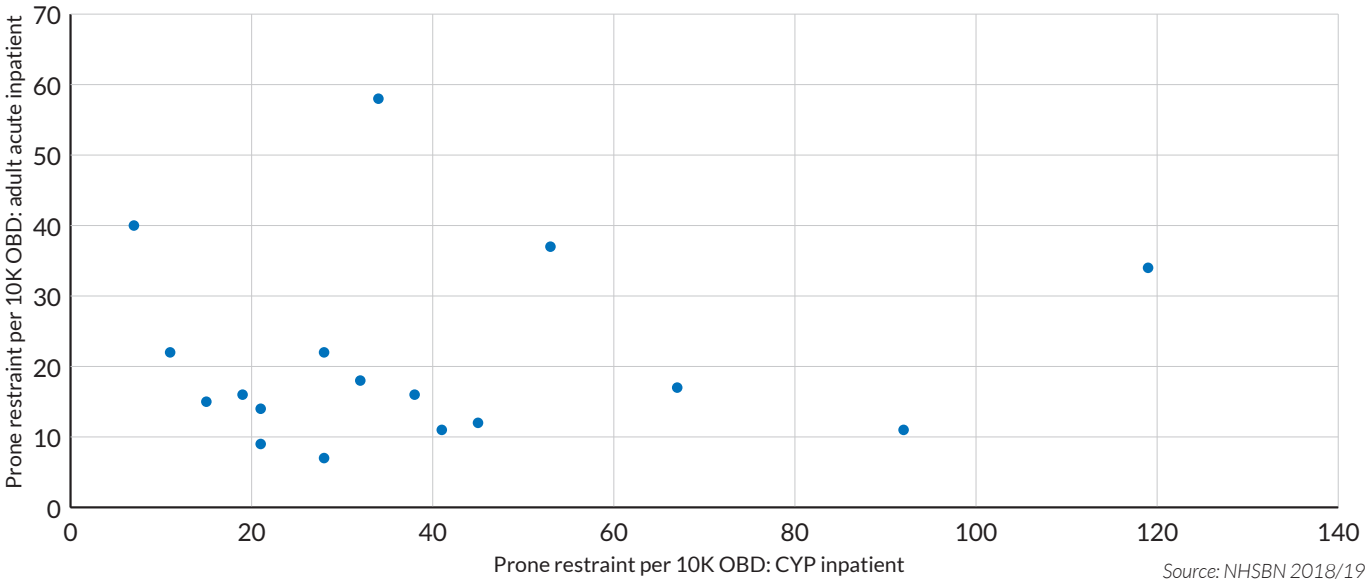
Figures 15 and **16** illustrate the comparison of adult acute and CYP levels of restraint. **Figure 15** highlights a median ratio of 5.6 CYP incident of restraint when compared with adult acute inpatient services. **Figure 16** shows a median ratio of 2.3 CYP incident of prone restraint when compared with adult acute inpatient services. It should be noted that two CYP outliers were removed due to data quality concerns.

Figure 15: CYPMH general admission and adult acute inpatient restraint per 10,000 occupied bed days



Source: NHSBN 2018/19

Figure 16: CYPMH general admission and adult acute inpatient prone restraint per 10,000 occupied bed days



Source: NHSBN 2018/19

During deep-dive visits, managers and clinicians alike explained this discrepancy as differences between the presentation of mental illness in children and adults. However, there is neither an evidence-base nor consensus to suggest that this is an acceptable reason for the disparity. NHSBN data for 2018/19, focusing on the adult population, suggest the use of prone restraint may increase in step with LoS.

Within the CYP inpatient setting, this association cannot be explained through admitting a different client mix as there is a centralised admission and bed-finding process for CYPMH admissions taking the decision of who to admit away from the inpatient unit.

To reduce the apparent need for these actions, trusts and providers should ensure that:

1. Where possible a mix of clients are admitted (rather than those with similar diagnosis).
2. There is an appropriate therapeutic environment, including psychological formulation and interventions.
3. QI projects addressing restraint consider the cohort of young people on the ward, the appropriateness of admitting young people who may not benefit from being within a restrictive environment, as well as de-escalation techniques.
4. Provider organisations must have oversight of the levels of restraint and seclusion using per occupied bed days rather than the raw number, and a target to reduce restraint and seclusion in young people to the same if not better level than in the adult inpatient population. This should be regularly reported at board level.

The SafeWards initiative has been used nationally within the adult inpatient settings to great benefit, and restraint has been a focus of national benchmarking. This has resulted in significant decreases in restraint and particularly prone restraint for adults. Improvements within the CYPMH estate is likely to be enhanced by monitoring of restraint through the national Clinical Reference Group. A number of recommendations have been proposed by NICE on managing violence and aggression in CYP, covering the appropriate use of restrictive interventions, including restraint and seclusion.[35] Additionally, NICE published a quality standard on violent and aggressive behaviours in people with mental health problems,[36] as well as relevant recommendations in the section on referral in crisis and challenging behaviour in the NICE guidance on psychosis and schizophrenia in CYP.[37]

It must be ensured that all staff have adequate training in psychological theory and models focused on preventing escalating distress. It is essential that staffing is safe and therapeutic with the correct skill mix and training. This needs to directly link to the therapeutic purpose of the ward and the identified needs of the CYP.

[35] *NICE (2015) Violence and aggression: short-term management in mental health, health and community settings NG10. NICE. https://www.nice.org.uk/guidance/NG10*

[36] *NICE (2017) Violent and aggressive behaviours in people with mental health problems QS154. NICE. https://www.nice.org.uk/guidance/qs154*

[37] *NICE (n 30).*

CASE STUDY

Reducing the use of restrictive practices

Northamptonshire Healthcare NHS Foundation Trust

Northamptonshire Healthcare was a significant positive outlier in terms of use of both seclusion and restraint (NHSBN 2018/19). The trust attributed this to the introduction of pods in de-escalation rooms and seclusion rooms across the service, as well as use of these for restraint feeding or inserting a nasogastric tube under restraint. The team found the use of pods to provide greater safety in terms of posture and aspiration risk, and increased comfort for the young person and the team.

Since 2017, the trust has been using body-worn cameras to improve the safety of patients and staff. The trust won the award for Best Product or Innovation in the public sector at the HSJ Patient Safety Awards in 2018. The team said evidence indicates that the use of video recording devices may reduce the incidence of aggression and violence while also providing greater transparency and enabling increased scrutiny for any subsequent actions taken in response to such occurrences. Body-worn cameras will be used in the event of an incident unfolding or member of staff feeling threatened. The camera will be immediately activated, and the individual being recorded will be notified, wherever possible.

The use of the Mental Health Act

Accessing appropriate Mental Health Act data was a challenge. It was not possible to identify how many Mental Health Act assessments were undertaken, but only identify the number of young people detained when the assessment was undertaken within a CYP service. This meant that we were unable to determine nationally the number of Mental Health Act assessments and Section 136 assessments, as well as the outcome of such assessments. We did however seek feedback from deep-dive visits. Significant concern was raised over young people being detained for disorders of emotional dysregulation and self-harm which were unlikely to benefit from an admission into an adolescent inpatient unit.

It appears that there are several reported factors driving this:

- Limited community intensive support services for young people with significant self-injurious behaviours and emotional dysregulation. While all services have crisis teams, and the majority are able to provide support in the community, there are fewer organisations which provide a service to manage the behaviour in an ongoing way, and less skilled staff able to mitigate the community risk whilst treating the young person. It is notable that within adult services, there is a recognition that the admission of people with a personality disorder cluster should only have a short crisis admission. This is backed up by research and best practice evidence. However, it is also notable that this is not replicated within CYP services. There is a common acknowledgement that if these young people are admitted, the inpatient environment is not conducive to rapid recovery because these young people are seen as the most likely to escalate into challenging and self-injurious behaviours in this setting as the restrictive nature of the environment can act as a trigger. As such, these young people often need admission to a PICU unit. Recommendation 4 looks at this impact on the PICU environment.
- The pressures on admission for a young person are different from an adult. There is increased pressure for an admission for a young person from families or their carers who may feel that they have reached the limit of their support. Additionally, there are often social care complexities leading to challenging decisions around housing, and a perceived need to be more protective of young people than their adult counterparts. To account for these considerations thoroughly, deep-dive visits have identified that children and young people are more likely to be detained or admitted having presented on Section 136 if they are assessed by an adult Section 12 approved doctor without the presence of a CYP Section 12 approved clinician.
- Deep-dive findings found young people with complex social circumstances and challenging behaviour who are within a social crisis, rather than a clear mental health crisis, were the young people most at risk of an inappropriate admission in these circumstances. This may explain increases in detention. While recognising the impact of the assessing doctor, it is also noted that the alternatives to detention are sparse. The GIRFT data identified no knowledge of

non-health-based places of safety, and deep-dive visits identified a theme that social care struggled to respond by identifying alternatives to the Section 136 suite in a timely manner. There is evidence of best practice to avoid admissions which are driven by social crisis rather than mental health crises. An example is Safe Beds in Lancashire Care, where a young person can be placed in a safe bed on the inpatient unit, (but not admitted to the unit) for a period of 72 hours while the social crisis is resolved through multiagency work. It is also notable that the trust reports no concerns with young people remaining in the safe beds for longer than 72 hours.

- It is common for the out-of-hours Mental Health Act assessments to be undertaken by psychiatrists who are not specialists within child and adolescent psychiatry. This is common practice and may increase detentions. This is an important point as decision-making within a Section 136 assessment requires excellent knowledge of the community offer and what risks these services can manage. It is not enough to suggest a CYP-approved clinician is involved remotely with a Section 136 assessment. This is because the decision-making for detention under the Mental Health Act lies with the assessing doctor and, while specialist advice can be helpful, it is not likely to significantly change the outcome.

It should be noted that there are opportunities for integrated budgets to support CYP when there are social care needs as well as mental health needs.[38]

CASE STUDY

The use of 'safe space beds' to reduce the numbers of young people with mental health issues presenting at acute hospitals

Lancashire & South Cumbria NHS Foundation Trust

Colleagues at The Cove are using a 'safe space beds' model to reduce the numbers of young people under the age of 18 with mental health needs unnecessarily accessing A&E departments in the LSCFT footprint where the young person has no acute physical health requirements.

Following an initial mental health assessment, if a young person is unable to return to their current residence due to their risk presentation they will require a short term residential safe place. In the standard CAMHS pathway, these young people are usually admitted to a paediatric ward for a short period of time to maintain their safety. However, in this new model, The Cove provides three dedicated 'safe space' beds to replace the function of those paediatric admissions. The requirement for admission to a 'safe space' bed is often for one of the following reasons:

- for short term crisis management, problem solving, self-soothing and family support prior to facilitating a safe discharge with the appropriate follow-up;
- whilst awaiting an emergency social care response, as the young person is unable to return to home/ placement due to presenting risk but does not require a CAMHS inpatient admission;
- whilst awaiting a CAMHS inpatient access assessment or whilst waiting to access a CAMHS inpatient bed.

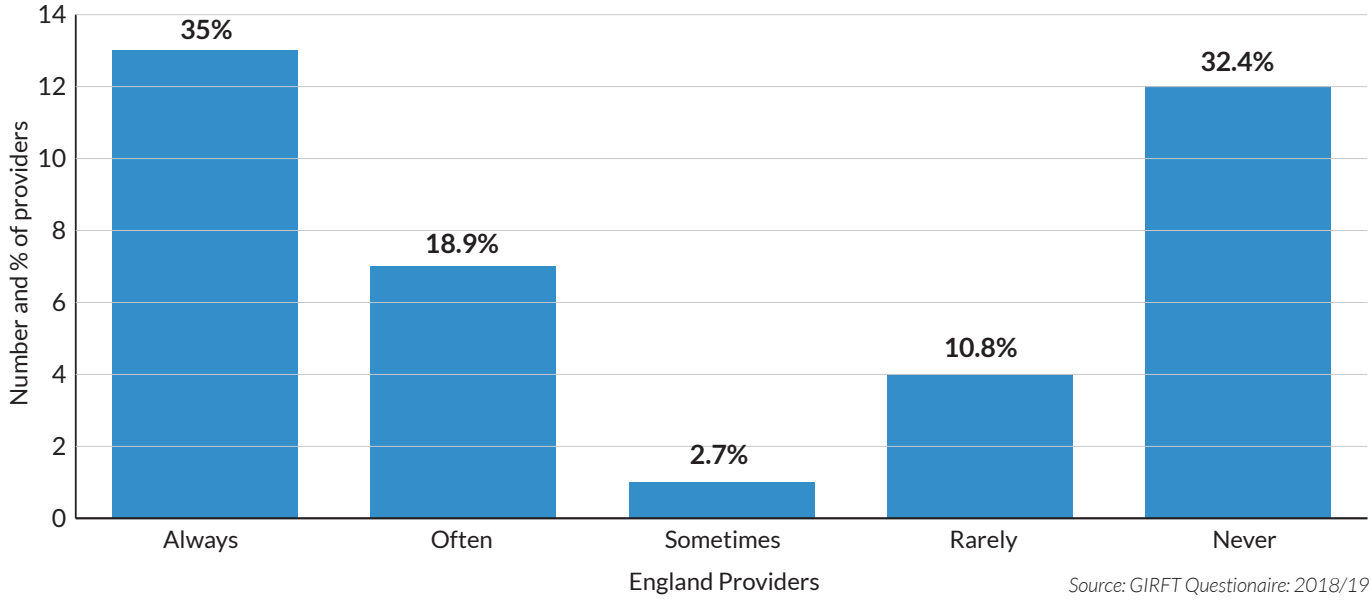
There is a detailed Standard Operating Procedure (SOP) in place for the use of 'safe space' beds to ensure that a safe and effective service is provided.

It is anticipated that the majority of young people will be discharged after a one-night residential stay (as this is the current pattern for paediatric admissions), but where this is not possible an urgent planning discussion will be arranged between the CAMHS community team manager and the modern matron at The Cove to consider the barriers to safe discharge. Due to the limited bed numbers the maximum length of stay should be no more than 72 hours.

[38] *NHS England and NHS Improvement (2017) Integrated personal budgets and personal health budgets. NHS England and NHS Improvement. https://www.england.nhs.uk/publication/integrated-personal-budgets-and-personal-health-budgets/*

Figure 17 shows the baseline position for CYPMH psychiatrists completing Section 136 assessments, with responses for 'always' and 'never' being in close proportion at 35.1% and 32.4%, respectively.

Figure 17: Section 136 assessments undertaken by CYPMH psychiatrists



Source: GIRFT Questionaire: 2018/19

It is recognised that the pool of approved clinicians and Section 12 approved doctors is far smaller in the field of child and adolescent psychiatry than within the field of adult psychiatry. It is important to remember the role of non-medical approved clinicians, and how a drive to increase their numbers in the field of child and adolescent psychiatry may have a significant impact on the number of CYP specialists available for Mental Health Act assessments. It should be noted that deep-dive visits have indicated young people are less likely to be admitted or detained when Mental Health Act assessments included CYP clinicians.

An additional area of concern is the staffing of the Section 136 suite. GIRFT data suggests that 53% of services had either full or partial CYPMH clinician staffing. While it is presently seen as unacceptable that a young person under the age of 16 is admitted to an adult ward, providers will often have processes in place allowing a young person to remain within the Section 136 suite while awaiting a bed within an adolescent inpatient unit, often for days at a time. These processes, while working within the remit of voluntary admissions and the Mental Health Act, may result in a risk that young people who are held within a Section 136 suite have neither the environment nor staffing expertise to support their distress. This increases the risk that their presentation will escalate while a bed is being sought and increases the likelihood that a PICU bed will need to be identified (or decreasing the chances that de-escalation will result in a general admission bed being needed).

Whole pathway

An admission into an inpatient unit, or acceptance into a crisis team, should not trigger a decrease in the input from the community team providing the young person's usual care. Instead, it should drive increased engagement and support to ensure that the urgent care pathway is joined up without siloed sections. Admissions, as far as possible, must be planned by the community team, with a pre-admission meeting to review the community care being provided and explore all options of alternatives to admission. Robust personalised care support plans should be in place with a single point of contact to help children, young people and their families or carers navigate care and treatment pathways.

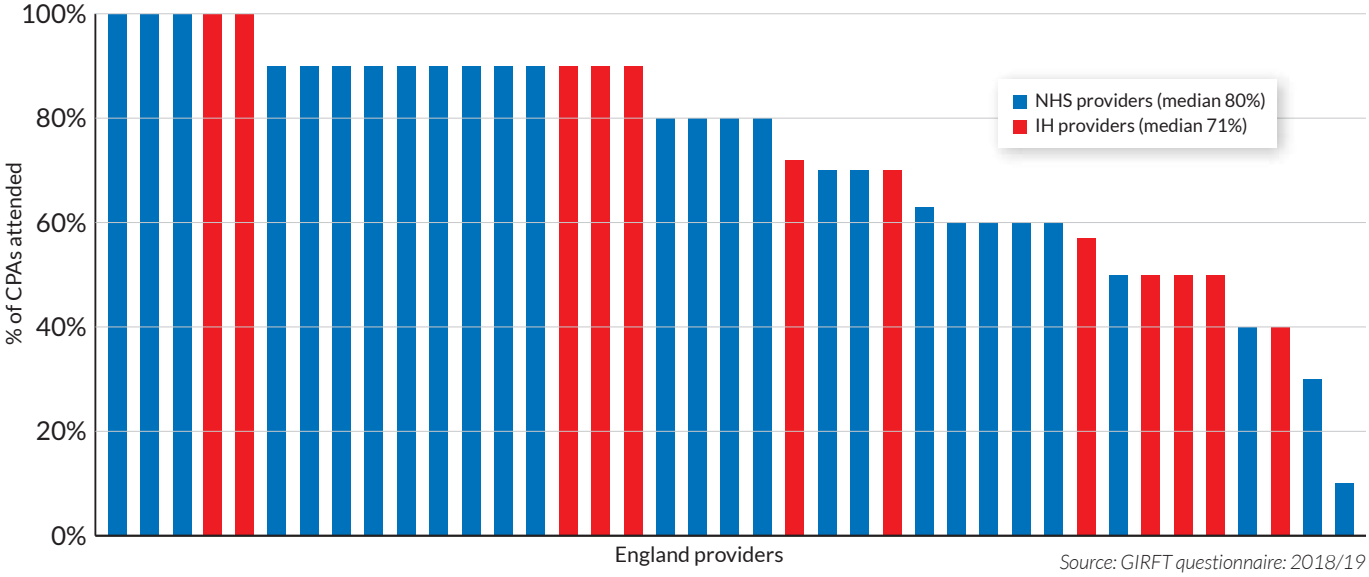
Care, Education and Treatment Reviews (CETRs) have been used to avoid admissions for people with a learning disability for some time with great success. The process involves convening a meeting with the community team, specialist learning disability advisors, the family and other agencies involved in the care of the patient. Discussions are then had on the present community treatment, with recommendations made over additional routes for community care with admission only considered if all else has been attempted. On deep dives, we observed no barriers to implementing this, such as staffing requirements and training.

The NHS Long Term Plan has a commitment to keyworkers for CYP with autism and/or learning disability who are at risk of admission or admitted to hospital. This is being piloted in 2020/21 for a full roll out from 2022/2023. The impact of this initiative will be closely followed for learning across the wider CYP population. There is evidence of poor links between the community teams and inpatient services as demonstrated by attendance at the Care Programme Approach (CPA). Furthermore, there are poor links to other co-dependent organisations such as addiction services, education services and the criminal justice system. Though we recognise that many were in early stages of development we noted that this was consistent across the three well-established NHS-led provider collaboratives along with those early within their development. There is anecdotal evidence, gathered during the deep-dive visits, that the increase in use of videoconferencing during the COVID-19 crisis has driven better engagement due to ease of access. This has also been demonstrated through the high levels of virtual consultations identified in the section *Impact of COVID-19*, page 32.

It should be noted that NICE guidance has been published on care pathways and coordination of care,[39] eating disorders,[40] and psychosis and schizophrenia in CYP.[41] NICE has also published guidelines on transition between inpatient mental health settings and community or care home settings,[42] and the accompanying quality standard.[43] Lastly, in 2018, the Royal College of Paediatrics and Child Health, with other professional bodies, published service standards to support development of pathways of care for CYP with ongoing health needs.[44]

Figures 18 and **19** show the provider range for both NHS and IH providers. **Figure 18** of the CPA attendance by an appropriate community team shows NHS providers with a median of 80% and IH providers with a median of 71%. **Figure 19**, showing the active involvement of care coordinators in care, highlights NHS providers with a median of 60% and IH providers with a median of 85%.

Figure 18: CPA attendance by appropriate community team



Source: GIRFT questionnaire: 2018/19

[39] *ibid*

[40] *ibid*

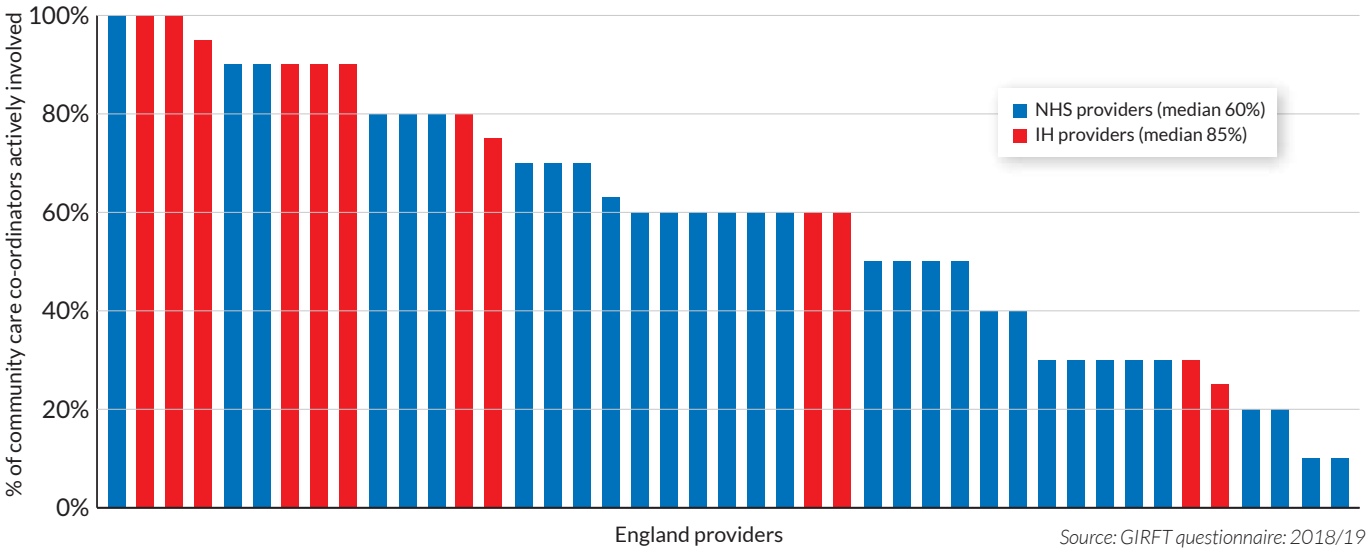
[41] *ibid*

[42] *NICE (2016) Transition between inpatient mental health settings and community or care home settings NG53. NICE. https://www.nice.org.uk/guidance/ng53*

[43] *NICE (2017) Transition between inpatient mental health settings and community or care home settings QS159. NICE. https://www.nice.org.uk/guidance/qs159*

[44] *Royal College of Paediatrics and Child Health (2021) Facing the Future - standards for ongoing health needs. RCPCH. https://www.rcpch.ac.uk/resources/facing-future-standards-ongoing-health-needs*

Figure 19: Care coordinators actively involved in care



Source: GIRFT questionnaire: 2018/19

It is imperative to high quality care and short LoS that the community team remains engaged with the inpatient team during a young person's admission. Young people frequently experience the transition from inpatient care to community care as something they are not prepared for. This drives anxiety and a risk of a relapse of symptoms. Anecdotally, this also leads to inpatient teams feeling that a young person must be stable and well before discharge.

Community care coordinators often find that they have neither the training nor the time within their job plans to support young people on the crisis pathway. As such, their input and care regularly stop until the young person returns to the community team.

There are good examples where the engagement between community and inpatient teams has been successfully implemented - North West London through their CRAFT model and at Cheshire and Wirral with their admission assessment model. Both providers have seen significant reductions in admission and, when a young person is admitted, there is increased clarity over the aim of the admission and shorter LoS. Within the recommended model there is a need to determine the role of the inpatient admission, what treatment would be expected and a description of the outcomes that will trigger a discharge. A discharge date is set before the admission commences and whilst not binding allows an effective monitoring of the progress of admission and expected outcomes.

Both models are based on the concept of a structured, multiagency and multidisciplinary meeting for all young people at risk of admission into an inpatient unit. The assessment will be attended by inpatient and crisis specialists. The meeting will identify the needs of the young person and where best these needs will be met. The aim is to avoid an inpatient admission if possible. If an inpatient admission is agreed, the meeting will determine the expected interventions on the unit, the expected outcomes, and the criteria to be met for a discharge to take place. Within the CRAFT model, the community care coordinator will then maintain care coordination responsibilities while their patient is admitted to the inpatient unit.

While this model is a large step and requires a significant shift in the thinking of the crisis care and inpatient pathway, it establishes the inpatient stay as only a part of a patient's journey. It is recognised that community care coordinators would require training and supervision to undertake such a role alongside senior management support. Capacity within the community teams would need to be reviewed to ensure that the function can be undertaken.

It is possible that using a tool such as the Clinical Utilisation Review (CUR) will enable a very high level of data collection around this process, indicating why treatment targets are not being reached and allowing QI processes to start. Using a CRAFT model with CUR data collection will enable clarity over the inpatient model and, therefore, workforce. It will drive the LoS data and unit safety.

Clinical flow

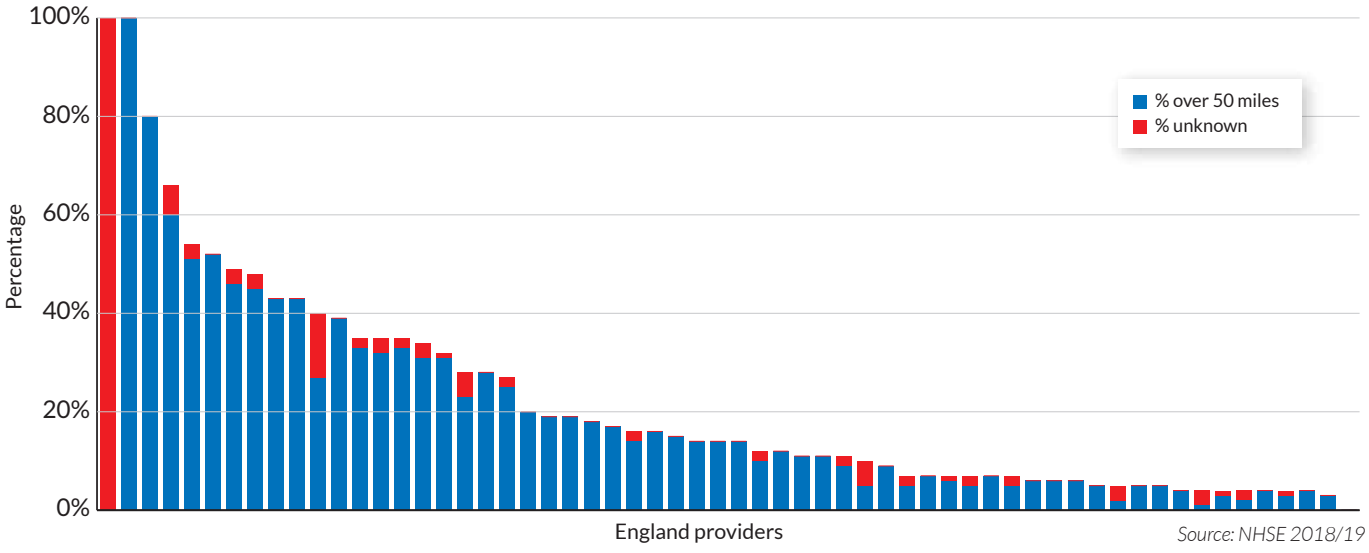
We are concerned that the data we considered in this review showed a significant proportion of young people were admitted far away from home, with distances between their ward and home often being 70km or more. Although there is no research on the impact of this, clinicians routinely report feeling dislocated from their patients when admitted further from home and parents have highlighted distance from home as an important factor to them. The data collected within this project points to longer LoS for those units which admit further from the patient's home. However, due to several confounding factors, including that most units which admit patients further from home are within the IH sector, clear interpretation is difficult.

It is important to ensure that the young person remains linked with their community, family, and local teams. This can only be achieved by remaining within a short distance from their address, and within a unit that has strong links with community mental health services. The data collected for this report was based on distance from home following the national recommendation that no-one should be treated more than 50 miles from their home address.[45] This metric does not capture all patient flows; a metric to do this requires in-depth knowledge - for example, three miles in London can be a longer journey than 75 miles in Berkshire - and takes no account of the relationship between the unit and the community.

Natural clinical flow is a more complex metric which identifies when a young person is admitted within a setting which has strong links between the inpatient, crisis, and community settings, either through the services being provided by the same provider or within an NHS-led provider collaborative area. This requires knowledge of the CCG areas associated with a crisis pathway and measures the care settings patients would usually be expected to flow to based on their home address and services commissioned and provided locally. This has now been mapped onto NHS-led provider collaborative areas which are identified as being the natural clinical flow. For this recommendation to be achievable, commissioners and NHS-led provider collaboratives will need, in addition to decreasing bed usage, to use the available data to understand peak demands and co-ordinate any requirements for bed closures. At present, NHS-led provider collaboratives are not looking at their data in such a detailed way. The NHS-led provider collaborative CYP implementation group continues to review such data to develop bed plans.

Figure 20 illustrates the 2018/19 position and provider variation of general CYP admissions by distance from last known address. NHS England and NHS Improvement data showed 82.4% of admissions during 2018/19 were admitted within their natural clinical flow which has been set-up to manage OOA placements. The mean distance travelled for patients admitted within their natural clinical flow was 18km, compared to 70km if admitted outside their natural clinical flow.

Figure 20: General CYP admissions by distance from last known address



Source: NHSE 2018/19

[45] *ibid*

There remains variation in the number of available beds within each NHS-led provider collaborative and, while there are enough beds nationally, the distribution is not even and not all the NHS-led provider collaboratives have enough beds to manage their demand. We were unable to identify from national data sources the exact number of beds within each NHS-led provider collaborative. However, the areas with the least beds have advanced plans for new units – for example, West Yorkshire will have a new 22 bedded unit due to open in December 2021. There is flexibility built into the CYP inpatient estate due to the high level of IH sector beds, which are often not tied to a specific region or NHS-led provider collaborative. The advantage of using natural clinical flow over distance is that there can be a movement of bed numbers through the judicial use of the IH sector. The IH sector has also shown flexibility in the opening of more beds within an area. This flexibility is crucial to the success of NHS-led provider collaboratives given that some NHS-led provider collaboratives will be looking to release funding from inpatient settings to the community, whereas others will have identified, through careful bed modelling, a requirement for additional bed capacity to meet the needs of their population who would otherwise be placed OOA.

Demand and capacity modelling should be undertaken using effective solutions such as the CUR, with a focus on investing in admission avoidance services. The use of further beds should only be considered when there is clear evidence that the NHS-led provider collaborative has significantly fewer beds than the national average per population and admission avoidance services have been optimised.

Recommendations: Restrictive interventions and the use of the Mental Health Act

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
5. All provider organisations must focus on reducing the incidence of restraint, prone restraint, and seclusion and should: • Ensure levels of restraint in the CYP inpatient population are no higher than in the adult inpatient population. • Have a clear plan in place to reduce incidents of restraint and seclusion. Improvement activity should be based on benchmarking with peers aiming for milestones year on year to achieve a position in the top decile.	**a** All NHS and IH providers must have a clear QI plan in place to address restraint and seclusion with an aim to reduce incidents of restraint by at least 10% year on year. The plan must include an aim to improve data collection on restraint episodes.	All NHS and IH providers.	• Demonstrable decrease in restraint and seclusion. • Increase in the quality of reporting of restraint episodes.	For progress within 6 months of publication.
6. When requiring a Mental Health Act assessment, CYP must be assessed by clinicians with the right skills in a child appropriate environment.	**a** Improve the national offer on support and training on reducing restrictive practices in CYP inpatient services. Ensure that there is an appropriate therapeutic environment to support the development of psychological formulation and de-escalation interventions.	HEE/NHS England and NHS Improvement. All NHS and IH providers.	All CYP inpatient staff have accessed high quality CYP focused reducing restrictive practice training.	For progress within 18-24 months of publication.
7. Commissioners, including lead providers within a collaborative, must ensure that there are effective protocols in place so that when a social need, rather than medical, is present there is a clear and understood pathway to follow which operates both in and out of hours.	**a** Commissioners and providers must develop a clear, commissioned, multiagency pathway.	Commissioners, providers.	• Decreased inappropriate admissions to CYP inpatient units. • Decreased LoS within the Place of Safety/ Section 136 suites.	For progress within 18 months of publication.

Crisis and community services

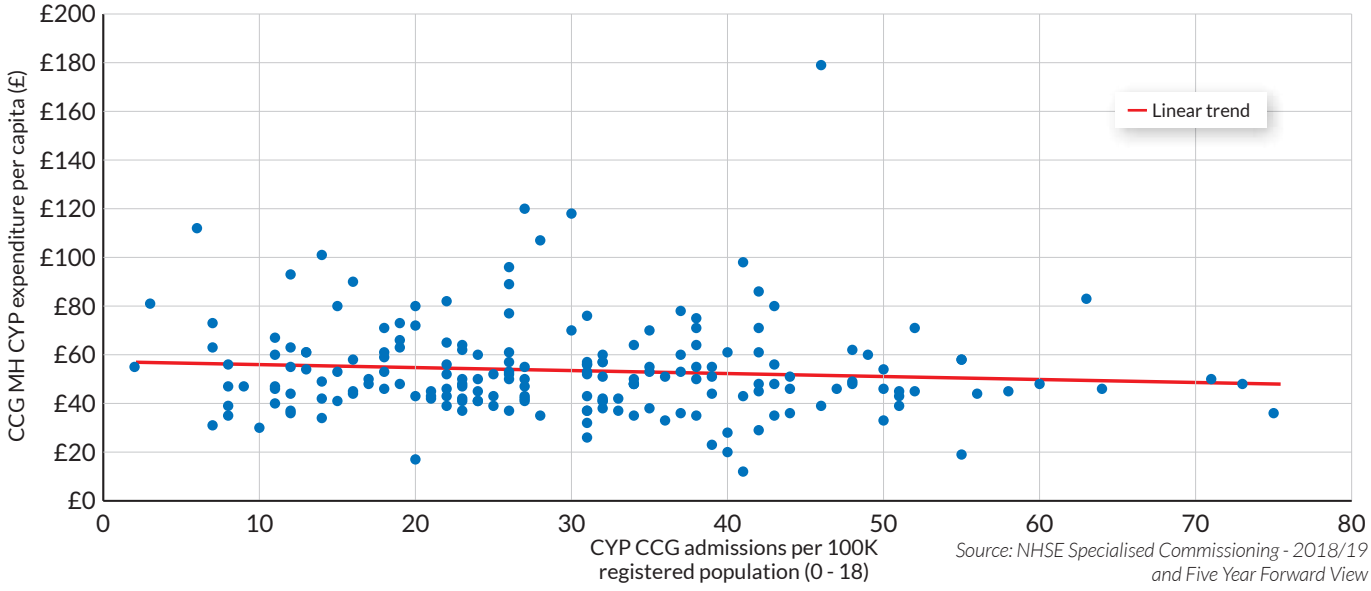
There has been success with the access and waiting time standards for eating disorders and early intervention in psychosis in improving access to services and providing NICE compliant care. However, it is very notable that there is no relationship between the total NHS community spend on CYPMHS and the subsequent number of young people who are admitted to a psychiatric hospital. This suggests that whilst individual parts of the community, crisis and urgent care pathways may be working well, there is no clear best practice model of integrating all the separate parts together. Developing and understanding such models is likely to require more resource.

Within this section we look at:

- Intensive community support teams (ICSTs): Whilst this is not nationally recognised terminology, these are teams that have an express function of supporting young people with defined mental health needs who require more intensive support than a standard community team can provide. Their remit is to avoid young people escalating to the point of crisis.
- Crisis services/teams: these are multidisciplinary and often multiagency teams who support young people in crisis, often regardless of the diagnosis. They manage the short-term crisis and refer back to community teams when possible.
- Intensive home treatment (IHT) teams: these teams provide additional support to a crisis team or intensive community support team to increase the frequency or intensity of care.

Figure 21 shows the CCG range and the relationship between CYP CCG investment and admissions per CCG.

Figure 21: CCG CYP MH: expenditure and inpatient admissions



Source: NHSE Specialised Commissioning - 2018/19 and Five Year Forward View

Intensive community support services are an area of rapid growth with both targeted intensive community support teams (ICSTs), such as enhanced out-of-hospital offers for severe eating disorder presentations, and more general intensive home treatment teams (IHTs). IHTs can offer an intensive community component to the crisis and inpatient pathway and continue to develop more specialised targeted services in line with the NHS Long Term Plan ambitions, such as eating disorders, learning and/or neuro-disability and early intervention in psychosis. This intensive component is just one element of the specialist intervention offer.

ICS teams are not alternatives to admission or a response to a crisis but provide teams that are able to deliver stepped levels of care to avoid patients entering crisis in the first place. An example of such a service is the SLaM Eating Disorder Service which has avoided all eating disorder admissions for a period of a year due to effective treatment and care pathways. Such services are not necessarily significantly cheaper than inpatient admissions, but the flexibility of services and maintaining community links, along with the expense of opening new units, suggests that this is the way forward. The funding for CYP community eating disorder services and the evidence-based model for delivery includes:

- enhancing the delivery of intensive outreach and home treatment to reduce the need for admission;
- the offer of step up or down care;
- in-reach support in inpatient settings if admission is required.

Crisis services and IHTs contribute different functions within the urgent and emergency mental healthcare pathway to provide better care at home and admission avoidance. The NHS Long Term Plan sets out that all CYPs experiencing a mental health crisis will be able to access crisis care 24 hours a day, seven days a week by 2023/24, with a single point of access through NHS 111. The Long Term Plan crisis provision is CCG funded, however it is possible that as NHS-led provider collaboratives become more mature that they also provide specific, pathway defined admission avoidance services. **Appendix 2** (page 103) presents the variation of CCG provision in England during 2018, illustrating the rapidly developing nature of CCGs' CYP urgent and emergency mental healthcare services reporting crisis assessment.

In terms of a comprehensive CYP crisis offer, this should consist of:

1. single point of access including through 111 to crisis support, advice and triage;
2. crisis assessment within the emergency department and in community settings;
3. crisis assessment and brief response within the emergency department and in community settings, with CYP offered brief interventions;
4. IHT services aimed at CYP who might otherwise require inpatient care or intensive support that exceeds the normal capability of a generic CYP mental health community team.

For functions 1 and 2, the crisis assessment and brief response must operate 24/7. For function 3, the IHT function should be available seven days per week across locally determined extended hours.

Ensuring a clear local offer for CYP in crisis and/or requiring intensive home treatment

Urgent and emergency mental health and intensive community intervention services within CYPMHS have been a rapidly growing area driven by national recommendations and investment. However, there is yet no consistent operational or staffing model/approach. The available data on these rapidly developing services was from 2018 and out of date by the time of the deep-dive visits. The data identified significant variations in both development and the crisis model adopted. Some variation is warranted in relation to local context, but some is not. While deep-dive visits identified that there has been investment in this area over the prior 18 months, driven in part by the COVID-19 pandemic, it remained unusual for a collaborative to report consistency of approach or an integrated pathway across the NHS-led provider collaborative area. Provider collaboratives do not have the responsibility for commissioning this pathway and as such this observation is one of unwarranted variation between trusts in a defined area (in this circumstance using the provider collaborative footprint as the defined area). NHS-led provider collaboratives are in their infancy, however it is hoped that embedding a best practice evidenced through good data collection will influence the system commissioners and result in a more consistent approach.

Table 2 presents the baseline crisis service models in 2018, with only 33.3% of services having a dedicated CYP urgent and emergency team or sub-team in place 24/7. Whilst recognising that the Long Term Plan established a baseline target of 30% coverage by 2019/20 and that achieving this early is a positive, it remains a considerably different picture to adult crisis services. Furthermore, it was found that 5.6% of the providers who responded reported a lack of specialist CYP crisis provision with adult crisis services providing some under-18 CYPMH provision outside normal working hours.

Table 2: CYP crisis service models

	England – Yes
Dedicated children and young people's urgent and emergency team or sub team - 24/7	33.3% (18/54)
Dedicated children and young people's urgent and emergency team or sub team - not 24/7	51.9% (28/54)
Adult providing some under 18 CAMHS provision outside normal working hours	5.6% (3/54)
Other crisis model	9.3% (5/54)

Source: NHS England and NHS Improvement Crisis audit 2018

Table 3 shows the CYP crisis service coverage, with only 33.9% of England providers operating 24/7 CYP crisis services, and 46.3% having a published urgent mental health helpline.

Table 3: CYP crisis service coverage

	England – Yes
Providers operating 24/7	33.9% (21/62)
Providers with a published mental health child phone line	46.3% (25/54)

Source: NHS England and NHS Improvement Crisis audit 2018

Such variation in the urgent and emergency mental health and intensive community intervention services are not present within adult crisis services. Adult crisis services have been guided by national policy and have existed for much longer and, as such, have converged on a more consistent model for the adult mental health context. Although the adult model is unlikely to be the most efficient model for CYP, it does indicate the need to work towards parity with adult services in terms of services and outcomes for CYP and address resource, skills, training, hours of operation and functions.

While it can be recognised that different local contexts and community and inpatient services will result in natural (i.e. warranted) variation in the provision of crisis services, presently these variations often appear to be related to funding decisions or workforce constraints rather than an understanding of the best, the most effective and efficient clinical model. This is for both CYP themselves and in consideration of the whole pathway. The COVID-19 pandemic has resulted in all areas now providing a 24/7 initial response service and a published mental health child phoneline. However, there remains much to do to develop not just individual teams but an integrated pathway.

There is still wide variation in service models, referral rates, staff competencies and training and, crucially data. This was uncovered both in the data pack and deep-dive visits, which made it more difficult to understand both the impact of variation across an NHS-led provider collaborative footprint and the ability to compare effectiveness at a local level. It is notable that services are not yet collecting consistent or comparable outcome data on their crisis services.

While we are unable to make recommendations about specific crisis clinical models, due to both the lack of evidence as well as the variation within services required to manage the complexity of the whole urgent care and crisis pathway, processes need to be embedded to ensure that system leaders and commissioners are well informed and supported to develop the most effective and efficient whole pathway models across the footprint of the NHS-led provider collaborative. This must

include effective activity and data collection to guide an effective response to CYP, and make most efficient use of staffing and resources. We recommend that the National Crisis Audit continues to identify and describe national provision and the variation at national level. We also recommend there is further research into effective and efficient service models for the whole community and inpatient pathway, and effective clinical practice in CYP urgent and emergency mental healthcare and intensive community intervention services.

The role of A&E or paediatric wards within the crisis pathway

Young people often present to A&E or a paediatric ward while within a mental health crisis. Frequently this is the right environment to receive physical health care. However, all too often in deep-dive visits we heard that young people remained in such environments longer than necessary without appropriate levels of specialist mental health input, and a gap in the understanding within A&E and paediatric teams in how to achieve best outcomes for these young people (including use of medication). There also need to be robust personalised care support plans in place, with clear outcomes.

CASE STUDY

The Paediatric Critical Care in Practice (PCCP) e-Learning portal

Healthy London Partnership

Following a successful funding bid to HEE London, the Healthy London Partnership developed and rolled out the Paediatric Critical Care in Practice (PCCP) eLearning portal, in August 2018. The aim of the project was to provide a consistent training and support offer to the paediatric workforce, across the 30 acute paediatric hospital sites in London, to enable safe and effective delivery of paediatric critical care within a high dependency setting. The training was designed in a way as to complement face to face training (e.g. simulation) undertaken in each hospital site. The portal has nine modules, eight of which are physical health related. Following requests from paediatric staff registered to use the portal for mental health content to be added, the first mental health module, Eating Disorders, was launched on the portal in 2020. Further modules are in development, including one focused on self-harm. All module content has been developed by clinicians in London. The eating disorder module was developed by a consultant psychiatrist and consultant paediatrician.

Successes and lessons learnt

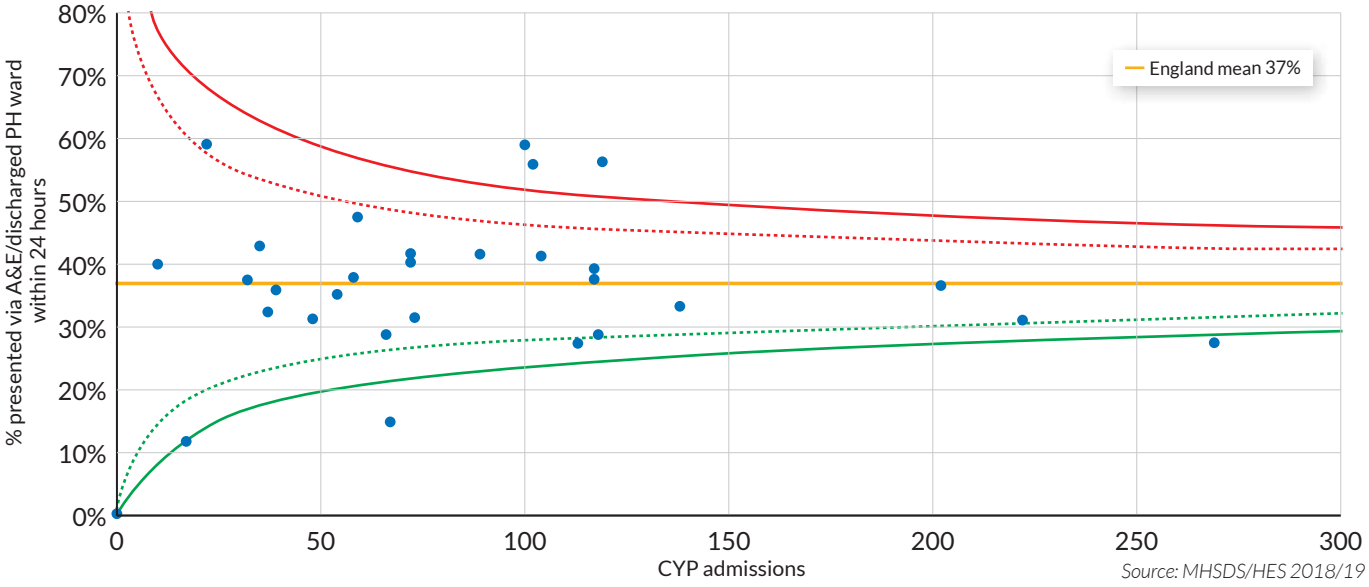
Since the portal launched 1,000+ paediatric professionals across all 30 acute paediatric hospital sites in London have registered to use it. There have been 9,000+ sessions on the portal in this time. 60% of those registered are nurses (various bands), 35% doctors (various grades) and the rest are allied health professionals.

A consultant paediatrician at Kings College said: "Having used the e-learning portal I know first-hand what an excellent resource it is for the paediatric community across London. The modules on the PCCP eLearning portal have been developed by frontline clinicians and reflect the areas of clinical priority for acute paediatrics. Being mindful of the varying demands on clinicians' time, this platform presents an incredibly flexible and user-friendly interface for engaging in educational activities in a way which can be incorporated around the busy lives of frontline clinicians. PCCP is designed with the multi-professional team in mind to reflect how clinical care, centred on CYP and their families/carers, is delivered in real life. I would very much encourage and recommend colleagues across London to register for an account."

Funnel plots

Funnel plots are a good way to identify and show variation. For example, **Figure 22** shows the CYP admission presenting to A&E or discharged from a physical health ward 24 hours prior to admission.

Figure 22: CYP admissions that presented to A&E or discharged from a physical health ward 24 hours prior to admission



Source: MHSDS/HES 2018/19

How funnel plots work

The x-axis plots the volume metric (CYP admission) and the y-axis plots the outcome metric (% presented to A&E). Each black dot represents a specific provider. The mean value for the population (in this case 37%) is shown by the amber line.

The curves on either side show the likelihood of an outcome varying from the average due to chance alone:

- The inner curves (the dotted lines) show two standard deviations from the mean. 5% of values are likely to be beyond these curves due to chance.
- The outer curves (the solid lines) show three standard deviations from the mean. 0.3% of values are likely to be beyond these curves due to chance.

Accuracy and volume

When there is less volume (x-axis), the accuracy of calculating the variation due to chance is poorer, so the funnel curves are further from the average. When there is greater volume, the accuracy of calculating the variation due to chance is better, so the funnel curves are closer to the average.

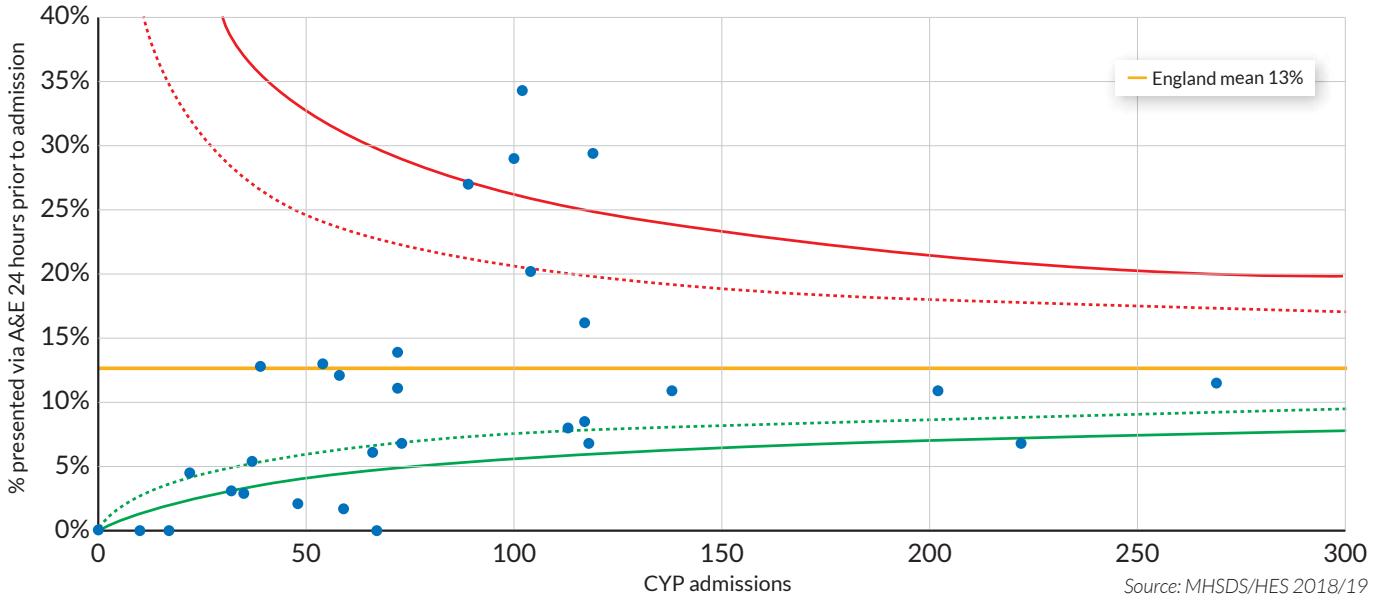
Variation caused by other factors

'All things being equal', funnel plots accurately show the variation from the average.

With **Figure 22** it is relatively easy to measure variation, so we can be reasonably confident that the funnel plot shows the outcome accurately. However, **Figure 23** looks at **CYP admissions that presented to A&E 24 hours prior to admission.** Here more providers than might be expected have outcome values below the lower funnel. This is called 'over-dispersion' and indicates that all things are not necessarily equal – other factors may be influencing the data. In this example, it could be the interrelated nature of **Figure 22** as some providers are achieving low new A&E admissions due to presenting via a different physical health wards or as a result of good clinical practice with the CYP crisis services.

Figure 23 shows the CYP admissions that presented to A&E 24 hours prior to admission, with the mean in England recorded at 13%.

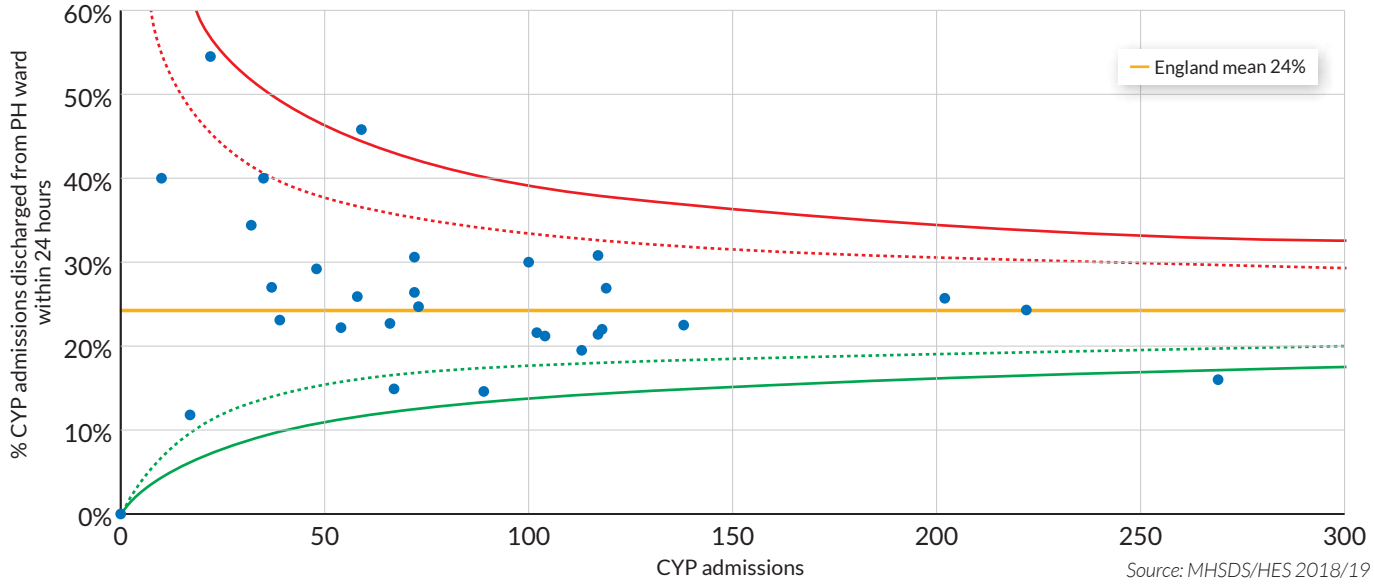
Figure 23: CYP admissions that presented to A&E 24 hours prior to admission



Source: MHSDS/HES 2018/19

Figure 24 shows the CYP admissions discharged from physical health ward 24 hours prior to admission, with the mean in England recorded at 24%.

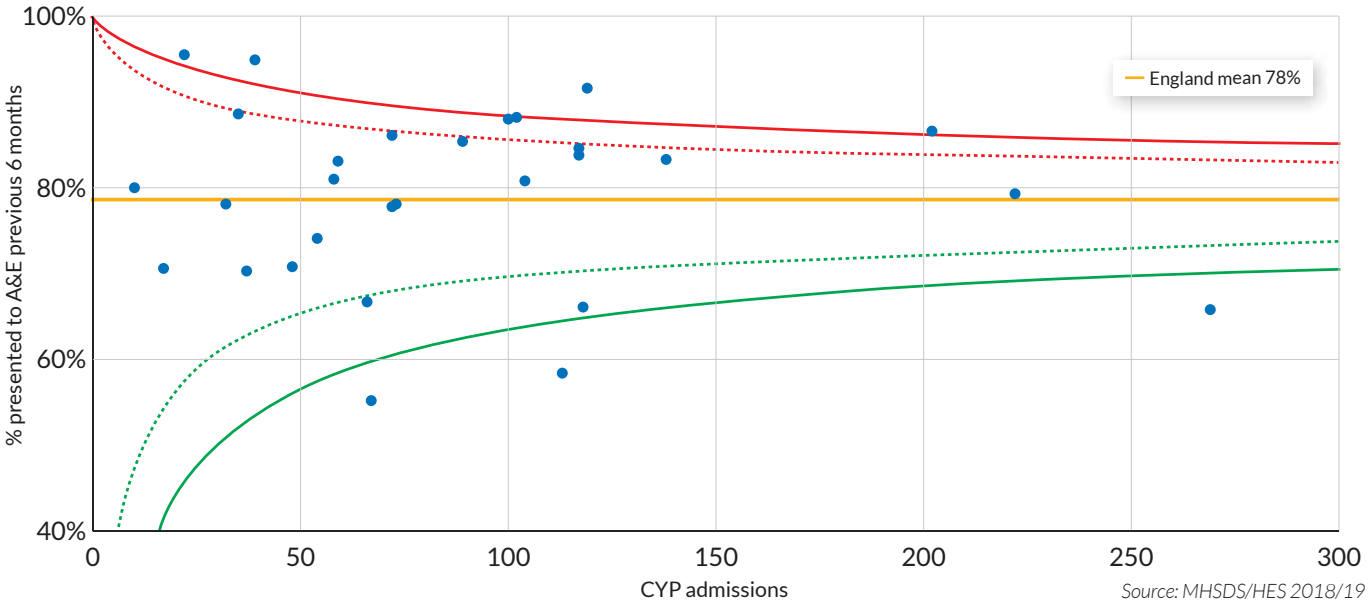
Figure 24: CYP admissions discharged from physical health ward 24 hours prior to admission psychiatric inpatient unit



Source: MHSDS/HES 2018/19

Figure 25 shows the CYP admissions that presented to A&E six months prior to admission, with the mean in England recorded at 78%.

Figure 25: CYP admissions that presented to A&E six months prior to admission to psychiatric inpatient unit



Source: MHSDS/HES 2018/19

During deep-dive visits, there was significant variation in how an A&E department in non-mental health trusts responded to an eating disorder patient. Best practice leads to early, holistic, and effective treatment of the physical and mental health consequences of the disorder which can result in an avoided admission to psychiatric inpatient units with perceived benefits to the young person and system. In contrast, poor practice leads to little effective physical or mental health support while a young person is seen to wait for an inevitable transfer to a psychiatric inpatient unit despite the risk of worse outcomes. While recognising the CQC recommends paediatric and A&E staff must have adequate training and understanding of CYPMH needs, it does not appear this is being implemented in practice. There have been concerns over the use of nasogastric tube feeding on paediatric wards, managing children with neurodiversity, and use of restraint (including medication) on young people within a general hospital setting. Best results have been reported in those hospitals where a positive approach is taken to refeeding and discharging. Anecdotally, these hospitals have higher levels of paediatric support into the eating disorder service. It should be noted that the Royal College of Paediatrics and Child Health issued a position statement on the role of the paediatrician in supporting children and young people's mental health.[46]

The CQC Assessing Mental Health in Acute Trusts inspection framework asks how the mental health needs of patients, including young people, are met when attending A&E.[47] The service specific statement of good practice for psychiatric liaison asks if *'the service has written operational policy or guidance that explains the referral process to: local mental health services; primary care services; specialist mental health services for older people; and CAMHS to support inspectors to enquire around policies relating to patients including young people?'*. However, there was a gap in practice found in deep-dive visits.

The data in **Figure 25** demonstrated this is clearly a significant workload for physical health staff. A key priority of this report is on avoiding mental health admissions and ensuring that community teams are able to provide the crisis and interventions that young people require. Crisis services will need to establish strong working relationships with their acute hospital colleagues and more acceptance of young people spending short periods of time in an acute setting than very long periods of time in a mental health setting. For this to be achievable, it will require further understanding and training of the acute hospital staff in CYP mental health presentations, treatment, and outcomes. Success in this area will also require a recognition of the time spent supporting young people within the acute setting and for this to be recognised as a core responsibility of A&E and paediatric wards with the associated QI, data collection and funding.

[46] *Royal College of Paediatrics and Child Health (2020) Role of paediatricians in supporting children and young people's mental health - position statement. Royal College of Paediatrics and Child Health. https://www.rcpch.ac.uk/resources/role-paediatricians-supporting-children-young-peoples-mental-health-position-statement*

[47] *Care Quality Commission (2020) Inspection framework: NHS trusts and foundation trusts. CQC. https://www.cqc.org.uk/sites/default/files/20200115_Trust_wide_well_led_inspection_framework_V7.pdf*

Deep-dive visits identified that there is an important role for CYP liaison psychiatry. However, this area of speciality is usually related to the mental health implications of serious physical health illnesses and where the overlap between mental and physical health is blurred. In some organisations liaison psychiatry and crisis psychiatry have been combined which usually results in dominance of the crisis psychiatry. This report did not explore the impact of liaison psychiatry on the urgent care pathways.

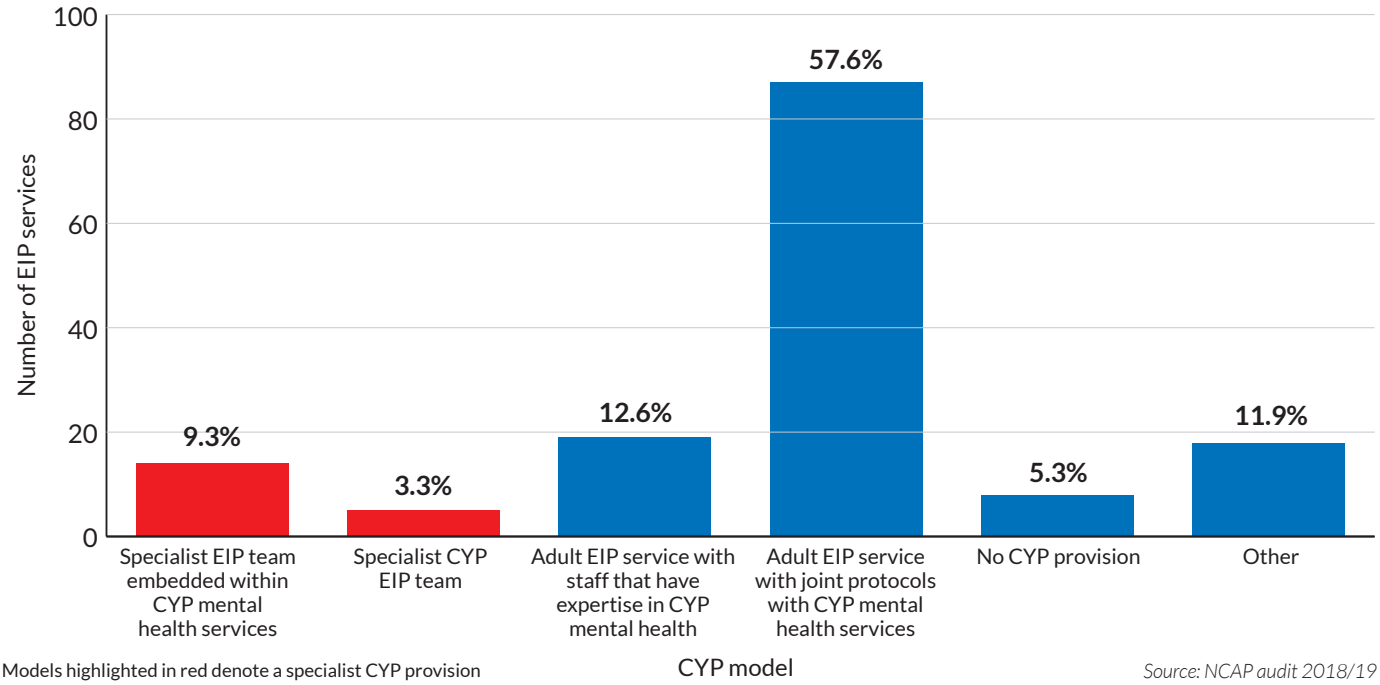
Intensive community support teams

Crisis services are a crucial lifeline to young people at risk of serious harm. However, all too often these young people have either been known to a community service or have been waiting for an intervention. It is a commonly held belief that there is a need for early recognition and intensive support to people with serious mental illness. First, this led to the development of early intervention in psychosis (EIP) teams and later to the development of CYP eating disorder services. However, while young people with emotional dysregulation/personality disorders and young people with neurodiversity are high users of crisis services, this is not common in equivalent intensive community services. Nationally mandated services are often minimally developed, often to the bare minimum when the driving force is the cost of the service rather than the cost per outcome, whereas evidence-based best practice and demonstrably cost-effective services are not. This links in with previous points about strengthening the wider crisis pathway and ensuring good links and strong working relationships between inpatient and community.

In CYPMHS, there are few personality disorder services, trauma services or autism and/or learning disability services. At the time of this data collection, 5.3% of trusts had no CYP EIP provision with just 12.6% having a described specialist CYP EIP team (specialist EIP team embedded within CYP mental health services or CYP EIP team). The yearly National Clinical Audit of Psychosis audit indicates the presence of a specialist CYP EIP team is best practice. At the point of this data collection, only two eating disorder services were meeting waiting time criteria. NHS England and NHS Improvement set a target for all CYP eating disorder services to meet the standard that by March 2020/21, 95 per cent of children and young people in need would begin treatment within one week for urgent cases and four weeks for non-urgent cases[48]. This target was on track for being met. However, during the pandemic performance dropped. Nationally, in March 2021 only 61% of patients started urgent treatment within one week and 73% started routine treatment within four weeks[49], a worsening picture from the data collected in 2018/19.

Figure 26 illustrates the demand for EIP services in England, with 57.6% linked to adult EIP services with joint protocols with CYPMH. In some areas, a day hospital may be available. These services are usually CCG funded but may be specialist commission funded.

Figure 26: EIP: model of provision for CYPMH



Models highlighted in red denote a specialist CYP provision

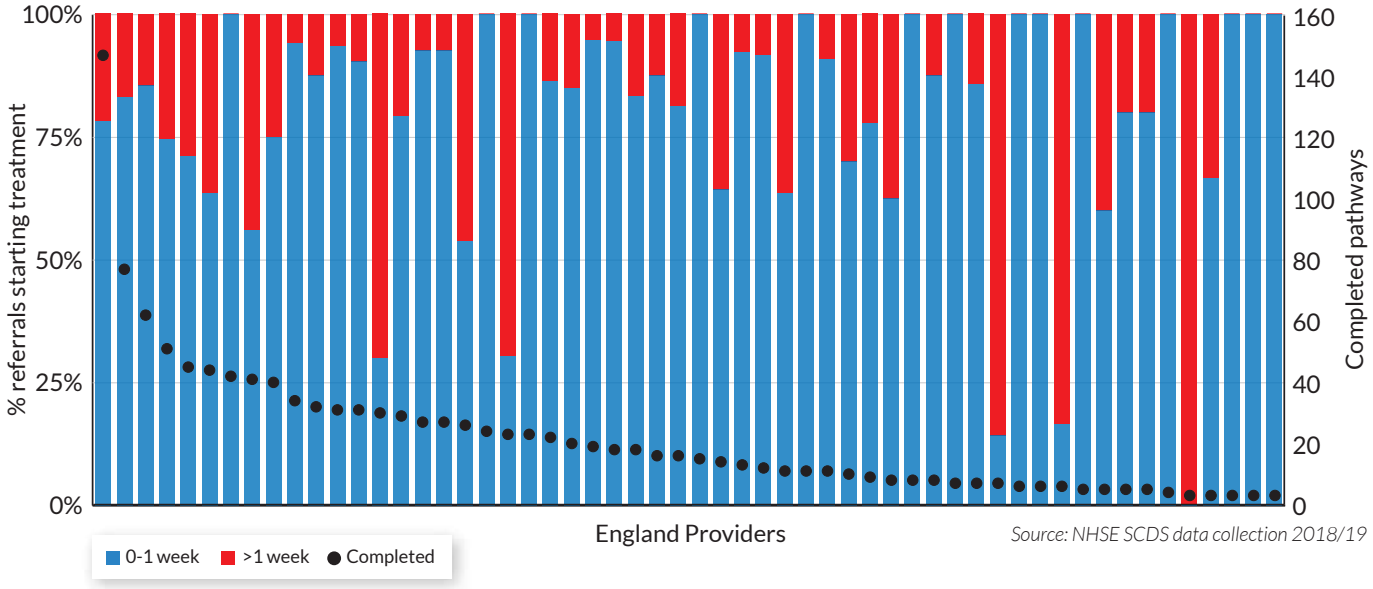
Source: NCAP audit 2018/19

[48] *https://www.england.nhs.uk/mental-health/cyp/eating-disorders/*

[49] *http://www.england.nhs.uk/statistics/statistical-work-areas/cyped-waiting-times/*

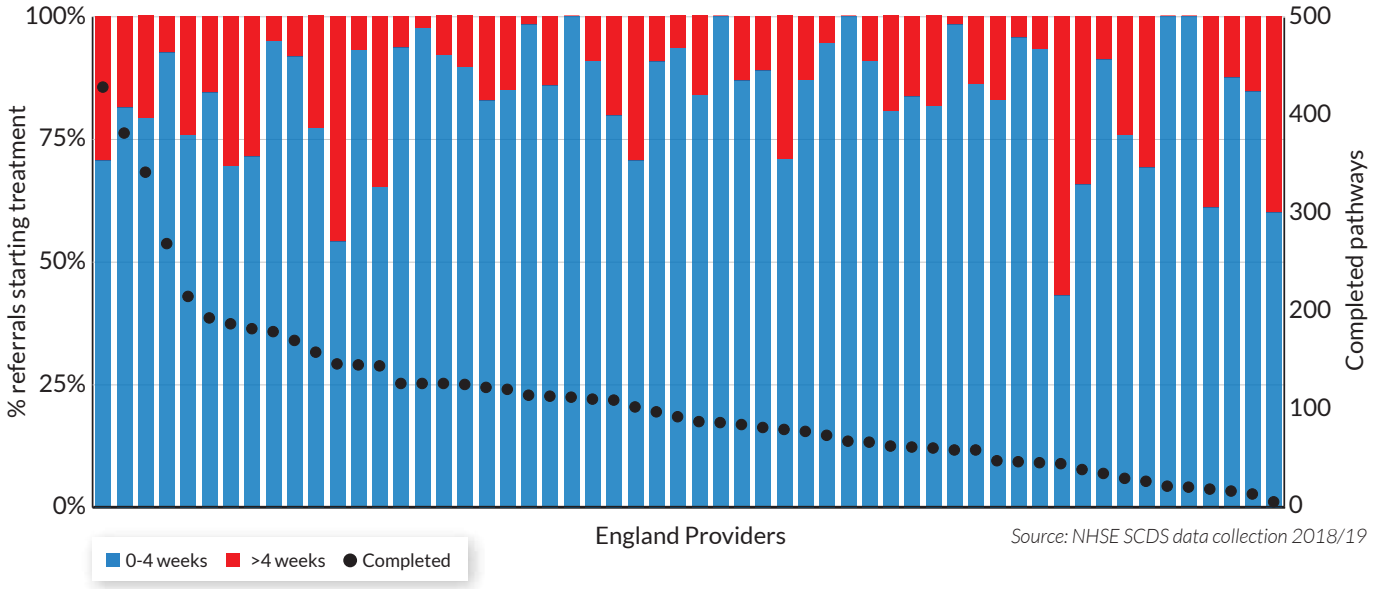
Figures 27 and **28** illustrate the demand for community eating disorder services across England. **Figure 27** shows 79.5% of CYP with a suspected eating disorder requiring urgent treatment who start NICE concordant treatment in the community within the CYP ED service in England met the one week waiting time in 2018/19. The number of young people starting NICE concordant eating disorder treatment requiring urgent treatment represented about 0.3% of the referrals to CYPMH services in 2018/19, with a provider range of 0.1 and 1.0%. **Figure 28** shows 83.1% of CYP with a suspected eating disorder requiring routine treatment who start NICE concordant treatment in the community within the CYP ED service in England met the met the four-week waiting time in 2018/19. It is positive to see these large numbers. The number of young people starting NICE concordant eating disorder treatment, requiring routine treatment represented about 1.5% of the referrals to CYPMH services in 2018/19, with a provider range of 0.1 and 3.8%.

Figure 27: CYP eating disorder waiting times: urgent



Source: NHSE SCDS data collection 2018/19

Figure 28: CYP eating disorder waiting times: routine



Source: NHSE SCDS data collection 2018/19

It is clear that the approach for CYP in crisis must be a whole pathway approach with as much, if not more, focus on the intensive community support teams than the crisis teams. NHS-led provider collaboratives have less influence in developing these teams but feel the greatest impact when they are lacking.

Recommendations: Community and crisis services

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
8. The crisis and urgent care pathways, including inpatient admissions, must be seamless with consistent treatment plans, objectives, and care coordination. In most circumstances, this will require the community care coordinator remaining as the main point of contact and driver of care regardless of the crisis, urgent care or inpatient setting the patient is within. There must be a robust preadmission assessment process including input from the inpatient unit, crisis services, community team and when necessary the local authority. The aim of the assessment process should be to avoid admissions if at all possible.	**a** Providers to review the CRAFT model and implement a similar model of community engagement of young people within the crisis pathway.	Providers.	Increased percentage of young people reporting satisfied or very satisfied on patient reported satisfaction questionnaires.	For progress within 12 months of publication.
	b To review the contracting arrangement for crisis services and community services to allow the implementation of the new model.	Commissioners including lead providers within a collaborative.	Using stratified data, reduced proportion of young people admitted for longer than 60 days.	For progress within 12 months of publication.
	c Provision of training for community staff to ensure staff are skilled to implement new model.	Providers.	Decreased number of inappropriate admissions as defined by the lead provider within the collaborative.	For progress within 12 months of publication.
	d Providers to review the learning from CETRs within their trust and ensure that any learning is implemented.	Providers.		For progress within 12 months of publication.
9. Commissioners must ensure that young people are admitted within their natural clinical flow, recognising that there may be patient choice or specific clinical needs to admit outside. This should be in line with the national CYPMH Competency Framework.	**a** Commissioners including lead providers within a collaborative to undertake bed modelling with the use of an appropriate modelling tool.	Commissioners and lead provider/s of an NHS-led provider collaborative.	95% of young people admitted within their natural clinical flow.	For progress within 12 months of publication.

Recommendations: Community and crisis services (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
10. There must be an effective and sufficiently resourced CYP urgent & emergency mental health pathway based on local needs and with effective data collection to drive QI. The pathway, as indicated in the Long Term Plan, will operate 24 hours a day, seven days a week. It will combine crisis assessment, brief response, and intensive home treatment functions.	**a** To drive continued investment, including re-investment into: • An urgent and emergency response. To ensure the urgent and emergency mental health pathway combines crisis assessment, brief response and intensive home treatment functions. • Linking to recommendation 11, ensuring that there are effective processes and policies linking the urgent and emergency services to the intensive community intervention services.	Commissioners of the urgent care pathways	• All CYP experiencing a mental health crisis will be able to access age-appropriate crisis care 24 hours a day, seven days a week. • Increase in proportion of young people in a crisis receiving crisis care. • Decreased proportion of young people in a crisis requiring admission to a paediatric ward or mental health inpatient unit.	For progress within 18 months of publication.
11. Individual providers and commissioners must ensure there are evidence-based crisis avoidance, specialist intensive community support teams to provide treatment to high-risk young people with the aim of avoiding them entering a crisis.	**a** Invest in evidence-based crisis avoidance, specialist intensive community support teams. These teams must be multiagency in nature.	Commissioners and providers.	Increased access to specialist intensive community support teams nationally.	For progress within 24 months of publication.
	b There must be ongoing evaluation and sharing of best practice as services are developed at a local and national level.	Providers and through national NHS-led provider collaborative forums.	A reduction in the number of young people, who are known to services, requiring crisis support.	For progress within 24 months of publication.
	c Providers must enable effective coding of these services and ensure the flow of data from these teams to the MHSDS.	Providers and through national NHS-led provider collaborative forums.		For progress within 24 months of publication.
12. The urgent and crisis care pathways, including those for eating disorders and neurodevelopmental disorders, must work across physical and mental health organisations in a seamless and effective way with a recognition that best outcomes are not always achieved in a mental health setting.	**a** The role of A&E and paediatric wards to be clearly identified, through commissioned arrangements, within the urgent and crisis care pathway.	Commissioners including lead providers within a collaborative.	Decreased number of young people admitted to adolescent psychiatric inpatient unit from A&E or paediatric ward.	For progress within 12 months of publication.
	b Where specialist paediatric input is required, such as within the eating disorder pathways, there is identified and commissioned paediatrician input.	Commissioners including lead providers within a collaborative.	Increased staff satisfaction in managing young people with mental health needs within an acute hospital setting.	For progress within 12 months of publication.
	c For A&E and paediatric staff to access appropriate training such as the training developed by Healthy London Partnership.	Providers and commissioners including lead providers within a collaborative.	Increased staff satisfaction in managing young people with mental health needs within an acute hospital setting.	For progress within 12 months of publication.

Workforce

Workforce data was a challenge to collate. While inpatient units themselves hold extensive data on staffing, vacancies and turnover, this is used at trust level and not at a national level. This data is collected through the NHSBN data collection, allowing a snapshot of unit returned data, the different models of care and data collection. Consequently, there was an inability to effectively compare staffing between teams and units. This again led to difficulties understanding the clinical model. Furthermore, national data does not differentiate between vacancies filled long-term with a member of agency staff, and vacancies being filled by rapidly cycling agency staff or by substantive staff at the trust. Despite recognition of the varying staffing models, we were not able to collect data on the impact of vacancies, agency use or turnover due to unwarranted variation in the recording of data and a poor response to this question within the GIRFT questionnaire. Data quality was too poor to complete a representative analysis of LoS and long-term agency use as only 21% (12/58) providers completed both LoS and the long-term agency questions (GIRFT/NHSBN, 2018/19). It is clear, as indicated in Recommendation 1, that there is a clear relationship between low staffing levels and long LoS.

Retention and recruitment

NHSBN data highlighted vacancy rates within adolescent inpatient units at the time of data collection were at a mean of 19% which is higher than the national average for mental health services (14.3%). Within this figure, there is vast variation with one service reporting almost 70% vacancy rates and four services reporting no vacancies. Within the NHSBN data collection in 2018/19 four out of five of the highest vacancy rates were from the IH sector inpatient services. Additionally, there is also significant variation in the sickness rates across units with a mean of 5%, varying between 14% to 1%. We were not able to gain a clear picture of staff turnover but feedback from deep-dive visits certainly identified high staff turnover as impacting on the quality of care.

Through the GIRFT questionnaire, we identified 61% of units had supervision rates over 85%, with a variation between 100% and 50%. This did not show a clear association with quality of care. This is likely due to a number of confounding factors. However, at deep-dive visits the importance of high-quality supervision was identified as a factor in staff retention.

At the deep-dive visits, units with good recruitment and retention reported positive trust recruitment and retention programmes. These units usually operate at lower bed occupancy levels, have high levels of supervision, usually have higher baseline staffing, and all report a large degree of control over the admission of young people through robust bed management processes at an NHS-led provider collaborative level. Therefore, units can maintain a balance of presentations ensuring that there is rarely, if ever, a unit full of young people with challenging self-injurious behaviours and associated challenges to the staff. Anecdotally, such situations lead to rapid burn-out and staff turnover, leading to an unhealthy therapeutic milieu.

It is imperative to remember that the national recommendations for safer staffing levels is based on the number of beds, but also on the recommended 85% occupancy levels. Therefore, units running consistently at or close to 100% occupancy levels may meet safe staffing levels but are running at 15% less staffing than the clinical model would suggest. An observation from deep dives was that such pressure can only lead to staff burnout and dissatisfaction.[50]

Table 4 presents the baseline CYPMH inpatient staffing in 2018/19, showing a provider range of 26.1 to 38.5 staff per 12 beds across CYMPH general and eating disorder services for both NHS and IH.

[50] *NHS England and NHS Improvement (2019) Safer staffing. NHS England and NHS Improvement. https://www.england.nhs.uk/ourwork/safe-staffing/*

Table 4: CYP inpatient staffing levels 2018/19

Service type	England		
	Providers	Clinical staff in post	Benchmark (Provider range)
CYP general admission	40 (85%)	2,226 (6 and 195)	35.2 staff per 12 beds (40 and 70)
NHS CYP general admission	32 (97%)	1,795 (6 and 195)	38.5 staff per 12 beds (32 and 70)
IH CYP general admission*	8 (57%)	431 (24 and 126)	26.1 staff per 12 beds (12 and 61)
CYP Eating disorder admission	6 (55%)	231 (29 and 44)	33.7 staff per 12 beds (39 and 62)
NHS CYP Eating disorder admission	3 (60%)	123 (36 and 44)	37.0 staff per 12 beds (47 and 62)
IH CYP Eating disorder admission*	3 (50%)	107 (29 and 42)	30.6 staff per 12 beds (39 and 57)

* data relates to sites rather than providers

Source: NHSBN 2018/19

At the time of data collection, there was no granular data of community service staffing levels within different community teams. Additionally, the rapid national change in crisis services led to data that was either not present or not recognised by teams at the deep-dive visits. Understanding the staffing of the intensive community support services was even less successful. This was clearly understood at a local level, but not yet across the footprint of NHS-led provider collaboratives. Consideration must be given as to how crisis service and intensive community support service workforce data is collected and flowed in the future. It should be noted that the vast majority of intensive community support teams flow workforce data through the community team services without separate service lines for their own area of specialism.

All trusts should address vacancy rates and use of agency. It is not enough for a unit to be part of a trust recruitment and retention programme as the CYPMH estate is small and the units usually make up a very small part of the trust workforce. The small size of most inpatient units results in a relatively small number of staff with little opportunity for learning across different units within the same trust. This may be exacerbating the impact of poor job satisfaction within a unit on staff retention and staff turnover. While clear that staff recruitment, retention and training remains a trust level priority, there are advantages in developing NHS-led provider collaborative wide initiatives to ensure that there is shared learning around recruitment and retention, and mitigation of low morale and poor job satisfaction.

Staff training within adolescent inpatient units

As noted, the staff turnover within adolescent inpatient units remains high and the complexity of young people requiring admission increasing. We have made recommendations that focus on the interventions offered within the inpatient unit and a consistent therapeutic model. In addition, GIRFT noted the need for further understanding on supporting young people with neurodiversity including personalised care training. During deep-dive visits, we frequently heard that service provision is planned on numbers of specific staff professions or groups, rather than a focus on staff skills and competencies. There is significant work being undertaken nationally by HEE, the Personalised Care Group, the Clinical Reference Groups, and the policy team to co-ordinate and focus on training. From deep-dive findings, training is seen as a priority for most inpatient units and crisis services. However, there does not currently appear to be enough alignment between trust training programmes, NHS-led provider collaborative programmes, regional programmes, and national programmes. Local alignment of available training should be undertaken through the development of a local workforce strategy to support delivery of the NHS Long Term Plan, with a focus on staff skills and competencies rather than raw staff numbers. Such a strategy must interface seamlessly with the wider system strategies for workforce development embedded within the local transformation plans and work across inpatient and community settings. While CYP workforce strategies are being developed at a national level, local strategies must not delay awaiting the finalisation of the national work.

Recommendations: Workforce

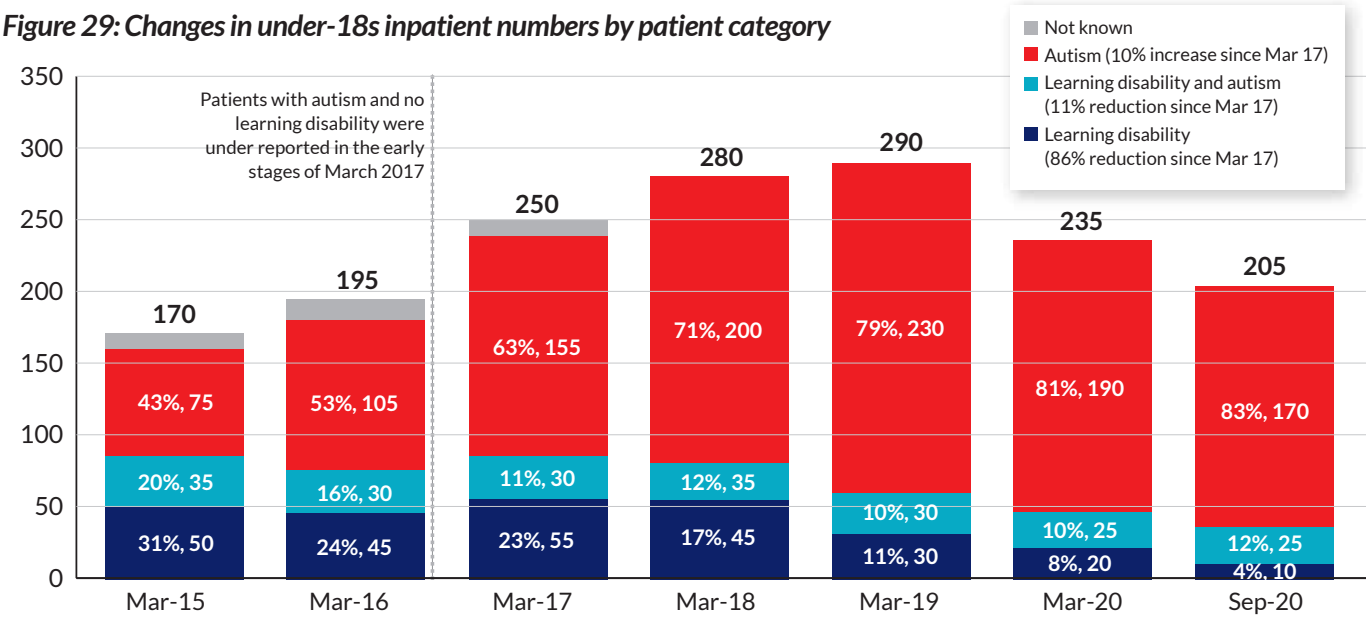
Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
13. Recruitment and retention of skilled staff must be a focus for all inpatient units. Data on staffing levels, vacancy rates, turnover and agency use for all urgent care and inpatient services should be collected at NHS-led provider collaborative level to support sharing of best practice and enable the challenges to be addressed as a systems issue. It is clear that there is a direct relationship between shorter LoS and more staff.	**a** A clear unit-level recruitment and retention programme needs to be in place that links with trust programmes.	NHS and IH providers.	Improved recruitment and retention at a local and national level.	For progress within 6 months of publication.
	b Consider national collection of routine workforce data for all CYP inpatient and community services.	NHS England and NHS Improvement and HEE.	Improved recruitment and retention at a local and national level.	For progress within 6 months of publication.
	c Sharing of best practice through NHS-led provider collaborative events.	NHS and IH providers and lead provider/s of an NHS-led provider collaborative.	Improved recruitment and retention at a local and national level.	For progress within one year of publication.
14. Trusts, commissioners and lead provider/s of an NHS-led provider collaborative should, taking into consideration national training initiatives, develop a local workforce strategy to support delivery of the Long Term Plan with a focus on staff skills and competencies rather than professions.	**a** Development of a local workforce strategy shared across the NHS-led provider collaboratives. The workforce strategy should identify the gaps in national training and fill these with local training offers.	NHS and IH providers, commissioners, and lead provider/s of an NHS-led provider collaborative.	Improved recruitment and retention at a local and national level.	For progress within two months of publication.

Support for CYP with autism and/or learning disabilities

The number of children and young people (CYP) requiring crisis support or inpatient care with a co-existing autism spectrum condition diagnosis (or suspected diagnosis) has significantly increased year on year. While the limitations with diagnosis data collection make this difficult to put a figure on, during deep-dive visits most units report approximately 50% of admitted young people have a diagnosis or suspected diagnosis.

Assuring Transformation (AT) data demonstrates this changing demography. Since March 2017, the number of under-18s with autism (and no learning disability) has increased (see **Figure 29**). Recording of data prior to March 2017 is incomplete, with a lack of clarity about the need to report those with autism and no learning disability. Clarification of this was made in 2016, considering a lead-in time for accuracy in reporting. Comparing data from 2017 to 2020 has seen the percentage of children included in AT data increase from 63% of the AT population to 83% of the AT population.[51]

Figure 29: Changes in under-18s inpatient numbers by patient category



Since March 2017, the number of under 18s with autism (and no learning disability) has increased.
In contrast the number of under 18s with a learning disability or learning disability and autism has fallen.

Source: NHS Assuring Transformation 2020

The CQC undertook a review of segregation in mental health wards for CYP and in wards for people with a learning disability and/or autism.[52] An interim report was published in early 2019. This review identified 20 young people in long-term segregation. While the report included 42 adults secluded within wards for people with autism and/or learning disability, at the time of the interim report being written, it identified 79% of the patients had autism although only 45% had a formal diagnosis. Communication with the authors of the report confirms that these statistics were consistent across the adult and child population. The messages from this report were confirmed through an NHS England and NHS Improvement internal review of all CYP being cared for in seclusion and long-term segregation in 2019. Nineteen children were reviewed, of which 47% had autism, and a further 26% had autism and learning disability. Only 11% of those whose care included the use of seclusion and/or long-term segregation did not have autism and/or a learning disability. The recommendations from this report alongside the CQC report informed the priorities of the Quality Taskforce.

At the end of 2018, the then Secretary of State for Health and Social Care, Matt Hancock, commissioned the CQC to review and make recommendations about the use of 'restrictive interventions' in settings that provide inpatient and residential

[51] *NHS England and NHS Improvement (2021) Assuring transformation data. NHS England and NHS Improvement. https://www.england.nhs.uk/learning-disabilities/care/atd/*

[52] *Care Quality Commission (2019) Segregation in mental health wards for children and young people and in wards for people with a learning disability or autism. Care Quality Commission. https://www.cqc.org.uk/sites/default/files/20191118_rssinterimreport_full.pdf*

care for this group of people. The CQC published its final report, 'Out of Sight – Who Cares?' in October 2020.[53] There is an understandable amount of concern about the use of restraint, prolonged seclusion, and segregation for people (including CYP) with mental health problems, autism and/or learning disability. The review examined the range of factors that lead to people being subject to restraint, prolonged seclusion or segregation, assessed the extent to which services follow best practice in minimising the need to use force, and identified what needs to be done to reduce the use of these practices.

The CQC 'Out of Sight – Who Cares?' report found that:

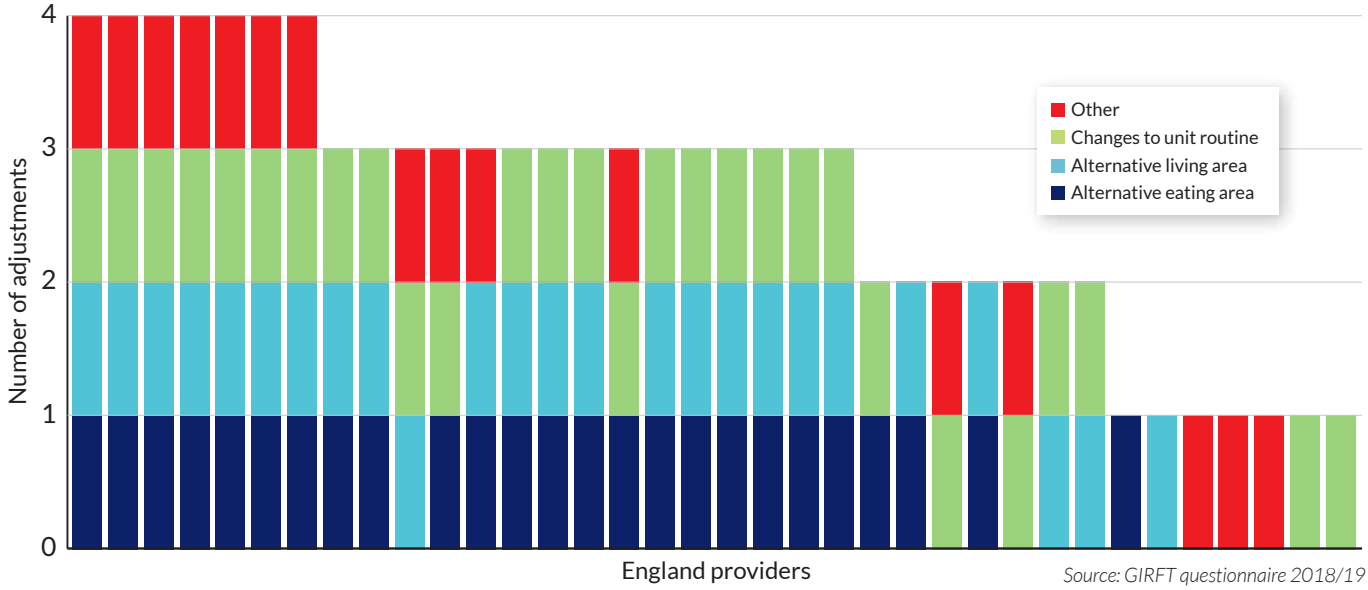
- People's human rights were potentially being breached because staff did not have the understanding, tools or support needed to make the human rights-based decisions that would have helped them to provide better, safer care.
- People were not having their needs met. Environments they were living in were not adapted to their sensory needs and they were not being offered support to communicate. Some providers were not making legally required reasonable adjustments under the Equality Act 2010.
- People were experiencing unnecessary restriction that was causing them distress. Decisions about restrictive practices were not reviewed regularly to make sure that this was the least restriction on people's rights at any given time.
- People were spending too long in highly restrictive situations, more likely to breach their human rights, because of a failure to plan and progress long-term goals, such as discharge planning.

It is vital that society protects the rights, welfare and safety of children, young people and adults with a mental health problem and autism and/or a learning disability, and that they receive the safe, high quality care that they deserve. The CQC should enhance its focus on training, environmental aspects and adapted therapeutic interventions and care for young people with autism and young people with a suspected diagnosis of autism on inpatient units. It should also include autism awareness and friendliness in its inspection regime, for both CYP inpatient services and CYP community-based services.

The CQC report findings are consistent with the findings from the GIRFT work and add to the importance of local plans to address the health and care inequalities for this cohort of young people.

Figures 30 and **Figure 31** present the range of reasonable adjustments for co-morbid autism, environmental and sensory, respectively. **Figure 30** shows how NHS providers averaged 2.5 environment adjustments, whereas IH providers averaged 3.0. **Figure 31** shows NHS providers averaged 3.4 sensory adjustments whereas the IH providers averaged 3.1.

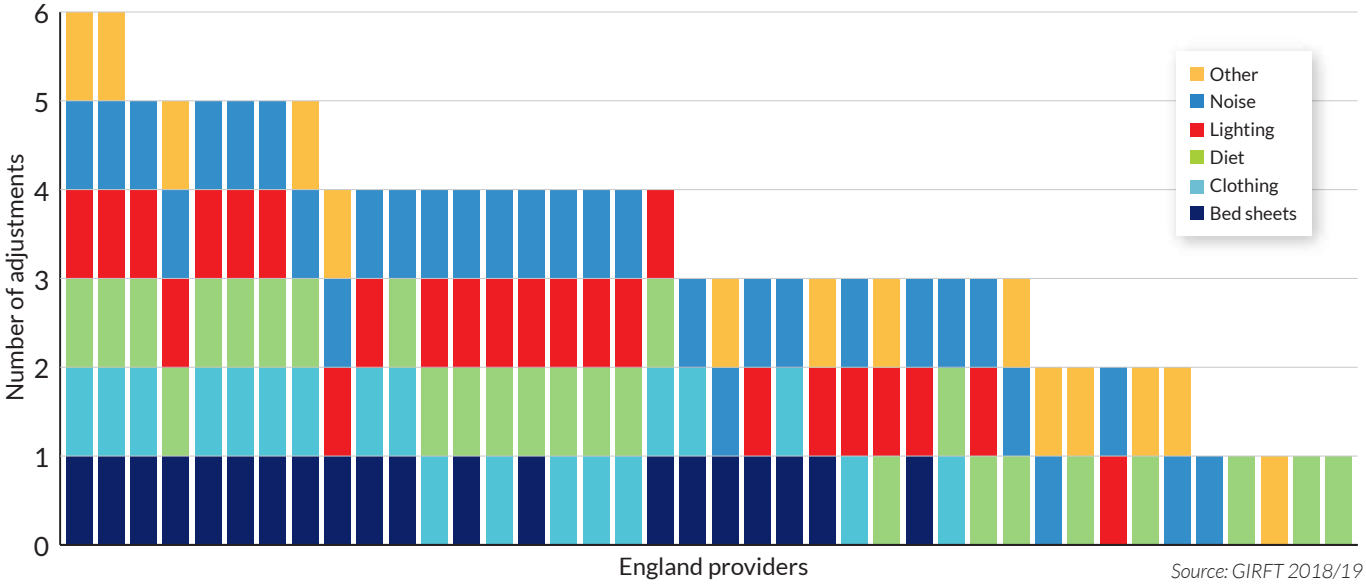
Figure 30: CYPMH inpatient services - Co-morbid autism: reasonable adjustments (environment)



Source: GIRFT questionnaire 2018/19

[53] *Care Quality Commission (2020) Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition. Care Quality Commission. https://www.cqc.org.uk/sites/default/files/20201218_rssreview_report.pdf*

Figure 31: CYPMH inpatient services - Co-morbid autism: reasonable adjustments (sensory)



Source: GIRFT 2018/19

Table 5 demonstrates the national autism training/accreditation, highlighting 100% of those who responded did not have National Autistic Society accreditation within their unit. Furthermore, 68% of providers do not provide specific training packages to staff when a young person with a complex autism presentation is admitted to their unit.

Table 5: Autism training/accreditation

	England		
	Yes	No	Providers
Does your unit have National Autistic Society accreditation?	0% (0/40)	100% (40/40)	72% (40/56)
Do you provide specific training packages to staff when a young person with a complex autism presentation is admitted to your unit?	28% (9/32)	68% (23/32)	57% (32/56)
Does your unit have access to an occupational therapist who has specialist training in assessing and supporting young people with autism?	66% (27/41)	34% (14/41)	73% (41/56)
Does your unit have access to a speech and language therapist who has specialist training in assessing and supporting young people with autism?	59% (24/41)	41% (17/41)	73% (41/56)

Source: GIRFT 2018/19

It should be noted there is NICE guidance on learning disabilities and behaviour that challenges service design and delivery, and makes recommendations covering services for CYP with autism and/or learning disability and challenging behaviour.[54, 55] This NICE guidance includes relevant recommendations on the organisation and delivery of services, knowledge and competence of health and social care professionals, and adjustments to the social and physical environment and processes of care. Additionally, there is NICE guidance on autism spectrum disorder in under 19s.[56]

It should be noted that there should be access to specialist mental health pharmacists to help ensure that medication is only used when necessary for the shortest time. However, we do not have a lot of evidence from deep dives on this.

While the priority must remain, through better community services and crisis support, on avoiding admissions of young people, particularly those with autism and/or learning disability, it is inevitable that at times young people with this comorbidity will be admitted. It is imperative that in such cases these young people receive the right care and environment for their needs.

Whilst we did not specifically focus on the Transforming Care programme, the learning and actions from that programme remain relevant to this report, in particular:

- CYP with learning disabilities and/ autism at risk of admission should be identified on the local Dynamic Support Register.
- CYP with learning disabilities and/autism should have a Community, Education and Treatment Review (CETR) 28 days prior to admission, and where admission occurs without a CETR, a post admission CETR should be initiated by the inpatient unit.
- CYP with learning disabilities and/autism who are in patient and/ have the most complex needs should be allocated a keyworker by 2023/24.

We recommend the CQC enhances its focus on training, environmental aspects and adapted therapeutic interventions and care for autistic young people and young people with a suspected diagnosis of autism and/or learning disability on inpatient units. This includes autism and learning disability awareness and friendliness in its inspection regime for both CYP inpatient services and CYP community-based services. The CCQI should enhance the Quality Network for Inpatient CAMHS (QNIC) standards regarding expectations of training, environmental aspects and adapted therapeutic interventions and engage with the National Autistic Society to develop autism accreditation for inpatient units.

We also recommend autism and learning disability training specific to CYP admitted to inpatient units and supervision for staff is prioritised. We recommend that each trust has an autism and learning disability strategy which has a focus on CYP and their families/carers, across community and inpatient contexts including transition to adult services.

[54] *NICE (2013) Autism spectrum disorder in under 19s: support and management CG170. NICE. https://www.nice.org.uk/Guidance/CG170*

[55] *NICE (2014) Autism QS51. NICE. https://www.nice.org.uk/Guidance/QS51*

[56] *NICE (2017) Autism spectrum disorder in under 19s: recognition, referral and diagnosis CG128. NICE. https://www.nice.org.uk/Guidance/CG128*

Recommendations: Support for children and young people with autism and/or learning disabilities

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
15. The additional needs and reasonable adjustments for young people with autism and/or learning disabilities, who are experiencing a mental health crisis, must be identified and managed in all settings.	Services must ensure that:			
	a There is effective and high-quality training for staff in autism.	NHS and IH providers.	Decreased length of time in contact with service for young people with a comorbid autism and/or learning disability.	For progress within 12 months of publication.
	b As already indicated within the Department of Health Building Notes, outpatient and inpatient environments are adaptable to the sensory needs of young people with autism.	NHS and IH providers.	Decreased number of admissions of young people with a comorbid autism and/or learning disability.	For progress within 12 months of publication.
	c Inpatient units' crisis services and intensive community support services ensure the availability of specialist assessments and care for young people with an autism spectrum condition diagnosis or suspected autism spectrum condition.	NHS and IH providers.	Increased percentage of young people reporting satisfied or very satisfied on patient reported satisfaction questionnaires.	For progress within 12 months of publication.
	d Effective digital solutions to promote communication are made available.	NHS and IH providers.		For progress within 12 months of publication.

Technology, data quality, outcomes and use of data

Quality improvement

QI is at the heart of all healthcare, and within mental health it is driven by many organisations including the National Collaborating Centre for Mental Health (NCCMH) and CCQI at the RCPsych.

The term 'quality improvement'[57] refers to the systematic use of methods and tools to try to continuously improve quality of care and outcomes for patients. There are a range of different methods and tools, such as Lean, Six Sigma and the Institute for Healthcare Improvement's Model for Improvement. There is no clear evidence that one approach is superior to others. Rather, it is the process of having a systematic approach to QI and applying this consistently that is important.[58]

While there are many different approaches to QI, there are some key principles that are common to all. These include:

- training staff in the nature of systems;
- using data to understand variation;
- giving all staff the opportunity to contribute and act on ideas for improvement;
- using many small-scale trials and tests as a way to learn and improve;
- ensuring a continuous focus on the needs and experiences of the people served by the system.[59]

While the importance of QI is clear and embedded in training curriculums and service specifications, it is not always implemented locally in an effective way. The QI question put into the GIRFT supplementary questionnaire asked for examples of QI projects on the inpatient ward. Additionally, questions were asked on the trust approach to QI and how projects are chosen and link to the trust QI strategy. From these three questions, it was possible to identify which inpatient units have a clearly defined QI approach with organisational buy-in and which units misinterpret QI - for example, by conflating national audit data collection as QI. This approach, while clearly needing the caveat of caution due to the lack of a qualitative interview at unit level, indicated a poor understanding/ implementation of QI in most units. **Table 6** provides an assessment of an organisation's QI approach. While recognising that 29% did not answer, the assumption is that units are proud of their QI programmes, so if there is one in train it will be mentioned.

Table 6: QI in NHS CYP inpatient units

	Number and % providers
QI approach	23% (8/35)
Possible QI approach	11% (4/35)
Quality but not improvement focused	9% (3/35)
No QI approach	29% (10/35)
Not answered	29% (10/35)

Source: GIRFT 2018/19

[57] *Alderwick, H., Charles, A., Jones, B. et al (2017) Making the case for quality improvement: lessons for NHS boards and leaders. The King's Fund. https://www.kingsfund.org.uk/publications/making-case-quality-improvement*

[58] *Ross, S. and Naylor, C. (2017) Quality Improvement in Mental Health. The King's Fund. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Quality_improvement_mental_health_Kings_Fund_July_2017_0.pdf*

[59] *Ham, C., Berwick, D., Dixon, J. (2016) Improving quality in the English NHS. The King's Fund. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf*

The deep-dive visits identified several high-quality QI projects, such as at the East London NHS Foundation Trust. It was no surprise to find that the units enthusiastic about QI at deep-dive visits would demonstrate positive variation in a number of key metrics. Accreditation standards through the CCQI now include standards related to the use of QI and involvement of patients in QI. However, evidence through the deep-dive visits suggests this is not yet well-embedded by many providers.

While there was great enthusiasm for QI, it was apparent at several deep-dive visits that the implementation of QI was not always present and there was even less consideration of QI at an NHS-led provider collaborative level. However, the recognition of its importance, and enthusiasm to embed QI in everyday work, was very clear and will be significantly enhanced through the development of a national forum and repository of best practice relating to QI.

Within adult inpatient services, there are presently three national improvement collaboratives on topics that are shared quality concerns: restrictive practice, sexual safety, and suicide prevention. However, there are no specific improvement collaboratives for adolescent inpatient units. This could be delivered through the RCPsych as a subscription-based activity and would engage all units in learning how to apply QI to solve a complex quality issue as well as drive improvement in an area of quality concern (also see *NHS Quality Improvement Taskforce*, page 27).

Data quality and use of data

Services must understand better the reasons young people are accessing services, the interventions offered and the outcome of such interventions. To achieve this effectively, the data must be recorded in such a way that it is easiy accessible and can be used as part of a QI programme as identified above.

Too often at deep-dive visits it became apparent that we did not have the data to understand the conditions or interventions that a young person was being admitted for, or if the unit was able to provide what was required. The lack of outcome data is important to address. There is a gap in the reporting mechanism and national data flow (i.e. Forms 1 and 2).

In addition, the low use of outcome measures made it difficult to see in the data if young people were receiving the right care. To achieve this, high quality, consistent and validated data, and paired outcomes are essential at all levels from a team within a service to the specialist commissioning data sets. Without this data, local QI projects will not be successful and national recommendations/policy will not be effectively set, as myths and assumptions around CYP care will persist. Therefore, an increased focus on data collection at all levels within the crisis and urgent care pathway is necessary. In particular:

- All young people accepted into an adolescent inpatient unit or crisis service must have a clearly documented diagnosis and reason for admission into the crisis pathway or inpatient service.
- A national approach to a definition of diagnosis/reason for admission should be developed through the CYPMH policy team/Specialised Commissioning Team/NHS Digital and adopted by all services.

Such an approach must result in accurate, useable data flowing to the MHSDS. Significant progress has been made in this area using SNOMED-CT codes. SNOMED codes can be used within the MHSDS and have been piloted in several trusts. National work has been underway to identify the most appropriate SNOMED-CT codes to be used.

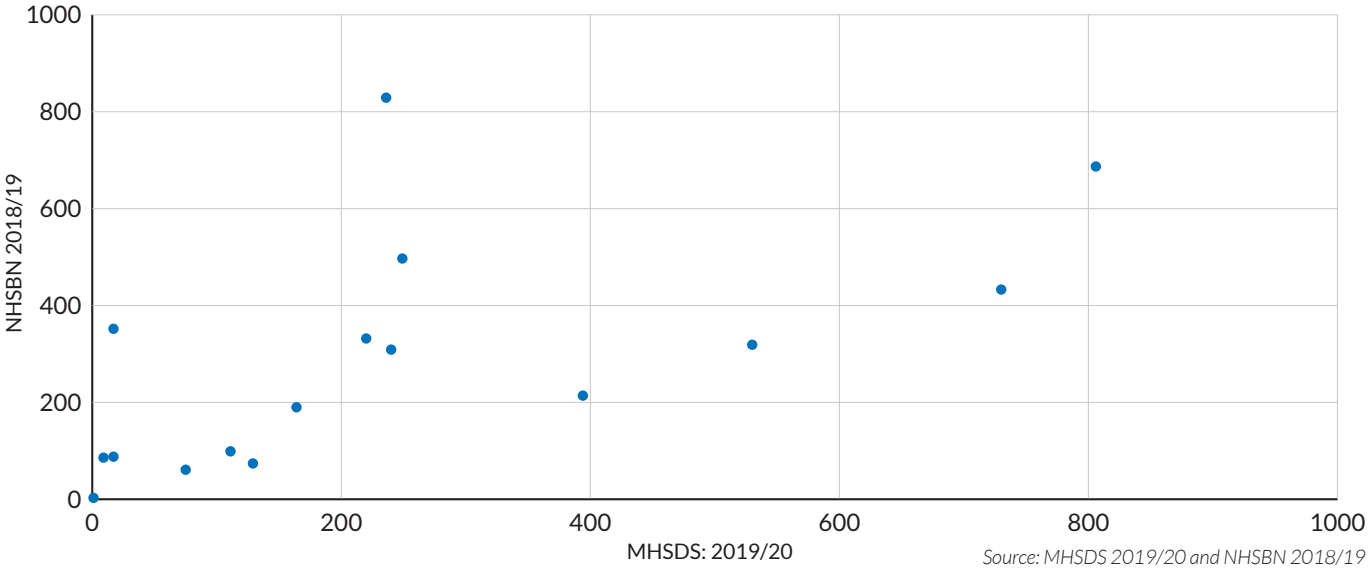
Complex data requests

It is notable that the complex commissioning and governance arrangements around the CYPMH urgent care pathways makes for complex data collection and requests, with little local or national coordination of the data required. It is common to see that within a single unit there are different sets of data requests for QI/audit requirements, trust governance processes, CCG assurance processes, NHS-led provider collaborative improvement processes and NHS England and NHS Improvement requirements through specialised commissioning and MHSDS. While this is apparent across the whole care pathway for CYP, it is most stark within the urgent care part of the whole pathway.

Numerous additional national project data requests are common, such as the annual crisis audit and benchmarking exercise. However, this is also a core responsibility of staff. It was notable that while internal and local data flows may have been effective, the data flowing to the MHSDS was patchy with poor validity. This resulted in the GIRFT data collection focusing on the yearly benchmarking returns. While recognising that there has been clear improvement in the flow of data to the MHSDS, our experience of accessing more recent datasets at the beginning of 2021, in order to develop GIRFT gateway metrics using the MHSDS, suggests that there remains a significant issue.

Figure 32 compares different restrictive practice data to establish the level of maturity in the national dataset. The objective of this analysis was to review the maturity of the restraint data recorded in MHSDS by comparing with the NHSBN data collection. We were unable to access comparable timeframes i.e. MHSDS data relates to 2019/20 whereas NHSBN relates to 2018/19. Therefore, the figures presented here should be treated with caution. However, the conclusion we would draw from this analysis, that maturity in the data set needs to improve, is also supported by compliance figures reported by NHSD. These show that approximately 50% of CYP Tier 4 inpatient services are not submitting restrictive practice data to the MHSDS as of March 2021.[60]

Figure 32: Data quality: CYP restrictive practice – restraint



Source: MHSDS 2019/20 and NHSBN 2018/19

There are three areas which require urgent improvement:

1. Diagnosis/reason for referral and acceptance into crisis pathway or inpatient service.
2. Intervention/reasons for delays in treatment/discharge within crisis pathway or inpatient service.
3. Outcome data on discharge from the crisis pathway or inpatient service and comparing this to data on admission.

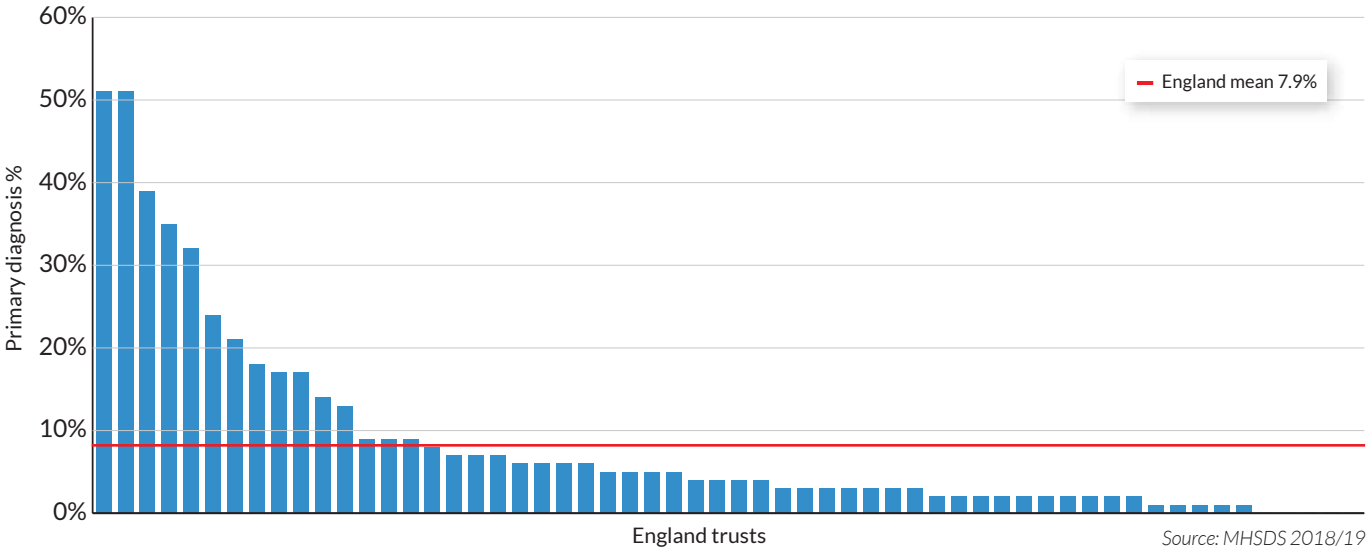
1: Diagnosis/reason for referral and acceptance into crisis pathway or inpatient service

When we were developing the provider level reports (PLR), the bed categorisation recorded in MHSDS was recorded at a low level which limited some aspects of our analysis. For example, we were unable to explore the number of Mental Health Act assessments undertaken within CYP general admission services in 2018 because only 50% of mental health admissions were categorised at that stage. A recent review in 2020 demonstrated that 97% of admissions were categorised and would therefore be possible if developing the PLR to cover 2020 (MHSDS 2018 and 2020).

The lack of data for admission into a service is of crucial importance – however, it is not surprising that it is poor. **Figure 33** illustrates the issue with data quality within CYPMH services, with an average of 7.9% of England trusts documenting the primary diagnosis of patients. Additionally, **Figure 34** illustrates the mental health diagnosis recorded at discharge for NHS providers was 64% in 2018/19, with IH providers reporting higher at 82%.

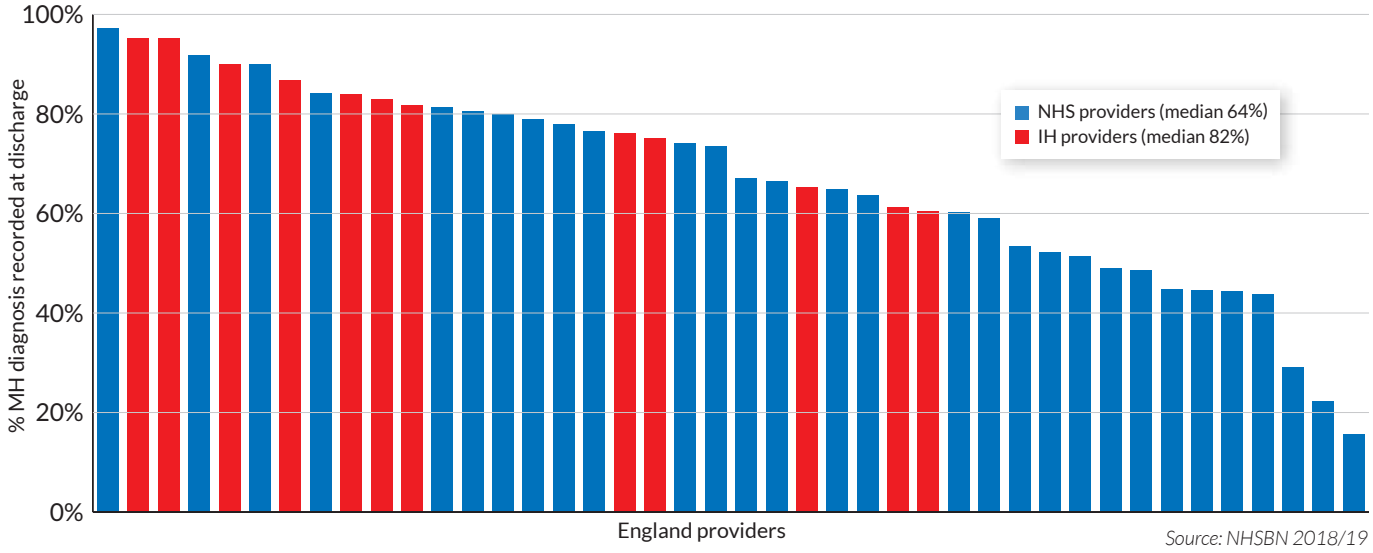
[60] *NHS Digital Restrictive Intervention reporting in Tier 4 CYPMH inpatient services , available via: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/restrictive-interventions-tier4-cypmh*

Figure 33: Primary diagnosis: cases under aged 18 during 2018/19



Source: MHSDS 2018/19

Figure 34: General CYPMH: admission by diagnostic group



Source: NHSBN 2018/19

Within CYPMHS, the complexity of presentations often results in difficulties in recording an ICD10 diagnosis which has meaning, as well as a lack of recording of secondary diagnoses and no benefit in understanding the treatment to be offered. Previous attempts to resolve these issues through clustering or different payment models within CYPMH have not been successful. For example, when the adult clustering model was applied to a CYP cohort of patients, less than 20% of the caseload could be clustered against the criteria. However, a number of pilots using technological solutions to identify pathways that patients are referred onto are making some headway.

Feedback at deep-dive visits was that the terminology of diagnosis is not helpful for CYP. A number of reasons were given as to why this might be:

1. The majority of young people in contact with specialist services have multiple diagnoses, are awaiting specialist assessments and have significant other factors affecting their presentation that need consideration – such as their social situation, neurodiversity, and educational pressures.
2. Presentations in young people can be atypical and fluctuate significantly. This can lead to diagnoses being given and frequently changed until there is consensus, which may take years. In these circumstances, the use of a single diagnosis can be unhelpful as it may lead to provision of the wrong treatment.
3. There is a strong feeling within CYPMH that giving a young person a diagnosis for a mental illness, which may not progress to illness in adulthood, is not morally right. While there are clear sides to this argument, many clinicians believe this results in a simple single diagnosis approach being taken up by services, leading to stigma and fewer life chances. Addressing this view will require both a local and national approach.

Based on the above points, CYP clinicians are more likely to develop a complex formulation to direct the treatment plan; however, such a formulation does not easily flow to the MHSDS.

There is some progress nationally to consider the use of SNOMED-CT codes to resolve this issue. The Department of Health and Social Care mandated that all mental health provider organisations to have adopted SNOMED-CT by April 2020.[61]

It has been possible to submit to the MHSDS in SNOMED-CT or ICD10 or current since 2016. However, a national approach is required to ensure that the coding of the diagnosis subset is consistent and acceptable across the CYP estate using the three aforementioned measures. All providers must adopt the nationally recommended diagnosis subset and ensure this data is recorded and flowed to the MHSDS. Beyond the use of SNOMED-CT codes is ensuring that services are collecting data on reasons for referrals not being accepted to understand capacity constraints and better understand demand on the system.

2: Intervention/reasons for delays in treatment/discharge within crisis pathway or inpatient service

A lack of outcome data, or data on care provided, results in the use of proxy measures, such as length of time in contact with crisis services or inpatients being judged on average LoS. This masks the complexity of the underlying work that is taking place.

Within the acute setting, the use of CUR tools has allowed acute hospitals to move beyond ward average stays to collecting data on presentations and pathways. CUR is a clinical decision support software tool that enables clinicians to make objective, evidence-based assessments on whether patients are receiving the right level of care in the right setting at the right time based on their individual clinical needs. CUR improves patient flow, identifying patients who should never have been accepted into the treatment option and demonstrating whether patients are clinically (and psychiatrically) appropriate for the level of care they are receiving. Within CYPMH services, there are presently two pilot studies underway to evaluate the use of CUR within adolescent inpatient units, in the South London Partnership and Alder Hey. While the pilot sites are focusing on inpatient units for CUR to be effective, the remit must be broad enough to cover crisis services as well. It remains too early to confirm the benefits of CUR within the CYP setting.

[61] *NHS Digital (2020) SNOMED CT. NHS Digital. https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/scci0034-snomed-ct*

CASE STUDY

Clinical Utilisation Review pilot

South London Partnership: South London and Maudsley NHS Foundation Trust, South West London and St George's NHS trust and Oxleas NHS Foundation Trust

The South London Partnership (SLP) is participating in the national CUR mental health pilot. CUR is an evidence based clinical decision support tool that enables both commissioners and clinicians in provider organisations to make impartial and objective, evidence-based assessments of whether patients are receiving the right levels of care, in the right setting, at the right time, based on the patient's individual needs. The pilot is in the implementation phase across 12 sites with CYPMH inpatient and crisis services across the SLP.

Two key principles of SLP CYPMH NHS-led provider collaborative have been that CYP, who require inpatient admission, receive care closer to home and that SLP promote and develop alternatives to admission, where these are appropriate. The tool supports clinicians to adhere to clinical best practice; identify the level of clinical care that patients need, determined impartially and based solely on patient need; understand reasons why patients are not in the most appropriate setting for their clinical needs and resolution for these; and helps identify gaps in service provision or capacity that would facilitate discharge from an acute care setting. The tool produces system-wide reports, with data across various outcome metrics that can be reviewed from ward to partnership group level to help develop and influence the identified improvements and changes. The data can be useful in engaging other stakeholders such as education and LAs in discussions about where pathway improvements are needed.

Potential benefits to CYP and their families/carers

The CUR tool has the potential to improve care, experience and outcomes to CYP and their families/carers by:

- reducing unnecessary admissions, inappropriate LoS and barriers to discharge, and improving patient flow;
- making discharges more effective;
- reducing inappropriate re-admissions;
- effectively reviewing caseloads;
- improving the child or young person's experience by ensuring they are placed in the most appropriate setting for the right level of risk, enabling staff to identify earlier when the children or young person needs to move through the pathway.

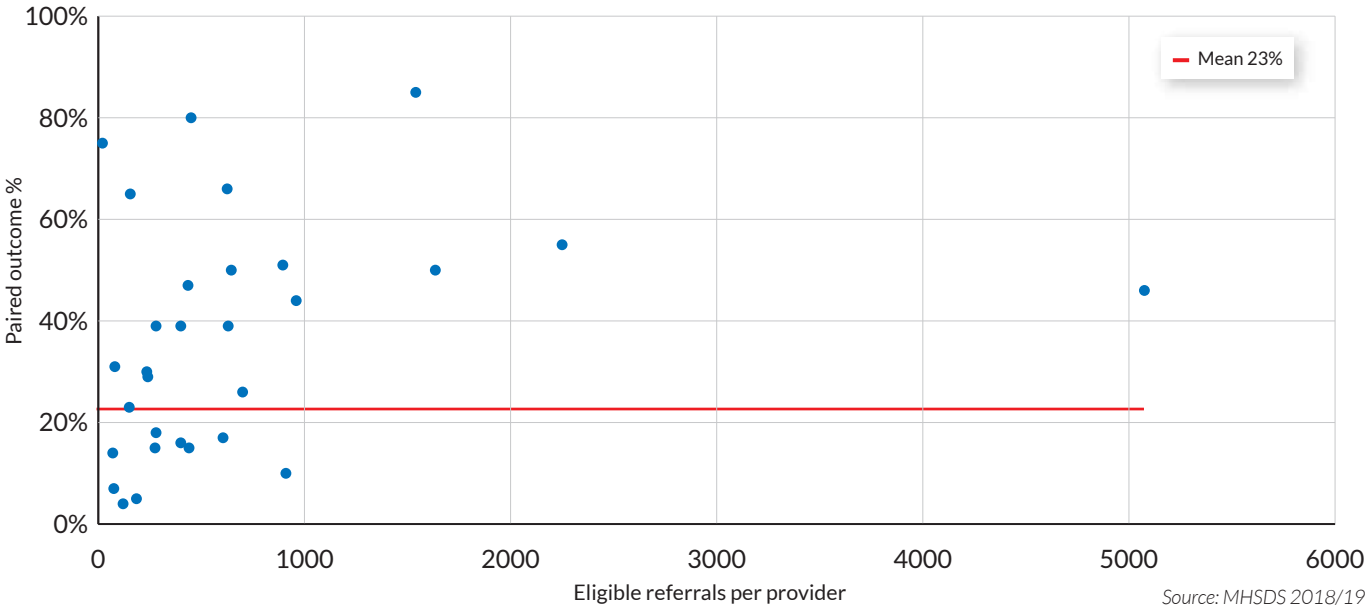
3: Outcome data on discharge from the crisis pathway or inpatient service, and comparing this data on admission

There is poor availability of outcome data, including patient reported outcome or data on delayed transfers of care; it is sparse, with concerns about quality and the fact that there is not enough obtained to drive any understanding and examination of unwarranted variation of clinical and patient reported outcomes. The chart below indicates the low usage of paired outcome measures within CYP services. Paired outcome measures are completed when a young person completes a standardised outcome questionnaire at the beginning of a treatment episode and then completes the same outcome questionnaire at a later point in their treatment cycle. Demonstration of improvement in outcome measures from the first point of contact with a service and then at discharge shows a successful intervention.

Given the state of outcome measure reporting, we did not seek improvement in the paired outcome measures but solely evidence that it is being done. It has been demonstrated that just completing paired outcome measures, and undertaking no other change in clinical practice, will drive shorter periods of treatment and greater patient satisfaction. All young people and their families or carers should be aware of the benefit of paired and routine outcome measures and demand that they are used within their episode of care. It would be unacceptable in any other area of healthcare for a cheap, easily implemented and demonstrably effective intervention to be denied to patients.

Figure 35 illustrates 51.7% (30/58) of CYPMH providers in 2018/19 submitted paired CYP reported outcome measurement data. The paired recording rates for trusts that submitted data was only 45%.

Figure 35: CYP reported outcome measurement: paired measure



Source: MHSDS 2018/19

We recommend that there is a focus on improving the collection and reporting of outcome measures. This will be at both a trust level as well as at a national level, through tools such as commissioning, service specification, and commissioning for quality and innovation (CQUIN).

CASE STUDY

Using goal based outcomes for service improvement

Derbyshire Healthcare NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust was part of the CYP Improving Access to Psychological Therapies programme in 2011/12 and has had a long period of implementation of outcomes recording, and experience in driving cultural change in recording outcomes. The programme looked at service transformation, accountability, and increased evidence-based practice.

The team developed a bespoke Electronic Patient Record (EPR) to capture meaningful outcome data. They developed a strategy which involved young people and their families/carers, alongside a senior steering group, co-producing engaging outcome measures. At their peak performance (2013/14), the team recorded 65% of all patients having a paired outcome measure. Goal-based outcomes developed by young people, for example being fit to attend school, going out with friends, and improving relationships with parents, evidenced a 92% improvement. Improvement in clinical-based outcome scores also saw a 50-75% improvement.

The team were able to use the paired outcome data to measure against the baseline LoS data, throughput through services, and access to therapies. Not only did the team find that young people accessed more target and evidence-based therapies, they also found an associated reduction in LoS, from an average of over 350 days in service to 250 days at the peak of their success. This significant reduction in LoS was attributed to targeting care planning using goal based outcomes, and giving a framework of measurement for the young person's journey of care. Commissioners were involved in feedback to demonstrate the effectiveness of the services being provided.

The improvement work was further built upon by working with experts by experience (i.e. CYP, their families and carers) around participation models to increase engagement and use of outcome measures. Young people were able to train staff on how to use the measures in a more effective and engaging way, to make them more likely to be completed, and improve the rate of compliance. Live EPR data was used to monitor the activity and used to support the service transformation steering group meetings.

Using goal-based outcomes and session feedback questionnaires to support the business case, the team made a successful bid for half a million pounds for investment in their liaison service in 2015.

The emerging impact of IT infrastructure

As noted within the *Impact of COVID-19* section on page 32, the move towards videoconferencing and digital solutions has led to better engagement with community teams and other crucial agencies as seen in deep dives. This has allowed for more rapid and better supported discharge packages of support. It is essential that these gains and new ways of working are further embedded by all organisations including the IH sector. It is also vital to be aware of the importance of digital inclusion to prevent widening of the health inequalities gap.

Trusts need a high level of IT infrastructure to maintain videoconferencing within inpatient units to ensure data safety and reliability. Most trusts do not yet have this. The benefits of videoconferencing in CYPMH inpatient units are potentially greater than in other inpatient units given the very large number of agencies that usually attend - for example schools, social care, CYPMHS community and, at times, adult mental health services if the young person is being discharged to adult community or IH care, families/carers, YOS, drug and alcohol services, and youth workers.

Recommendations: Technology, data quality, outcomes and use of data

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
16. All adolescent inpatient units and crisis services must improve the use of QI programmes to drive high quality care.	**a** For QNIC to strengthen the role of QI within their standards.	QNIC	All adolescent inpatient units meeting QNIC standards relating to QI.	For progress within 12 months of publication.
	b All providers to meet the QNIC standards for QI.	NHS and IH providers	All adolescent inpatient units meeting QNIC standards relating to QI.	For progress within 12 months of publication.
	c Consider the development of a national improvement collaborative on a topic that is a shared quality concern across adolescent inpatient units.	National Tier 4 Clinical Reference. provider collaborative	All adolescent inpatient units to have an active QI project.	For progress within 12 months of publication.
	d To identify a national forum for adolescent inpatient units which can host QI resources, successes, and learning.	Specialised Commissioning team.	All adolescent inpatient units to have an active QI project.	For progress within 12 months of publication.
17. All NHS commissioned services must have effective data collection processes to understand the reason for acceptance into a service, interventions offered and outcome of interventions. This data must be flowed to the MHSDS.	**a** Local data collection of reason for admission, intervention offered to be implemented.	Inpatient and crisis service providers through use of SNOMED-CT codes.	Improved data collection into MHSDS.	For progress within 12 months of publication.
	b This data must be collected and analysed at an NHS-led provider collaborative level.	Commissioners and lead provider/s of an NHS-led provider collaborative.	Best practice shared at NHS-led provider collaborative clinical forum. Monitored through Model Mental Health as a key metric.	For progress within 12 months of publication.
18. A national approach to a definition of diagnosis/reason for admission should be developed through the CYPMH policy team/Specialised Commissioning team/NHS digital and adopted by all services.	**a** Paired outcome measures must be implemented within all services.	NHS England and NHS Improvement.	Increased number of young people with a recorded diagnosis on MHSDS.	For progress within 12 months of publication.
	b Development of nationally accepted SNOMED-CT codes.	Inpatient and crisis service providers.	Increased number of young people with a recorded diagnosis on MHSDS.	For progress within 12 months of publication.
	c Implementation and use of diagnosis SNOMED-CT codes.	Inpatient and crisis service providers.	Increased number of young people with a recorded diagnosis on MHSDS. Increased number of young people with a recorded diagnosis on MHSDS.	For progress within 12 months of publication. For progress within 12 months of publication.

Recommendations: Technology, data quality, outcomes and use of data (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
19. Trusts and IH providers to be encouraged to invest in IT infrastructure for adolescent inpatient units. All inpatient patient-focused meetings must have the option of videoconference access.	**a** To ensure that their digital strategies include a specific focus on adolescent inpatient unit infrastructure.	Trusts and IH providers.	Improvement in NHS digital maturity scores for each organisation.	For progress within 12 months of publication.
	b To ensure each adolescent inpatient unit has a clinically- led initiative to increase videoconference access for carers, patients and the wider community team. Implementation monitored at NHS-led provider collaborative operational level.	Lead provider/s of an NHS-led provider collaborative to hold oversight of implementation and set targets to be achieved. Individual trusts and IH providers to develop and implement initiatives.	Increased percentage of activity undertaken through videoconferencing.	For progress within 12 months of publication.

Governance and advocacy

Reducing the impact of litigation

In 2019/20, the majority of claims (67/86) paid out were related to historic allegations of abuse in a mental health facility, such as assault by hospital staff. While the total cost of these claims was relatively small the recognition that the majority of the claims were related to abuse within the units is of clear significance. This is an indication of not just a litigation risk but safeguarding and quality. We recognise that these are claims of a historical nature and do not reflect current practice. However, it remains important that trusts review their governance processes and advocacy processes within inpatient units to ensure young people are able to speak up about inappropriate practices while on the unit, so that this can then be addressed at the time rather than historically. We recognise that this recommendation is covered through CQC Mental Health Act visits, as well via CQC inspections of CAMHS; however, enforcing this message remains important.

Recommendations: Governance and advocacy

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
20. There must be effective governance and advocacy systems in place in all CYP mental health inpatient units to ensure that young people are able to speak up should they be exposed to inappropriate practices.	**a** Individual inpatient adolescent units to ensure governance and advocacy systems are in place.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.
	b Ensure that systems are co-designed with young people.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.
	c Patient experience measure included in routine collection.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.
	d Young people able to contribute to service design evaluation and audit.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.

Recommendations: Governance and advocacy (continued)

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
20. There must be effective governance and advocacy systems in place in all CYP mental health inpatient units to ensure that young people are able to speak up should they be exposed to inappropriate practices.	**e** Ensure that there are processes in place, so the patient voice is clear within care planning.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.
	f Reasonable adjustments should be put in place to ensure children and young people with LDA access advocacy proactively.	Adolescent inpatient unit providers.	On-going monitoring through CQC Mental Health Act inspections. Increased percentage of young people completing patient experience measures during admission.	For progress within three months of publication.

Litigation

Reducing the impact of litigation

Each of the GIRFT programme teams have been asked to examine the impact and causes of litigation in their field – with a view to reducing the frequency of litigation and, more importantly, reducing the incidents that lead to it. It is important for clinical staff to have the opportunity to learn from claims in conjunction with learning from complaints, serious incidents (SIs)/ patient safety incidents (PSI) and inquests which will lead to improved patient care and reduced costs both in terms of litigation itself and the management of the resulting complications of potential incidents.

It was clear during GIRFT visits that many providers had little knowledge of the claims against them. This included some with high litigation costs per admission as well as those at the low end. Therefore, there is an opportunity to learn from the claims to inform future practice. Further work is needed at both a local and national level to analyse claims to maximise this opportunity to improve patient care.

Variation in average litigation costs

Data obtained from NHS Resolution reveals the clinical negligence claim costs for children and adolescents who are younger than 18 years old, from claims in acute mental health, community mental health services and psychology combined (see **Table 7**).

There has been variation in the number of claims over the previous five years, with the highest number of claims in 2019/20. The total claims costs increased significantly between 2016/17 to 2017/18, with claims totalling over £10m. Although the number of claims were low, one claim was high value at £8.3m which caused a sharp rise in costs. With the small number of claims being brought in this specialty, it is hard to draw clear trends. In this cohort of patients, there is an increased time lag in claims being brought from the time of incident, as children or adolescents claims can be made up to three years after their 18th birthday. In addition, these young people may rely on the support of advocates, and it is possible for a claim to be made after the standard three-year limit if circumstances dictate that this is difficult to determine the exact date of incident. In these cases, the three-year clock will start from the time the individual becomes aware of the concern and this point in time is known as the date of knowledge. Lastly, if the law determines that the patient does not have the mental capacity to bring a claim in the three-year limit, it will only begin once the patient regains capacity. If capacity is never re-gained, then a claim can be made at any time regardless of the time from the reported incident.

Table 7: Volume and cost of medical negligence claims related to children and adolescents mental health, community mental services and psychology notified to NHS Resolution 2015/16 to 2019/20

Year of notification	No. of claims	% change in no. of claims	Total claim cost (£)	% change in total claim cost
2015/16	13	-	1.5 million	-
2016/17	54	315%	3.8 million	163%
2017/18	37	-31%	10.0 million	163%
2018/19	16	-57%	1.4 million	-86%
2019/20	86	438%	3.0 million	111%
Grand Total	**206**	**-**	**19.7 million**	**-**

Source: NHS Resolution

Claims trends and causes

Table 7: Volume and cost of medical negligence claims related to children and adolescents mental health, community mental services and psychology notified to NHS Resolution 2015/16 to 2019/20

Cause	No. of claims	Total claim cost (£)
Assault, etc By Hospital Staff	132	£3,877,310
Fail / Delay Treatment	22	£1,357,759
Failure/Delay Diagnosis	9	£1,191,750
Self Harm	9	£9,179,019
Inappropriate Treatment	8	£1,218,600
Unexpected Death	5	£350,016

Source: NHS Resolution

Causes

Common causes for litigation in adult mental health, community mental services and psychology were identified. Across all three specialities, failure/delay to treatment was the most frequent cause of claim. It is important to note that more than one cause can be assigned to each claim. It is recognised that many claims may be reasonably attributed to areas of the healthcare system that require improvement.[62] Some of the claim cause codes including failure to supervise and inadequate nursing suggest further scrutiny of claims that feature these codes will enable clinical staff to learn and improve delivery of care.

Suicide

When a person takes their own life it has a devastating, lifelong impact on the family, carers and staff involved in that person's care. As shown by **Table 8**, the highest value claims relate to self-harm and unexpected death.

The NHS Resolution Safety and Learning team had undertaken further thematic analysis of all claims related to adult suicide to better understand the clinical and non-clinical themes in care from attempted and completed suicide that resulted in a claim for compensation.[63] Their analysis demonstrated that recurrent themes were consistent through many of the incidents associated with these claims, including poor management of substance misuse, difficulties with community especially in inter-agency working, inaccurate and poorly documented risk assessments and inconsistent observation processes. Furthermore, the SI investigations that followed the incident in these claims often lacked involvement of the family and the reports that were produced lacked robust recommendations that were consequently unlikely to impact on future practice.

Reviewing the highest value claims from child and adolescent mental health (14 claims > £1 million), nine claims related to suicides which were fatal. The remainder were attempted suicides and/or self-harm, where the patient survived with significant injuries including anoxic brain injury. Similar concerns related to risk assessment have been highlighted. In November 2020, the government set out plans for an independent inquiry, examining deaths in an English mental health unit, following concerns of a 14-year-old adolescent found hanged in his room in 2012.[64]

The most common cause for clinical negligence was assault by hospital staff. Recently, there has been media reports of historical abuse by staff to patients in mental health units.[65] Children and adolescents receiving mental health support represent a particularly vulnerable group where safeguarding should be prioritised for their safety, but also represents financial consequences when this does not occur.

The NHS report produces nine recommendations that guide mental health departments to improve clinical and non-clinical practice in this area and focus on a systematic approach to communication through all bodies involved in patient care.

[62] *Kaplan, C. (2006) Reducing Risk in Mental Health Services: The Work of the NHS Litigation Authority. Mental Health Review Journal, Vol. 11 No. 1, pp. 34-37.*

[63] *Oates A. (2018) Learning from suicide-related claims: A thematic review of NHS Resolution data. NHS Resolution. https://resolution.nhs.uk/resources/learning-from-suicide-related-claims/*

[64] *The Independent: New inquiry to examine NHS mental health deaths over two decades (2020) The Independent. https://www.independent.co.uk/news/health/nhs-inquiry-mental-health-essex-linden-centre-b1764134.html*

[65] *The Independent: Abuse survivors fight for justice after police drop investigation at child mental health unit (2020) The Independent. https://www.independent.co.uk/news/uk/crime/child-abuse-hill-end-mental-health-unit-investigation-sedation-police-b1281960.html*

Recommendations: Litigation

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
21. Reduce litigation costs by application of the GIRFT programme's five-point plan.	**a** Clinicians and trust management to assess their litigation claims covered under Clinical Negligence Scheme for Trust (CNST) notified to the trust over the last five years.	Clinicians and trusts management.	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	For progress within six months of publication.
	b Clinicians and trust management to discuss with the legal department or claims handler the claims submitted to NHS Resolution to confirm correct coding to that department. Inform NHS Resolution of any claims which are not coded correctly to the appropriate specialty via *CNST.Helpline@resolution.nhs.uk*	Clinicians and trusts management.	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	Upon completion of **a**
	c Once claims have been verified clinicians and trust management to further review claims in detail including expert witness statements, panel firm reports and counsel advice as well as medical records to determine where patient care or documentation could be improved. If the legal department or claims handler needs additional assistance with this, each trusts panel firm should be able to provide support.	Clinicians and trusts management.	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	Upon completion of **b**
	d Claims should be triangulated with learning themes from complaints, inquests, and SI/ PSI and where a claim has not already been reviewed as SI/PSI we would recommend that this is carried out to ensure no opportunity for learning is missed. The findings from this learning should be shared with all staff in a structured format at departmental/directorate meetings (including MDT meetings, and morbidity and mortality meetings where appropriate.	Clinicians and trusts management.	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	Upon completion of **c**
	e GIRFT clinical leads and regional teams to share with trusts examples of good practice where it would be of benefit.	GIRFT clinical leads	Findings will be shared with staff and staff will be cognisant of issues around litigation and ways to reduce the risk.	For continual action throughout GIRFT programme.

Notional financial opportunities

Calculating gross notional financial opportunities and cost implications in GIRFT reports

GIRFT reports provide financial opportunity figures to illustrate how improving clinical care will also improve productivity, using a methodology endorsed by the Healthcare Financial Management Association (HFMA). These figures are calculated after the report's draft recommendations are finalised, and after establishing what changes to clinical metrics they would be expected to deliver. The financial opportunity figures are not used to inform the report's findings or the development of the recommendations.

The financial opportunities provided are gross and notional. They are not inherently cash-releasing and apply a notional financial value to activity, ordinarily using figures from national prices or reference costs. They are not a net figure, because implementation costs could not usually be calculated in this way: costs may be locally contingent or otherwise not calculable using reference costs or national prices. Instead, implementation costs are identified separately, in consultation with colleagues in NHS England and NHS Improvement, once draft recommendations have been finalised from a clinical perspective.

The opportunities figure includes reductions to:

- length of stay (LoS);
- planned admissions where no benefit was achieved;
- readmissions/re-referrals;
- outpatient attendances and follow-ups; and unnecessary interventions and appointments.

Financial opportunities and potential cost implications from this report

There is an opportunity to create better value and improve the quality of mental health services for children and young people and this report supports current plans to deliver on this. The NHS Long Term Plan sets out a series of ambitious commitments that continue and extend the Future in Mind/Five Year Forward View programme to deliver access to high quality evidence-based support from early intervention through to intensive treatment for our most unwell young people. Those commitments are supported by a funding commitment that CYPMHS will grow faster than both total mental health service spending and overall NHS funding. The potential cost implications of this report have been carefully considered in this context and we do not anticipate any additional cost resulting from this report's recommendations.

There are challenges for CYPMHS within the call for wider alignment with services for all children and young adults with complex needs, as well as the move towards greater integration of Integrated Care Systems (ICS). However, these challenges also present opportunities for integrated pathways between community and inpatient settings. To achieve this commissioners, including but not limited to CCGs and lead providers within an NHS-led provider collaborative, will need to, based on best practice and outcomes data, re-allocate funding and re-invest savings achieved through integration across the pathway whilst reflecting local circumstances.

This report makes practical recommendations that will address many of the pressures faced by CYPMHS. However, it is recognised investment will be required in many areas if services can be substantially changed. We recommend future investment should be focused on alternatives to admission, ensuring that there are effective models of care to treat the presenting condition and promotion of early discharge. It is, however, important to drive high quality data and ensure appropriate length of stay links to better patient outcomes.

Areas are identified within the national report where there is potential to make significant changes that could contribute to an overall reduction in hospital bed days. If all children and young people were admitted for the necessary time as part of an integrated pathway, where appropriate earlier interventions and alternative services are offered, then many, if not most, young people would see a reduction in their length of stay. The potential gross financial opportunity related to CYPMHS hospital bed days if all providers shifted to the national average length of stay could be in the region of £11m (see below for more detail). This significant opportunity could help support investment in alternative services that cross system boundaries. Whilst demand for inpatient beds means such savings are not likely to be cash releasing, based on the potential bed day saving opportunity identified below (in the region of 14,000 bed days), this equates to over 300 beds (based on 80% occupancy) across the country. In practical terms, this could negate the need to build and staff in the region of 30 new wards.

Effective use of psychiatric intensive care unit beds (PICU) is also discussed throughout this national report. Avoiding unnecessary PICU admissions could release resources for investment in effective community support and other alternative services. A 10% reduction in PICU admissions could equate to a financial opportunity in the region of £3m (based on the average cost of an admission - NHSE Specialised Commissioning 18/19)

It should be noted that inconsistency in data quality and reporting, as well as limited use of outcome measures, means the amount shown above is illustrative rather than an identified 'saving'. Lack of data is a major factor behind unwarranted variation across mental health services. There is a drive to improve data quality through service specifications, commissioning arrangements and the development of an impact framework

Table 9: Notional Financial Opportunities

Improvement	Standard			Target		
	Activity	**Activity opportunity***	**Gross notional financial opportunity****	**Activity**	**Activity opportunity***	**Gross notional financial opportunity****
Free up inpatient capacity for those who most need it (through continued investment in community services) *(Recommendations 1, 4 and 5)*	*National average*			*Best quartile*		
Opportunity = Reduce acute CYPMH hospital length of stay *It should be noted that the target length of stay shown here includes all CYP hospital bed days. Lack of robust data precluded a separate calculation related specifically to very long lengths of stay (60+ days).* *Base data: NHSBN April 18 - Mar 19* *Cost estimated based on average CYPMHS bedday cost (18/19 ref costs uplifted to 20/21 prices)*	55.6 days length of stay	14,200 bed days	£11.39	48.3 days length of stay	26,100 bed days	£20.94m
Total			**£11.39m**			**£20.94m**

Notes to table:

* Activity opportunities are annual figures, based on one year of activity data (18/19). Unless specified, activity that could be avoided is shown.

** Costing of financial opportunity: unless otherwise stated, cost estimates are based on national average 18/19 reference costs, uplifted to 20/21 pay and prices using tariff inflation.

About the GIRFT programme

Getting It Right First Time (GIRFT) is a national programme designed to improve treatment and care by reviewing health services. It undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience, without the need for radical change or additional investment. While the gains for each patient or procedure may appear marginal, they can, when multiplied across an entire trust – and even more so across the NHS as a whole – deliver substantial cumulative benefits.

The programme was first conceived and developed by Professor Tim Briggs to review elective orthopaedic surgery to address a range of observed and undesirable variations in orthopaedics. In the 12 months after the pilot programme, it delivered an estimated £30m-£50m savings in orthopaedic care – predominantly through changes that reduced average length of stay and improved procurement.

The same model has been applied in more than 40 different areas of clinical practice. It consists of four key strands:

- A broad data gathering and analysis exercise, performed by health data analysts, which generates a detailed picture of current national practice, outcomes and other related factors.
- A series of discussions between clinical specialists and individual hospital trusts, which are based on the data – providing an unprecedented opportunity to examine individual trust behaviour and performance in the relevant area of practice, in the context of the national picture. This then enables the trust to understand where it is performing well and what it could do better – drawing on the input of senior clinicians.
- A national report, that draws on both the data analysis and the discussions with the hospital trusts to identify opportunities for NHS-wide improvement.
- An implementation phase where the GIRFT team supports providers to deliver the improvements recommended.

GIRFT and other improvement initiatives

GIRFT is part of an aligned set of workstreams within NHS England and NHS Improvement. It is the delivery vehicle for one of several recommendations made by Lord Carter in his February 2016 review of operational efficiency in acute trusts across England.

The programme has the backing of the Royal Colleges and professional associations and has a significant and growing presence on the Model Hospital portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency. The programme also works with a number of wider NHS programmes and initiatives which are seeking to improve standards while delivering savings and efficiencies.

Implementation

GIRFT has developed an implementation programme designed to help trusts and their local partners to address the issues raised in trust data packs and the national specialty reports to improve quality. The GIRFT team provides support at a local level through the NHS England regional teams, advising on how to reflect the national recommendations into local practice and supporting efforts to deliver any trust specific recommendations emerging from the GIRFT visits. GIRFT also helps to disseminate best practice across the country, matching up trusts who might benefit from collaborating in selected areas of clinical practice. Through all its efforts, local or national, the GIRFT programme strives to embody the 'shoulder to shoulder' ethos that has become GIRFT's hallmark, supporting clinicians nationwide to deliver continuous quality improvement for the benefit of their patients.

Glossary

Assuring Transformation (AT) Data
This is a national data collection developed in response to *Transforming Care: A national response to Winterbourne View Hospital and Winterbourne View Review: Concordat: A Programme of Action.* The data collection supports NHS England and NHS Improvement in monitoring the progress in moving people with learning disabilities from inpatient to community settings.

Care, Education and Treatment Reviews (CETR)
A Care, Education & Treatment Review (CETR) is a meeting about a child or young person who has a learning disability and/or autism and who is either at-risk of being admitted to, or is currently detained in, an in-patient (psychiatric) service. CETRs are part of the Transforming Care programme led by NHS England. The aim of Transforming Care is to reduce the number of people with a learning disability or autism living in an inpatient hospital unnecessarily.

Care Programme Approach (CPA)
CPA is a package of care that is used by secondary mental health services. It involves ensuring a service user has an assessment of mental and physical and social care needs, an assessment of safety and risk issues, a care plan, a care coordinator, and regular reviews. People with severe mental illness that is not well managed, or people with many professionals involved in their care, will likely get help under the CPA.

Care Quality Commission (CQC)
The independent regulator of health and social care in England. The CQC makes sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

Children and Adolescent Mental Health Services (CAMHS)
The name for the NHS commissioned services that treat young people with emotional, behavioural, or mental health difficulties. The term CAMHS is often now replaced with the term Children and Young People's Mental Health Services as a more inclusive and acceptable term, however both terms remain interchangeable. Within this document CAMHS has been used when referencing directly from another publication using CAMHS rather than CYPMH.

Children and Young People (CYP)
A term developed in conjunction with children and young people to describe people under the age of 18. It is a preferable term to children and adolescents.

Children and Young People's Mental Health Services (CYPMH)
Is the name for the NHS commissioned services that treat young people with emotional, behavioural, or mental health difficulties. The term CYPMH has replaced the term Child and Adolescent Mental Health Services (CAMHS), however both terms remain interchangeable.

Clinical Commissioning Group (CCG)
Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

Clinical Utilisation Review (CUR)
Is a clinical decision support tool that enables clinicians to make impartial and objective, evidence-based assessments of whether patients are receiving the right care, in the right place, at the right time and for the right length of time, according to a patient's individual needs.

College Centre for Quality Improvement (CCQI)
A part of the Royal College of Psychiatrists; works with mental health services to assess and improve the quality of care that they provide.

Commissioning for quality and innovation (CQUIN)
The CQUIN framework supports improvement in the quality of services and the creation of new, improved patterns of care by linking a proportion of providers income to the achievement of quality improvement goals.

Early Intervention in Psychosis services (EIP)
Services which aim to rapidly initiate specialist packages of care for those people newly experiencing symptoms of psychosis.

Health Education England (HEE)
The national leadership organisation for education, training, and workforce development in the health sector.

High dependency unit (HDU)
High dependency units are separate, potentially lockable areas within some adolescent inpatient units where higher levels of care can be provided for young people who cannot be cared for appropriately on an acute ward, but do not need to be transferred to a psychiatric intensive care unit.

Independent health (IH)
Independent health is the private sector of healthcare that is contracted by the NHS in the provision of healthcare or in the support of the provision of healthcare. It can be described as the independent health sector or as an independent health provider.

Integrated Care Systems (ICS)
Advanced local partnerships involving primary and secondary care, local councils, and others, taking shared responsibility to improve the health and care system for their local population.

Intensive Community Support Teams (ICTS)
These are teams that have an express function of supporting young people with defined mental health needs who require more intensive support than a standard community team can provide. Their remit is to avoid young people escalating to the point of crisis.

Intensive Home Treatment Teams (IHT)
These teams provide additional support to a crisis team or intensive community support team to increase the frequency or intensity of care.

Length of Stay (LoS)
The length of an inpatient episode of care, calculated from the day of admission to the day of discharge, and based on the number of nights spent in hospital.

Local Authority (LA)
An organisation that is officially responsible for all the public services and facilities in a particular area.

Mental Health Minimum Data Set (MHSDS)
Brings together information captured on clinical systems as part of patient care. It covers services provided in hospitals as well as in outpatient clinics and the community.

Multidisciplinary team (MDT)
A team of healthcare professionals from different disciplines.

National Collaborating Centre for Mental Health (NCCMH)
A collaboration between the Royal College of Psychiatrists and University College London which reviews national evidence to co-produce guidance, standards, workforce competencies and quality improvement initiatives to enable the delivery of high quality, equitable mental health care.

National Institute for Health and Care Excellence (NICE)
Provides evidence-based guidance, advice, quality standards, performance metrics and information services for health, public health, and social care.

New Care Model (NCM)
In 2015, in response to the Five Year Forward View, New Care Model Vanguards were identified to develop redesigns of whole health and care systems and test new and different ways of joining up health and social care services.

NHS Benchmarking Network (NHSBN)
A benchmarking service of the NHS which enables performance comparison between more than 300 health and social care organisations in the UK.

Out of area (OOA)
Out of area treatment occurs when a patient requires inpatient treatment but, due to their area having no local service or being at capacity, their treatment is provided outside of the usual local network of services.

Provider Level Reports (PLR)
Reports developed by NHS Digital, based on nationally available data, sent to individual providers allowing them to benchmark against a number of metrics.

Psychiatric Intensive Care Unit (PICU)
A psychiatric intensive care unit (PICU) is a hospital ward dedicated to the short-term management of people in an acutely disturbed phase of a serious mental disorder who cannot be safely managed in a general psychiatric ward. Core features include a high staff to patient ratio and a secure physical environment. Patients are usually detained under the Mental Health Act 1983 (Amended) and are often admitted because of the risk of aggression.

Quality Improvement (QI)
There is no single definition of quality improvement, however it can be described as the framework that uses specific techniques to systematically improve the way care is delivered to patients.

Quality Network for Inpatient CAMHS (QNIC)
A network of adolescent inpatient units run through the College Centre for Quality Improvement. It develops standards and best practice developed through the peers within the network.

Serious incidents (SI) /Patient Safety Incidents (PSI)
Serious Incidents, as set out in the Serious Incident Framework (March 2015), are 'events in healthcare where the potential is so great, or the consequences to patients, families and carers, staff or organisations are so significant'. Examples include unexpected or avoidable death of one or more people which includes suicide/self-inflicted death, and unexpected or avoidable injury to one or more people that has resulted in serious harm;

Standard Operating Procedures (SOPS)
A written set of instructions that a healthcare worker should follow to complete a job safely, with no adverse effect on personal health or environment, and in a manner that maximises the probability of a beneficial health outcome.

Whole time equivalent (WTE)
A unit that indicates the workload of an employed person in a way that makes workloads comparable. In healthcare, it is constructed by dividing working hours by 37 and treating anyone with more than 37 working hours as one WTE.

Youth Offending Services (YOS)
Youth offending teams work with young people that get into trouble with the law. They look into the background of a young person and try to help them stay away from crime. They also run local crime prevention programmes and help young people at the police station if they are arrested.

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- NHS Benchmarking Network
- NHS Digital
- CQC
- NHS England and NHS Improvement

We are grateful to NHS Resolution for the litigation data provided.

We acknowledge the work of other programmes, groups and individuals which has helped us in creating the questionnaire and deciding which metrics to explore. Most importantly we acknowledge that this report would have been impossible without the efforts of the numerous clinicians and other NHS staff who treat the patients and input their data.

We are grateful to NHS Digital for providing and agreeing that HES/MHSDS data could be used for the calculation of metrics in this report. This report also contains public sector information licensed under the Open Government Licence v3.0.

GIRFT report team

We wish to acknowledge the essential contribution to the production of this report from our colleagues at GIRFT and NHSBN, especially:

Dr Guy Northover – Clinical Lead;

Iyoni Ranasinghe – Editor;

Suzannah Davies – Review Project Manager;

Craig Colling – Analytics Manager;

Julie Renfrew – Principal Finance Analyst;

Matthew Barker – Senior Policy Lead;

Anna Woodford – Series Editor;

Melanie Proudfoot – Head of Communications;

Michelle Carter – Communications and Media Relations Manager;

John Machin – Clinical Lead for Litigation;

Dr Pratusha Babu – Clinical Fellow (Litigation);

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Professor Prathiba Chitsabesan – Associate National Clinical Director for CYPMH;

Kathryn Pugh – Deputy Head of Mental Health, CYPMH Programme;

Steve Jones – National Service Advisor, CYPMH Programme;

Eimhin Walker – Programme Manager;

Michelle Place – Senior Programme Manager, Community Integration and Early Help, CYPMH Programme;

Aga Wojciechowska – Programme Manager CYP Access, CYP Urgent and Emergency MH Care, Suicide Reduction.

Within the RCPsych:

Dr Bernadka Dubicka – Chair of the Faculty of Child and Adolescent Psychiatry;

Amar Shah – National improvement lead for the mental health safety improvement programme, quality improvement lead at the RCPsych.

The Clinical Reference Group, and in particular:

Louise Dougherty – Deputy Head of Mental Health Specialised Commissioning (CAMHS), Lead Commissioner Tier 4 CAMHS Clinical Reference Group, National Specialised Commissioning Team Mental Health NHS England and NHS Improvement.

Appendices

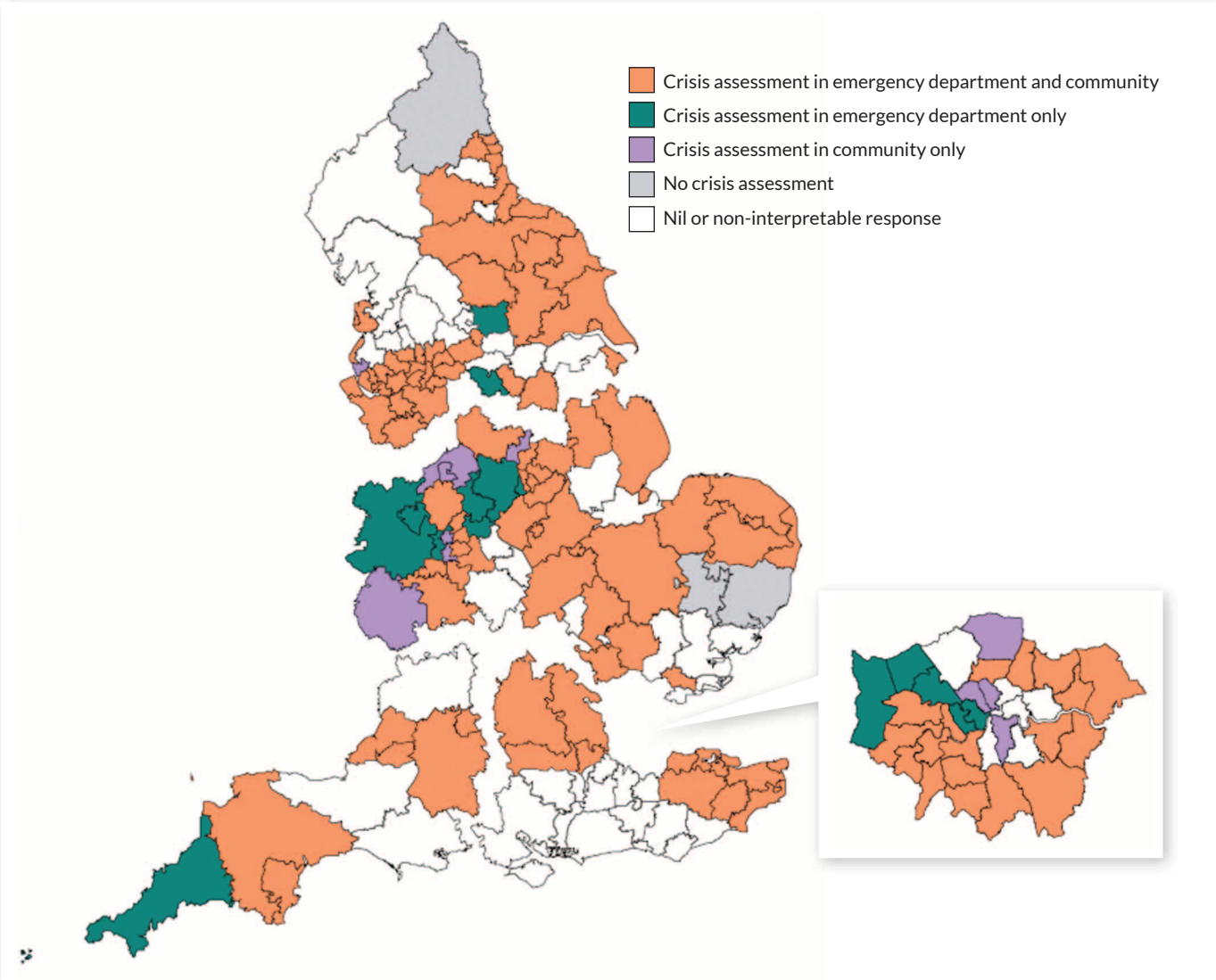
Appendix 1: List of CYP NHS-led provider collaboratives

Provider collaborative name	Oranisation/Site name
CAMHS - East Midlands	Nottingham CAMHS City Council Nottinghamshire Healthcare NHS Trust Northamptonshire Healthcare NHS Foundation Trust Lincolnshire Partnership NHS Foundation Trust Leicestershire Partnership NHS Trust Derbyshire Healthcare NHS Foundation Trust
Cheshire & Mersyside CAMHS	Cheshire and Wirral Partnership NHS Foundation Trust Cygnet - Bury The Priory - Altrincham/ Cheadle
Dorset and Wessex CAMHS (Phase 1) Kent and Sussex CAMHS (Phase 2)	Dorset Healthcare University NHS Foundation Trust Southern Health NHS Foundation Trust Sussex Partnership NHS Foundation Trust The Priory - Southampton/ Ticehurst Elysium Healthcare Cygnet - Godden Green
East of England	Essex Partnership NHS Foundation Trust Norfolk and Suffolk NHS Foundation Trust Cambridgeshire and Peterborough NHS Foundation Trust Central North West London NHS Foundation Trust (Milton Keynes) East London Foundation Trust (Luton and Bedford) North East London Foundation NHS Trust Hertfordshire Partnership NHS Foundation Trust Elysium
Greater Manchester CAMHS	Pennine Care NHS Foundation Trust Greater Manchester Mental Health NHS Foundation Trust Cygnet - Bury The Priory - Altrincham/ Cheadle
Lancashire & South Cumbria CAMHS	Lancashire Care NHS Foundation Trust The Priory - Altrincham/ Cheadle East Lancashire Hospitals NHS Trust Blackpool Teaching Hospitals NHS Foundation Trust
North Central and East London	North East London Foundation Trust The Whittington Hospital NHS Trust The Tavistock and Portman NHS Foundation Trust Barnet, Enfield and Haringey NHS Trust East London Foundation Trust
North East and Cumbria Specialist Services Partnership (NE&C)	Tees, Esk and Wear Valleys NHS Foundation Trust Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust South Tyneside NHS Foundation Trust
North West London	West London Mental Health NHS Trust Central North West London NHS Foundation Trust The Priory - Roehampton/ North London

Appendix 1: List of CYP NHS-led provider collaboratives (continued)

Provider collaborative name	Oranisation/Site name
South London Partnership	Oxleas NHS Foundation Trust South West London & St George's Mental Health NHS Trust South London and Maudsley NHS Foundation Trust The Priory - Roehampton
South West, CAMHS Tier 4	Somerset Partnership NHS Foundation Trust Cornwall Partnership NHS Foundation Trust Avon and Wiltshire Mental Health Partnership NHS Trust Livewell South West The Priory - Bristol Weston Area Healthcare Trust
South Yorkshire CAMHS	Rotherham Doncaster & South Humber NHS Foundation Trust Cygnet - Sheffield South West Yorkshire Partnership NHS Foundation Trust Riverdale Grange Sheffield Children's Hospital
Surrey Heartlands ICS Delegated Commissioning	Surrey & Borders Partnership NHS Foundation Trust Elysium Healthcare Cygnet - Godden Green The Priory - Ticehurst/ Roehampton
Thames Valley CAMHS	Oxford Health NHS Foundation Trust 2gether NHS Foundation Trust (Gloucestershire) Berkshire Healthcare NHS Foundation Trust The Priory - Bristol Huntercombe - Maidenhead
West Midlands CAMHS	North Staffs Combined Healthcare NHS Trust Black Country Partnership NHS Foundation Trust Birmingham and Solihull Mental Health NHS Foundation Trust Dudley and Walsall Mental Health Partnership NHS Trust The Priory - Woodbourne Coventry and Warwickshire Partnership NHS Trust Huntercombe (Stafford)
West Yorkshire CAMHS	South West Yorkshire Partnership NHS Foundation Trust Bradford District Care Trust Leeds Community HealthCare NHS Trust Leeds & York Partnership NHS Foundation Trust

Appendix 2: Present variation of CCG provision in England during 2018



Source: Urgent and emergency mental health care and intensive home treatment for CYP: 2018

Addendum

NHS Quality Improvement Taskforce

Introduction

The initial GIRFT report was focused on the urgent care pathway including general admission and eating disorder units. The terms of reference specifically excluded both secure and learning disability units. This addendum focuses specifically on the secure and learning disability units excluded in the main GIRFT report and uses additional data collected because of the support from the NHS Quality Taskforce.

This addendum should be read alongside the full GIRFT Children and Young People's Mental Health Services report. Themes are consistent across the General Adolescent Units (GAUs) and secure/learning disability units and the main recommendations and actions should be implemented for learning disability and forensic units. It is however notable that the deciles for the metrics are clearly different and the QI targets, while consistent in objectives, will have different target metrics.

Key recommendations

These recommendations are in addition to the main recommendations and are specific for the secure and learning disability estate:

1. All providers must have effective and efficient data collection processes. The data must be flowing to the MHSDS. While this must include all data requirements under the service specification, a particular focus should be on diagnosis, outcome reporting and restrictive interventions.
2. Within the secure and learning disability setting, the focus should be on a closer standardisation of the stratified LoS with a determination of best practice through national clinical forums. It is not appropriate to identify a target LoS as deep-dive visits did not allow the development of a clear clinical understanding of the factors driving LoS.
3. Commissioners and providers, including lead provider/s of the NHS-led provider collaborative, supported by national clinical reference groups, to develop clear admission criteria for admitting young people to forensic and learning disability units. This admission criteria must take into consideration the specific expertise of the unit, the presenting condition of the young person, the present mix of young people in the unit and distance from home.
4. All provider organisations must focus on reducing the incidence of restraint, prone restraint, and seclusion. The NHS England and NHS Improvement Medium Secure and Low Secure Networks should be encouraged to continue sharing best practice with monitoring of these metrics through the model mental health portal.
5. Each unit to be provided with their deep-dive pack and to identify areas where they are outliers within the data. The unit should respond to this either through presenting a clear clinical rationale and evidence of enhanced effectiveness to the quality taskforce or develop an action plan on bringing the unit out of the outlier position.

NHS Quality Improvement Taskforce

In autumn 2019, a National Quality Improvement Taskforce was established to improve current specialist CYP's inpatient mental health, autism, and learning disability services in England.

The taskforce seeks to make a rapid set of improvements in care over 18 months, through to mid-2021. As a consequence of COVID-19 however, the taskforce paused during 2020 and will therefore be continuing through to March 2022. The primary scope of the taskforce is to ensure inpatient services deliver safe, high quality care for CYP that is timely, treatment-focused, and outcomes-based. It will look at workforce, hospital facilities and inpatient admissions.

The taskforce's independent oversight board is chaired by Anne Longfield OBE, the Children's Commissioner for England. This provides independent, expert advice and scrutiny on the work of the taskforce. The delivery group is chaired by John Lawlor OBE, the Chief Executive of NHS Cumbria, Northumberland, Tyne and Wear, and senior responsible officer for the taskforce. This delivery group, made up of leaders from across the NHS and other key partners, will implement the taskforce objectives.

The clear links between the taskforce objectives and the GIRFT objectives have resulted in close working between the two. However, it has been of importance to the taskforce that both secure units and learning disability and autism units have access to similar data to understand unwarranted variations in care and identification of best practice. The GIRFT programme has been able to support the taskforce through developing a data pack using the GIRFT principles. While this data is not included within this report, each provider of secure or learning disability units has had an individualised pack and the opportunity to attend presentations of the data along with a clinical interpretation.

Process

The GIRFT Quality Taskforce extension uses the well-established GIRFT principles of collection of data at a national level, development of data packs to identify areas of variation and clinical interpretation of the data to focus on unwarranted variation and areas for quality improvement (QI).

While it was not possible to undertake deep-dive visits at each unit, two regional webinars were arranged, and the anonymised packs were sent out with a clinical interpretation of the data included in the pack. Clinical feedback from the webinars and specific advice and knowledge from experts in the field, Dr Gill Bell and Dr David Kingsley, was sought to help understand the variations within the data and develop effective action plans to drive QI.

The GIRFT Quality Taskforce extension was focused on the inpatient units only and did not include data on the learning disability or forensic community services or crisis services. However, the report is designed to be read alongside the Children and Young People's Mental Health (CYPMH) GIRFT report and findings.

It is notable that Psychiatric Intensive Care Units (PICUs) are included within this report rather than within the GAU report. PICU units are not identified as secure units and are included within this report because they were excluded from the GAU report.

Table 1: Number and type of units

Ward type	Number of wards
Low secure	11
Medium secure	7
PICU	11
Learning disability	8

Source: NHS England NHS Improvement Specialised Commissioning and NHSBN 2018/19

Data

We collected data from the Mental Health Minimum Data Set (MHSDS) and specialist commissioning data set. There is limited use of data from the NHS Benchmarking Network (NHSBN) as there is less engagement in this network from forensic units than in the GAU.

Data collection for the GIRFT Quality Taskforce extension was more limited than within the CYPMH GIRFT report as there is less engagement in the NHSBN for forensic and learning disability units. The NHSBN report was a significant source of data for the CYPMH GIRFT report. The time limitations also resulted in no GIRFT supplementary questionnaire being sent out.

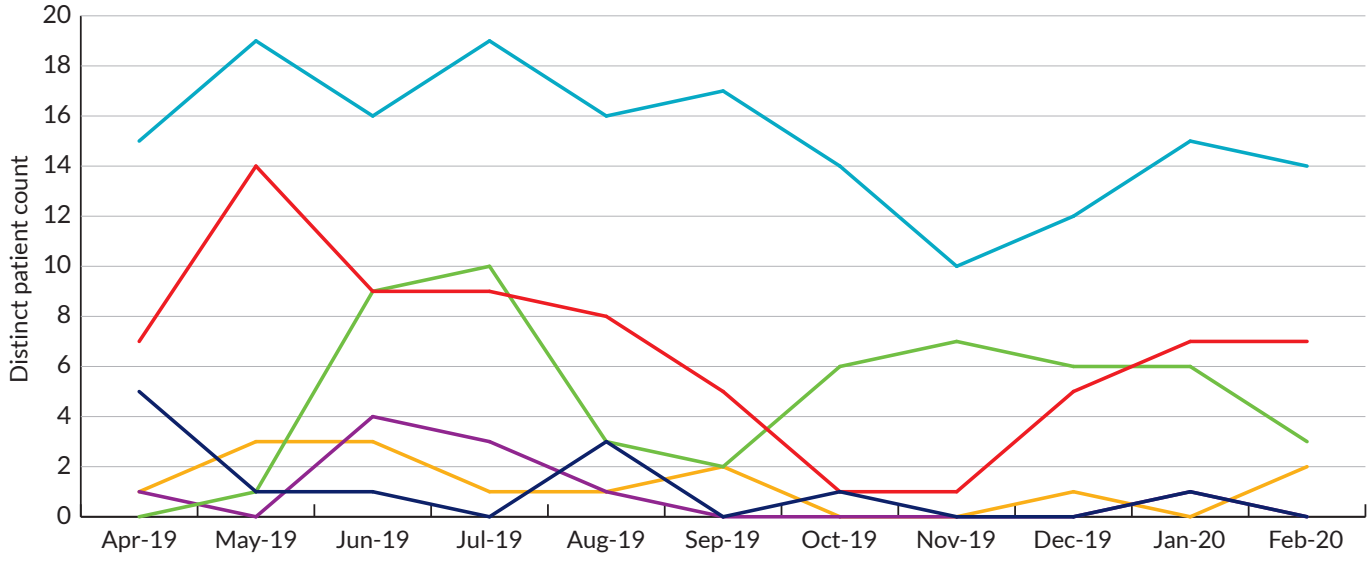
The main data source for this report is the MHSDS with additional data from the specialist commissioning data sets.

Main findings

1: Data is poor across the board, limiting the identification of variation in quality of care, and a requirement for improved data quality is clear.

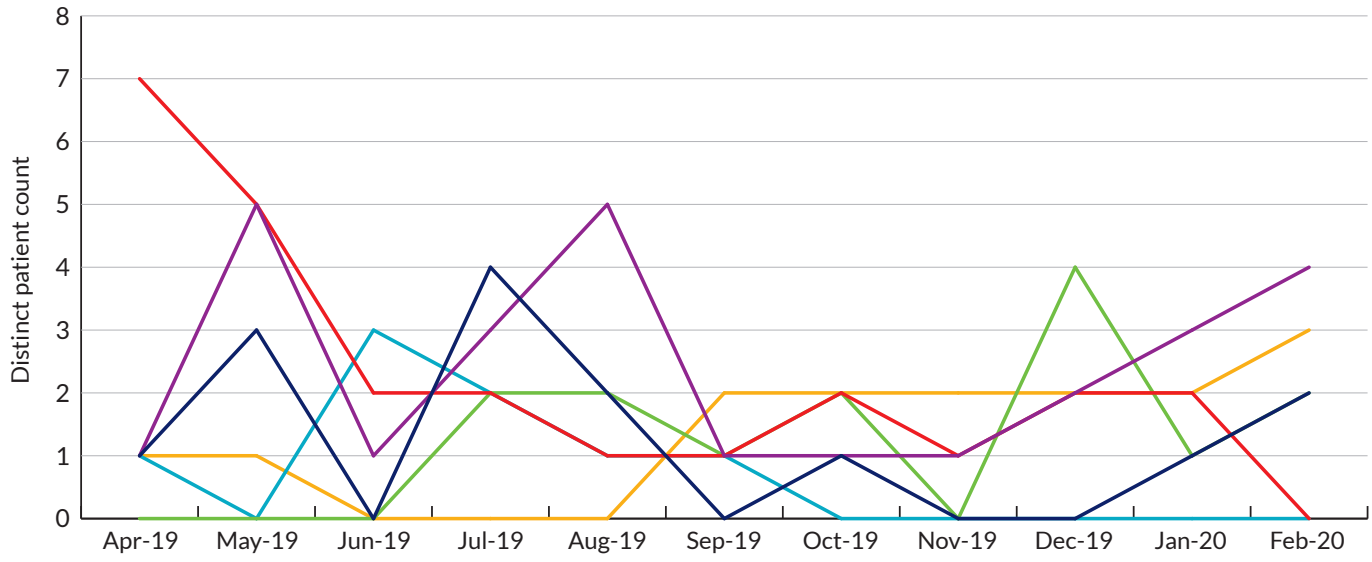
Consistent with the main CYP report, units do not consistently flow data to the MHSDS, making a national interpretation of the picture difficult. An example of the poor data can be seen within the seclusion data below – see **Figures 1-4**.

Figure 1: Data quality - prone restraint



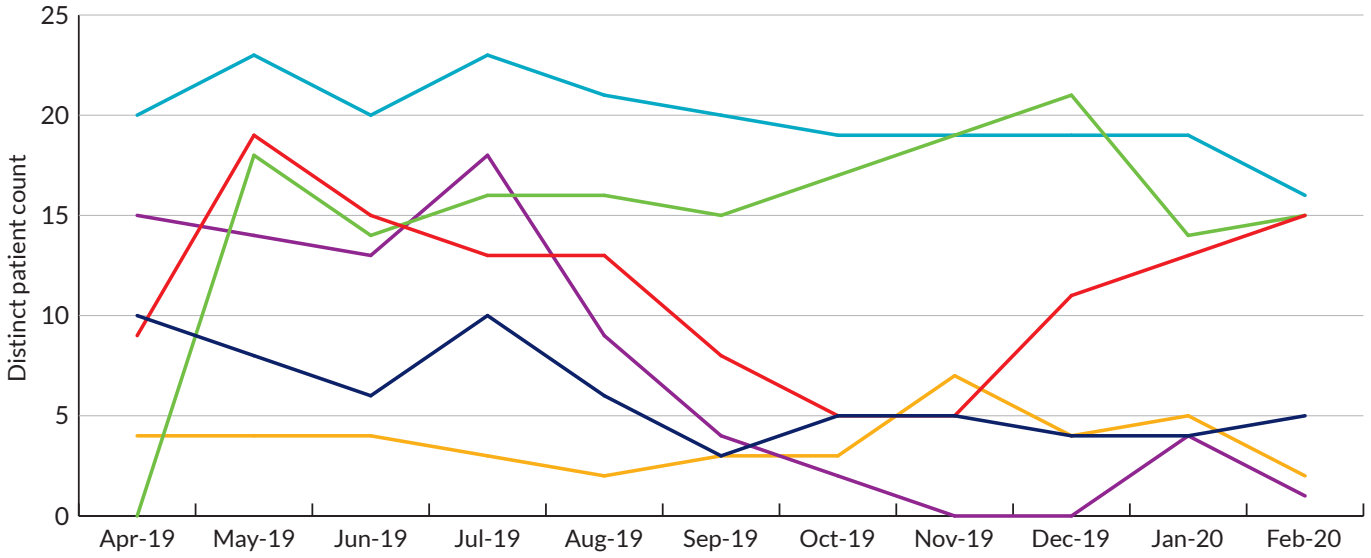
Source: MHSDS 2019/20

Figure 2: Data quality - seclusion



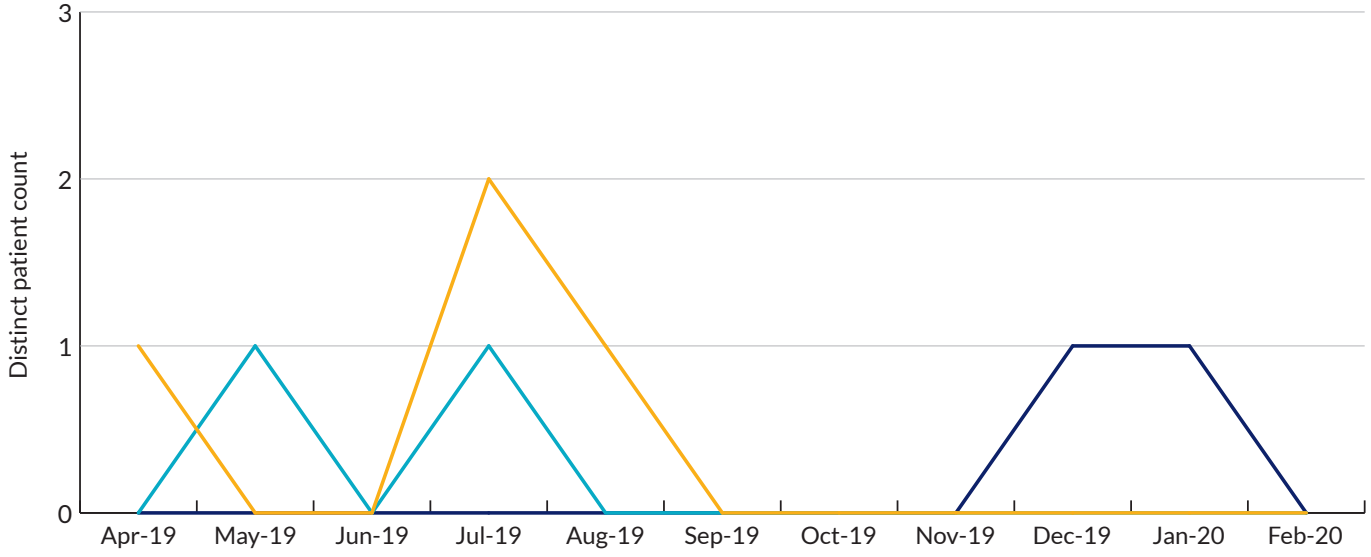
Source: MHSDS 2019/20

Figure 3: Data quality - physical restraint excluding prone



Source: MHSDS 2019/20

Figure 4: Data Quality - segregation



Source: MHSDS 2019/20

For segregation only three of the ten providers returned data. However, the poor returns are only part of the problem. Restraint data is best seen at a unit level rather than a provider level. However, we were unable, at the time of data collection, to obtain this through a combination of the challenges within the MHSDS and service returns. Diagnosis data is also very poor, and we were unable to report on outcome measures as this data was not returned in a quantity that could be analysed.

Recommendation

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
1. All providers must have effective and efficient data collection processes. The data must be flowing to the MHSDS. While this must include all data requirements under the service specification, a particular focus should be on diagnosis, outcome reporting and restrictive interventions.	**a** All NHS and IH providers must have a clear plan in place to improve the data quality and quantity on restraint and seclusion.	Inpatient and crisis service providers.	Improved data collection into MHSDS.	For progress within 12 months of publication.
	b Local data collection of reason for admission and intervention offered to be implemented.	Commissioners and lead provider/s of an NHS-led provider collaborative	Improved data collection into MHSDS.	For progress within 12 months of publication.
	c Data must be collected and analysed at a provider-collaborative level.	Commissioners and lead provider/s of an NHS-led provider collaborative	Improved data collection into MHSDS.	For progress within 12 months of publication.

2a: Average cost per bed day does not have a clear association with cost of admission

Across all the different unit types, this finding was consistent, although potentially less notable with the PICU units.

Figure 5: PICU - cost per admission and LoS

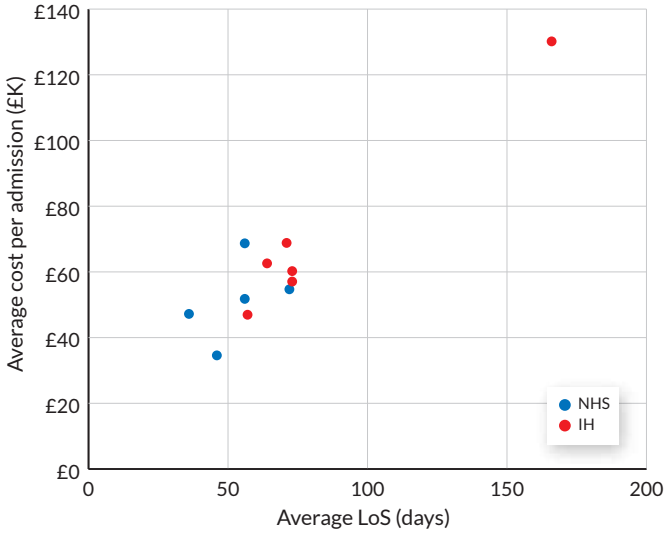


Figure 6: PICU - cost per admission and unit price

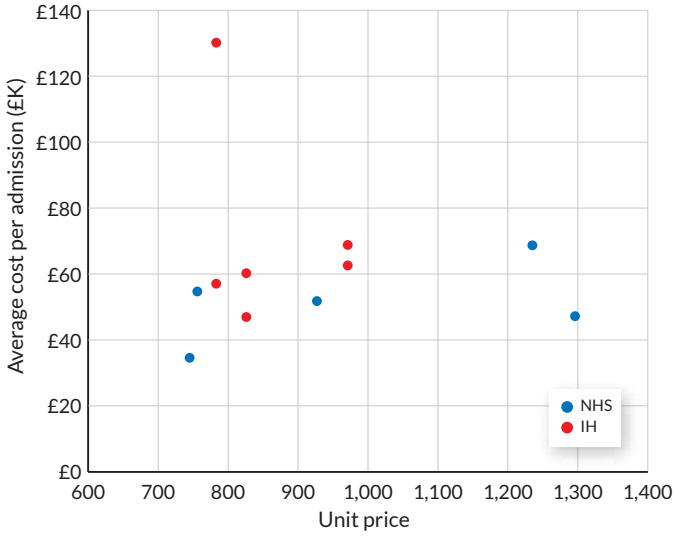


Figure 7: Low secure unit - cost per admission and LoS

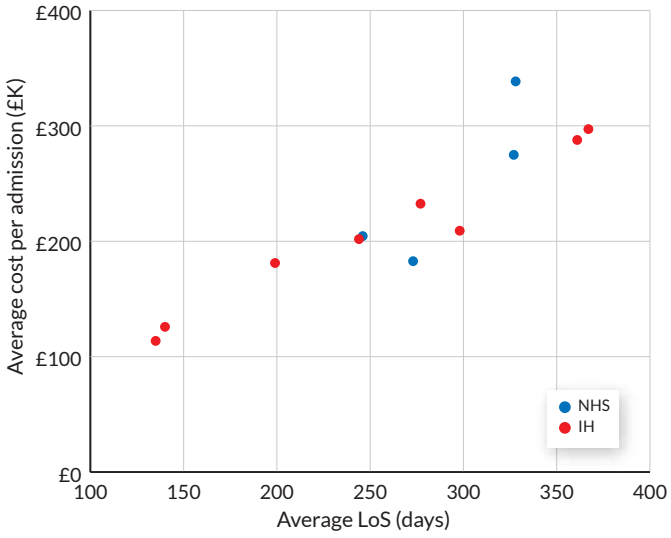
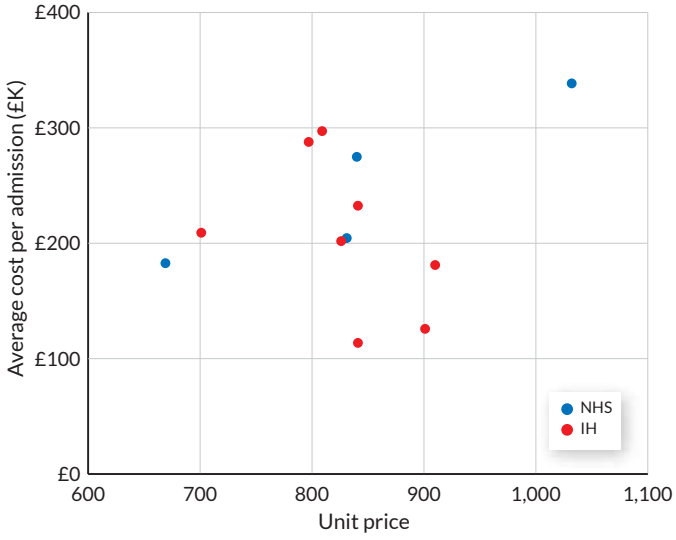


Figure 8: Low secure unit - cost per admission and unit price



Source: NHS England and NHS Improvement Specialised Commissioning: (SMH PLD) - 2018/19

Figure 9: Medium secure unit - cost per admission and LoS

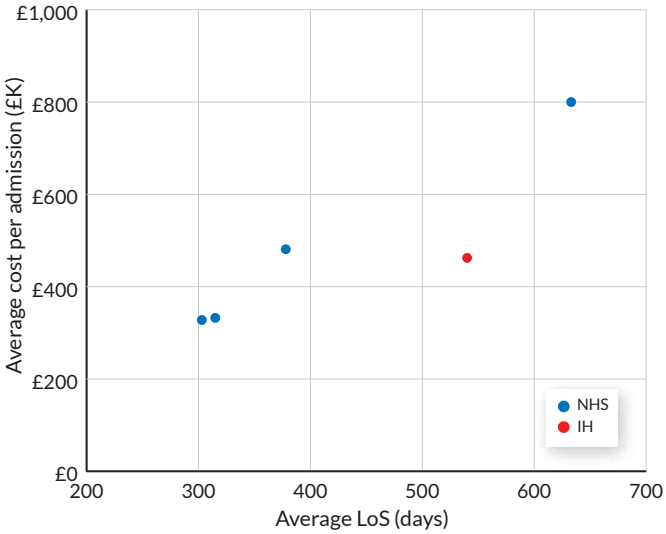


Figure 10: Medium secure unit - cost per admission and unit price

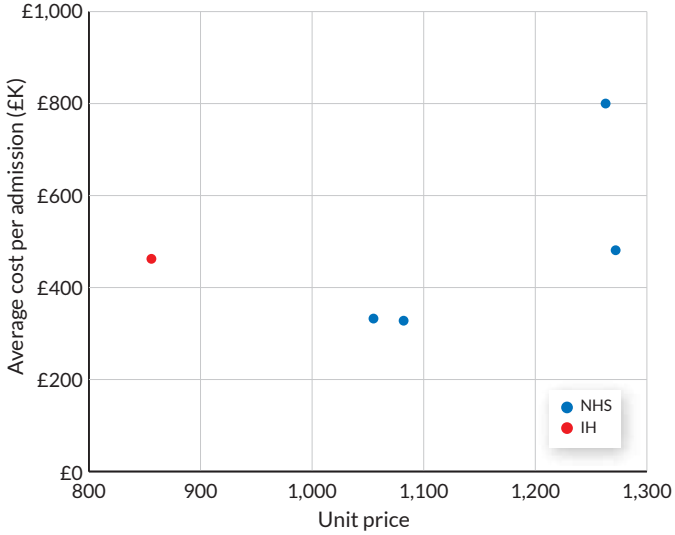


Figure 11: Learning disability - cost per admission and LoS

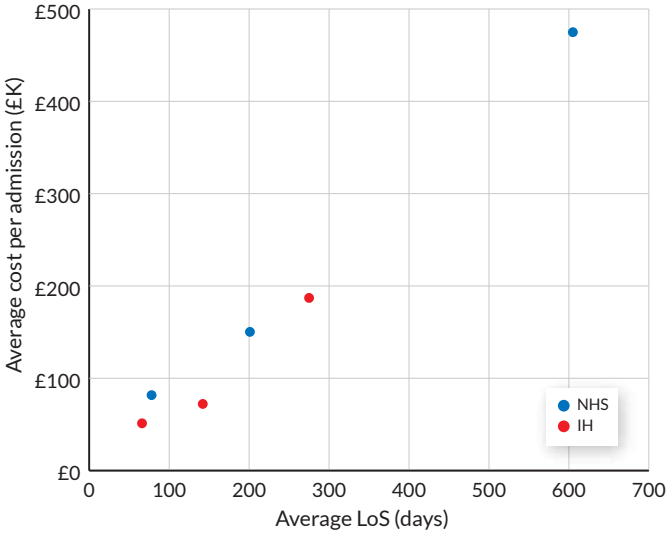
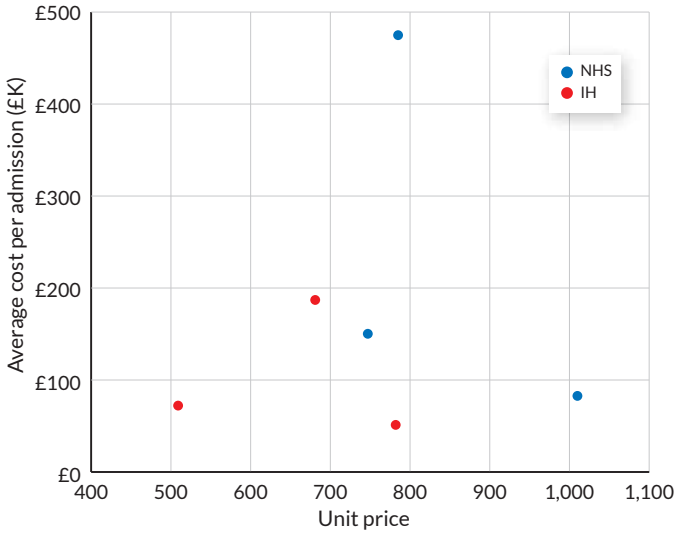


Figure 12: Learning disability - cost per admission and unit price



Source: NHS England and NHS Improvement Specialised Commissioning: (SMH PLD) - 2018/19

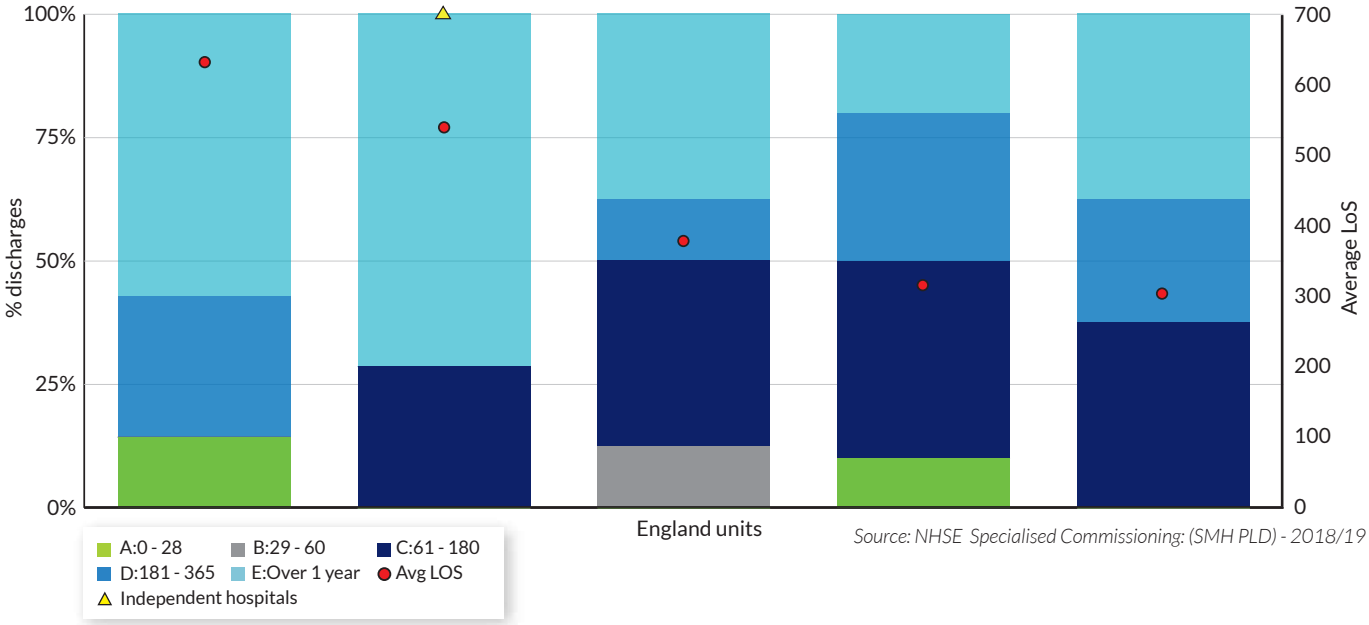
Using the low secure unit (LSU) as an example (see **Figures 5-12**), there is a clear linear association with the cost of an admission and the average length of stay (LoS) for the unit. This is to be expected as costs are based on a cost per bed day standard. However, there is no association between the cost per admission and the cost per bed day of a unit. This strongly suggests that those units with a higher cost per bed day must have a shorter LoS which results in little difference between the overall cost of the admission.

Given how challenging, costly and time consuming it is to open new units, and that the evidence suggests that there is higher efficiency in more expensive units, this confirms the finding in the CYPMH report that the focus of improvement should be on driving more efficient inpatient units to allow a greater number of young people to access the present service.

2b: There is significant variation of LoS across the secure and learning disability estate which cannot be explained as warranted

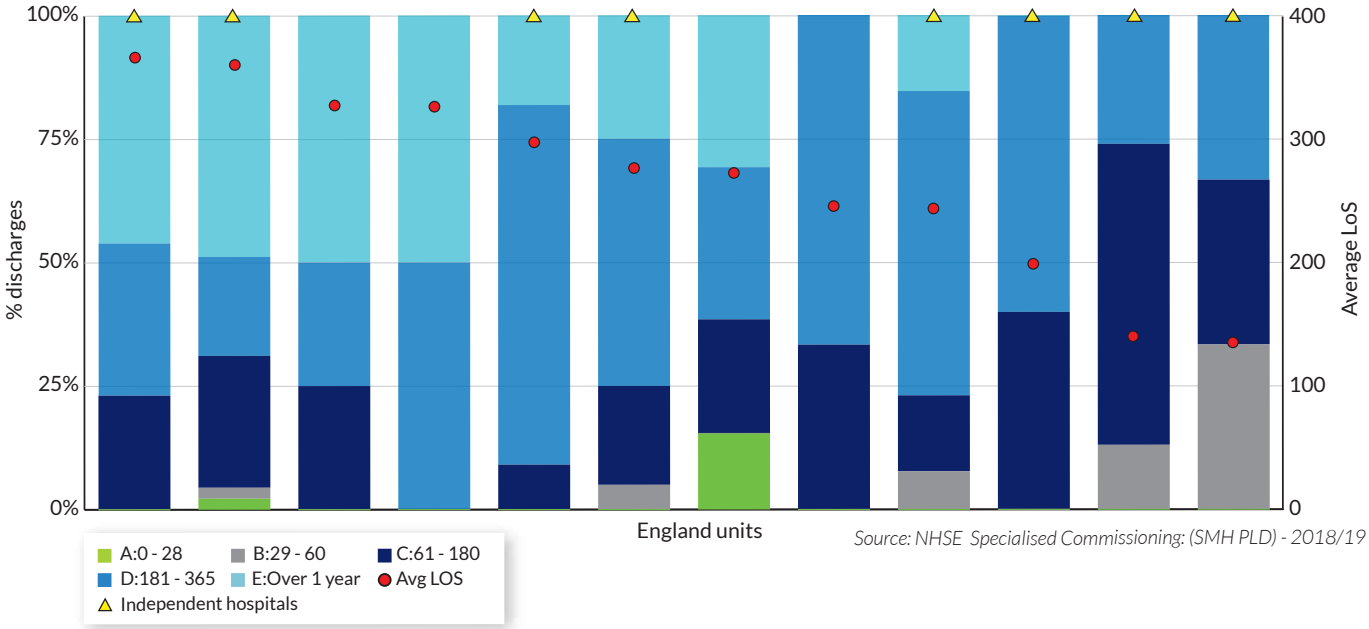
While within the PICU units there is a high degree of consistency of LoS, both as an average and when stratified (although one outlier to this pattern remains), this is not replicated across the forensic units or learning disability units. The variation suggests significant differences within the clinical model.

Figure 13: Medium secure units - average LoS



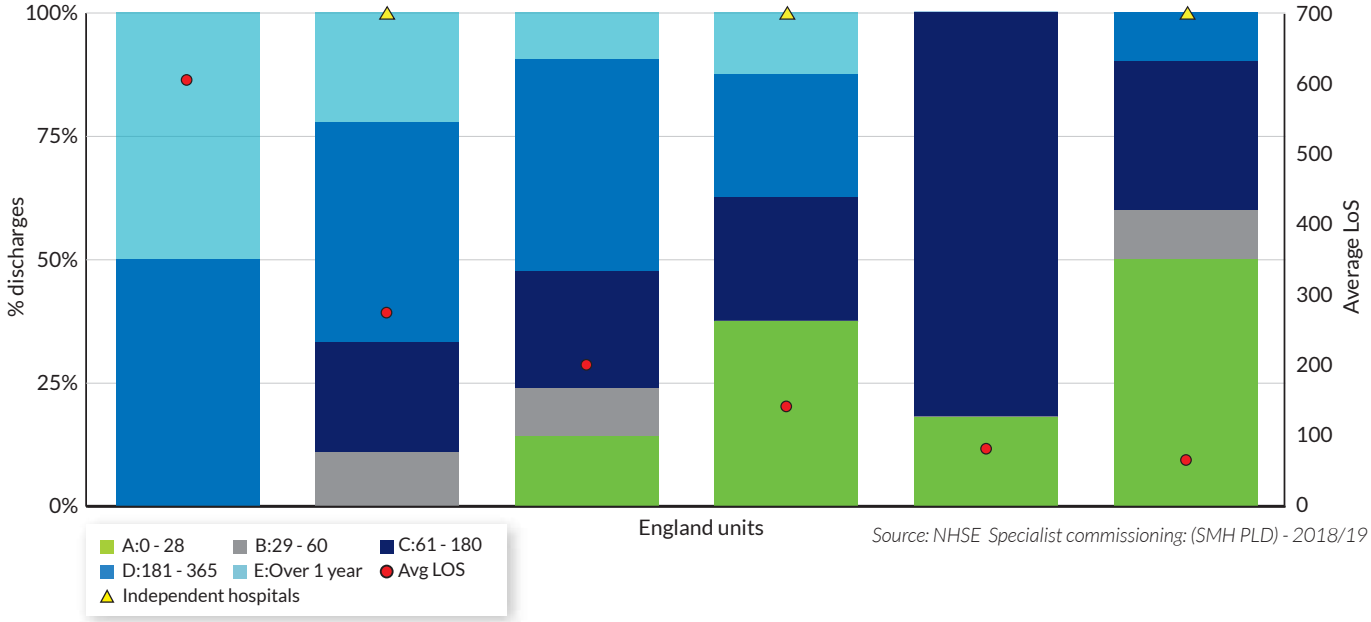
Source: NHSE Specialised Commissioning: (SMH PLD) - 2018/19

Figure 14: Low secure units - average LoS



Source: NHSE Specialised Commissioning: (SMH PLD) - 2018/19

Figure 15: CAMHS Learning disability - average LoS



Source: NHSE Specialist commissioning: (SMH PLD) - 2018/19

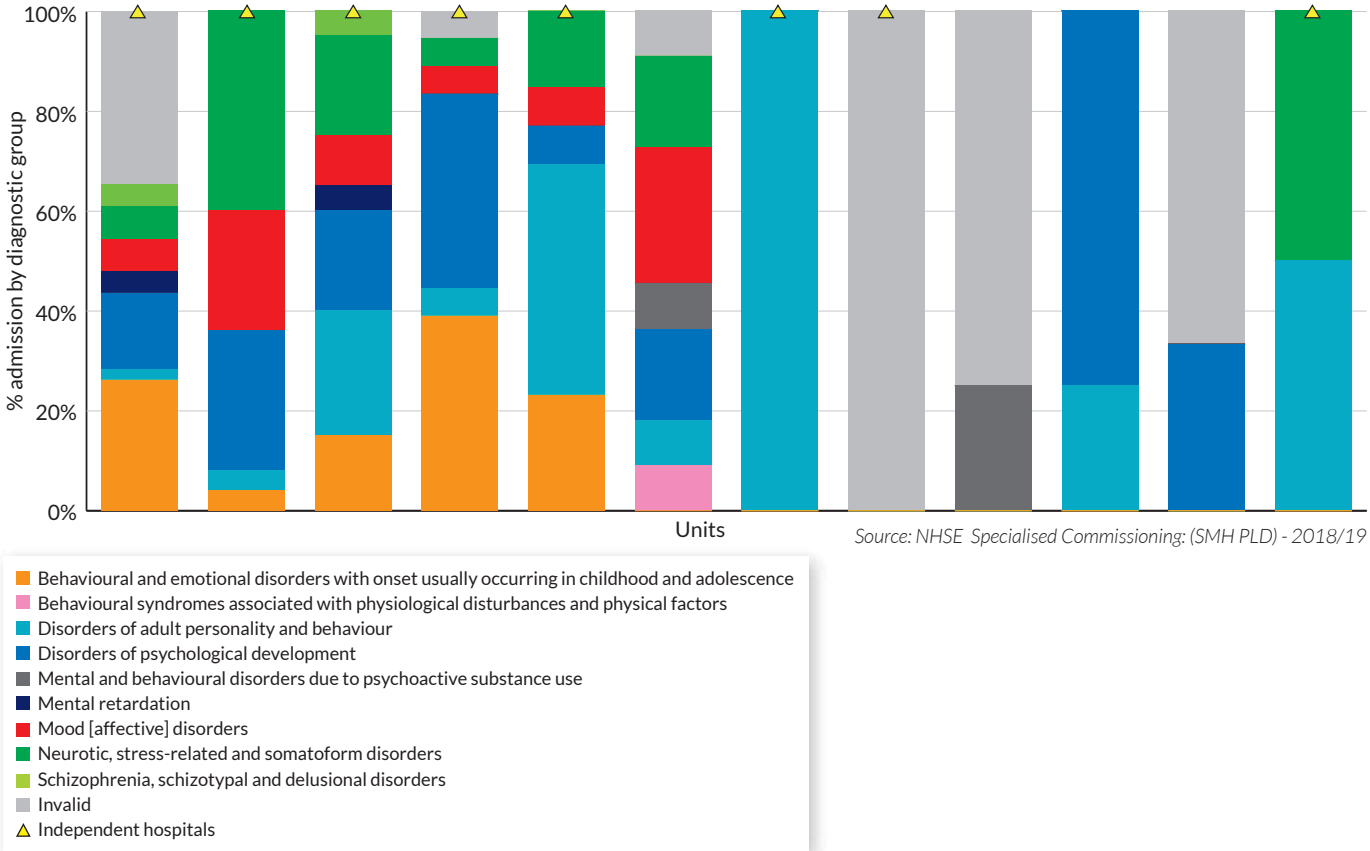
Recommendation

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
2. Within the secure and learning disability setting, the focus should be on a closer standardisation of the stratified LoS with a determination of best practice through national clinical forums. It is not appropriate to identify a target LoS as deep-dive visits did not allow the development of a clear clinical understanding of the factors driving LoS.	**a** National clinical forums to set a standardised expectation of stratified LoS. For this expectation to be incorporated into future service specifications.	Specialised Commissioning clinical reference group.	Clear national specifications and recommendations around expected percentage of patients discharged within stratified timescales.	For progress within 12 months of publication.
	b All NHS and IH providers to ensure that there are effective improvement plans in place to reach expectations of stratified LoS.	All providers.	Closer percentage of patients discharged within stratified timescales across all units	18 months.

It is important to recognise that within this recommendation, there is no assumption of an appropriate LoS. While within the PICU setting there should not be young people remaining on the unit for very long periods of time, this is not the case within the low secure or medium secure setting. LSUs, for example, provide longer-term therapeutic work for high risk young people which not only includes longer inpatient admissions but longer periods of leave working towards successful community discharge. Within medium secure units (MSU), the LoS may be set by a judicial process rather than clinical.

3: The diagnosis of admitted young people varies significantly from unit to unit

Figure 16: Low secure unit - admissions by ICD10 diagnostic chapter



Source: NHSE Specialised Commissioning: (SMH PLD) - 2018/19

While the finding within **Figure 16** is consistent across all units, it is less notable within the PICU setting and the poor data collection from the learning disability units means that comparison within those units is difficult. It is certain that this finding is a combination of poor recording of diagnosis, differences in approach to diagnostic criteria and challenges in flowing the data to the MHSDS.

Such variation was not expected within the MSU and LSU findings. For example, there was evidence of one unit having 100% of admissions with the same diagnosis. These units are all commissioned with the same service specification and no units have been commissioned for a single diagnosis. It is notable that we have been unable to undertake deep-dive visits to all units resulting in less clinical interpretation of the data. For example, the single diagnosis unit identified in **Figure 16** is a female only unit and there is a strong feeling it is more willing to diagnose personality disorder as a primary diagnosis than other units. The unit has a strong trauma-focused approach and reports very good outcomes. While the data suggests different units have different clinical approaches, it is not clear if, on a national level, the clinical needs of all young people requiring this level of inpatient care are being met. There is however also no evidence to suggest that the needs of these young people are not being met.

While the data suggests that some units have become specialised to manage a particular presentation, the outcomes or distance admitted from home for these units was not able to be compared with units without this level of specialisation. As such it is not possible to identify which is the best model for the inpatient units. However, as all units are commissioned to provide the same service it is imperative that there is a national approach to assuring units that have developed a speciality have the appropriate training and expertise to manage all young people who may be referred.

Recommendation

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
3. Commissioners and providers, including lead provider/s of an NHS-led provider collaborative supported by national clinical reference groups, to develop clear admission criteria for admitting young people to forensic and learning disability units. This admission criteria must take into consideration the specific expertise of the unit, the presenting condition of the young person, the present mix of young people in the unit and distance from home.	**a** National clinical forums to set a standardised expectation admission criteria. This expectation is to be incorporated into future service specifications.	Specialised Commissioning clinical reference group.	Clear national specifications and recommendations around expected percentage of patients discharged within stratified timescales.	For progress within 12 months of publication.

4: While data quality is poor there is clear variation in seclusion and other restrictive practices across the estate

Figure 17: Secure CAMHS - seclusion per 1,000 OBD

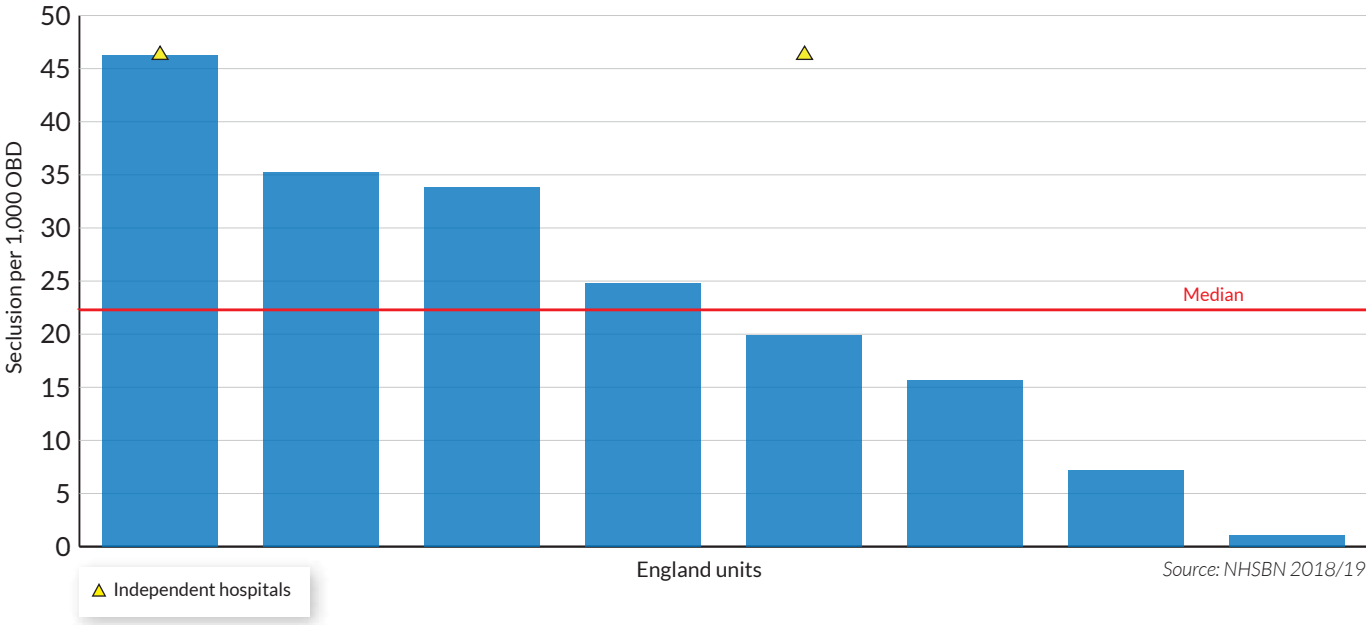


Figure 18: Secure CAMHS - restraint per 1,000 OBD

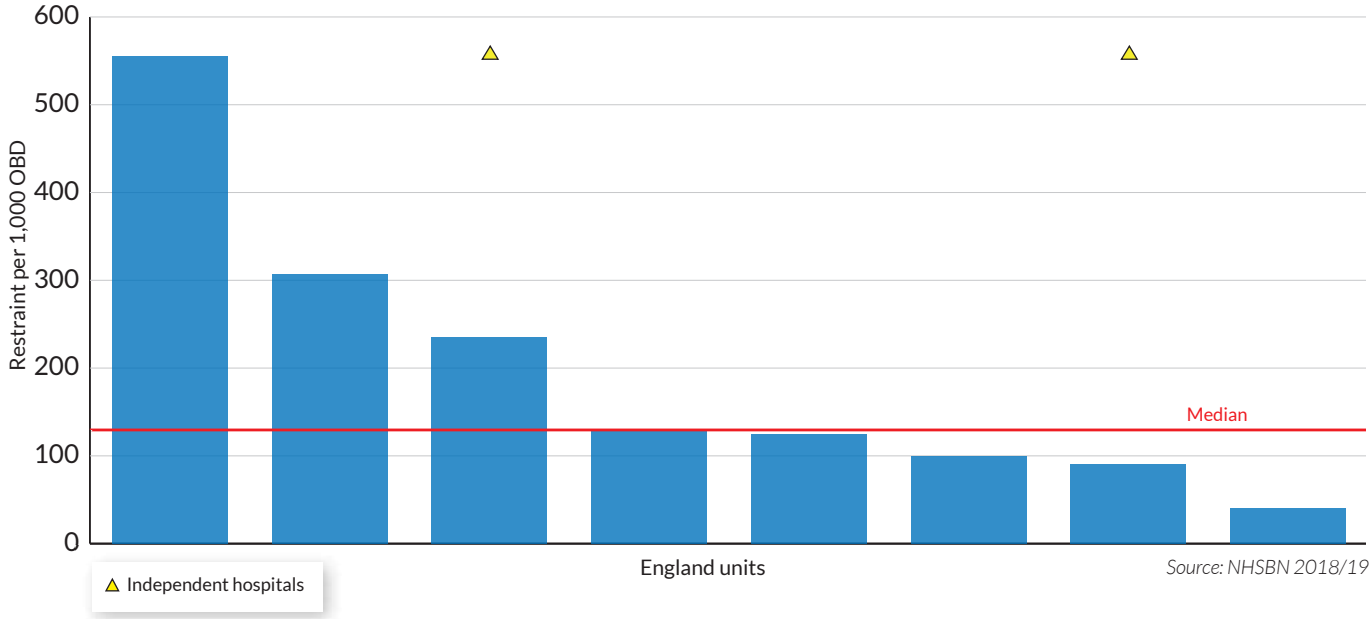
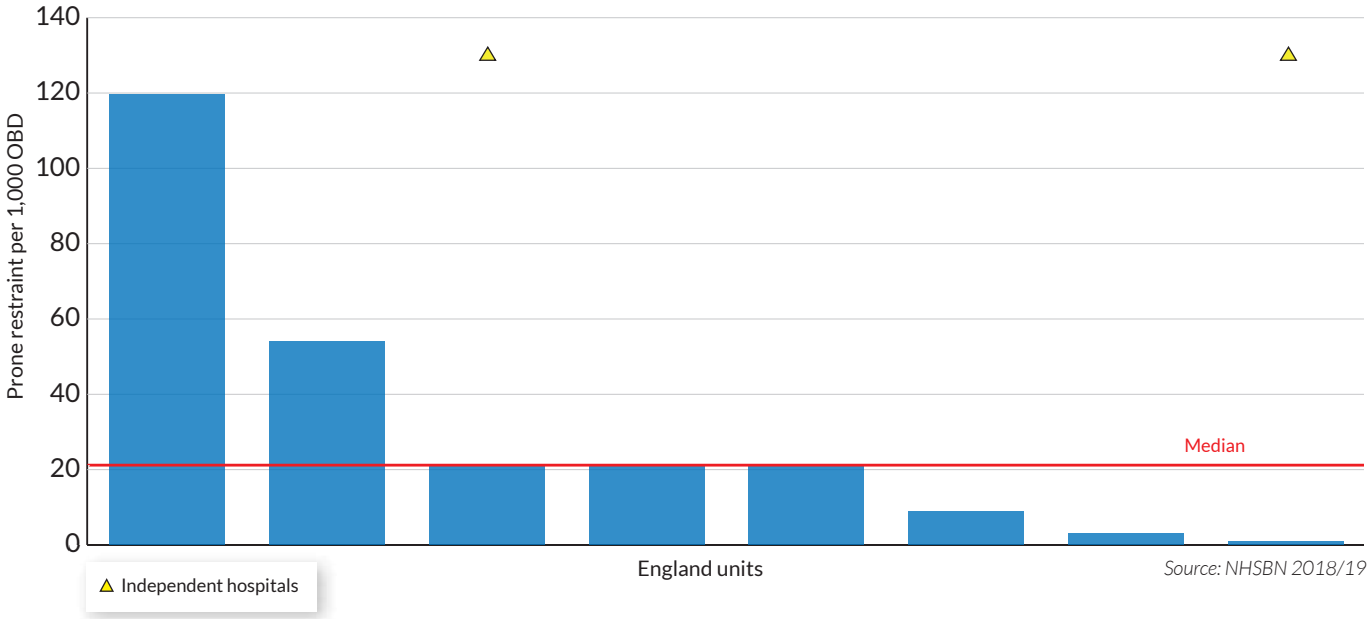


Figure 19: Secure CAMHS - prone restraint per 1,000 OBD



While the reporting of restrictive interventions has been a statutory responsibility as a consequence of the Use of Force Act 2019, we noted a large variation in the levels of reported restraint and seclusion – see **Figures 17-20**. While it is understandable that there are higher levels of restrictive interventions within the secure estate, the level of variation is extremely significant, indicating under reporting in some units and very worryingly high levels of restraint in others.

As per recommendation 1, all units must ensure high quality reporting of restrictive interventions.

Recommendation

Recommendation	Actions	Owners	How will we know an improvement has been made?	Timescale
4. All provider organisations must focus on reducing the incidence of restraint, prone restraint, and seclusion.	**a** NHS England NHS Improvement Medium Secure and Low Secure Networks should be encouraged to continue sharing best practice with monitoring of these metrics through the model mental health portal.	NHS England NHS Improvement Medium Secure and Low Secure Networks.	Consistent monitoring of these metrics through the Model Mental Health portal.	For progress within 12 months of publication.

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