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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Tuesday, 16th December, 2014 at 10.00 am

(A pre-meeting will take place for ALL Members of the Board at 9.30 a.m.)

MEMBERSHIP

Councillors

J Akhtar	-	Hyde Park and Woodhouse;
D Coupar (Chair)	-	Cross Gates and Whinmoor;
B Flynn	-	Adel and Wharfedale;
G Hussain	-	Roundhay;
G Latty	-	Guiseley and Rawdon;
S Lay	-	Otley and Yeadon;
J Lewis	-	Kippax and Methley;
K Maqsood	-	Gipton and Harehills;
E Taylor	-	Chapel Allerton;
S Varley	-	Morley South;
J Walker	-	Headingley;

Co-optees

Dr J Beal	-	HealthWatch Leeds

Please note: Certain or all items on this agenda may be recorded

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND THE PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified.**	

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3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 25 NOVEMBER 2014** To confirm as a correct record, the minutes of the meeting held on 25 November 2014.	1 - 6
7			**REQUEST FOR SCRUTINY** To receive a report from the Head of Scrutiny and Member Development introducing two Requests for Scrutiny.	7 - 12
8			**CHAIR'S UPDATE** To receive a report from the Head of Scrutiny and Member Development providing an update on some areas of work and activity of the Chair of the Scrutiny Board since the Scrutiny Board meeting in November 2014.	13 - 28

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9			**SCRUTINY INQUIRY: LEEDS' CHILD AND ADOLESCENT MENTAL HEALTH SERVICES AND TARGETED MENTAL HEALTH IN SCHOOLS** To receive a report from the Head of Scrutiny and Member Development introducing some additional information as part of the Board's inquiry into Leeds' Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health in Schools (TaMHS).	29 - 184
10			**WORK SCHEDULE** To consider the Scrutiny Board's work schedule for the 2014/15 municipal year.	185 - 188
11			**DATE AND TIME OF THE NEXT MEETING** Tuesday, 20 January 2014 at 10.00am in the Civic Hall, Leeds (Pre-meeting for all Board Members at 9.30am)	
			THIRD PARTY RECORDING Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

TUESDAY, 25TH NOVEMBER, 2014

PRESENT: Councillor D Coupar in the Chair

Councillors J Akhtar, B Flynn, G Hussain, G Latty, S Lay, J Lewis, K Maqsood, E Taylor, S Varley and J Walker

Non-voting co-opted member: J Beal (HealthWatch Leeds)

36 Chair's Opening Remarks

The Chair welcomed everyone to the November meeting of the Scrutiny Board (Health and Well-Being and Adult Social Care).

In particular, the Chair welcomed Councillor Graham Latty recently appointed by Council and a returning member to the Scrutiny Board.

37 Late Items

There were no late items; however members of the Scrutiny Board received the draft minutes from the Executive Board meeting, held 19 November 2014 (minute 43 refers). The draft minutes were referred to in the report but were not available at the time of publication.

38 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting. However, Councillor G Hussain drew the Board's attention to the fact that two close family members currently worked as General Practitioners (GPs) – with one working in the Leeds area. As this was not a pecuniary interest, Councillor G Hussain remained in the meeting for that part of the discussion (minute 42 refers).

39 Apologies for Absence and Notification of Substitutes

There were no apologies for absence and no substitute members were in attendance.

40 Minutes - 30 September and 28 October 2014

RESOLVED –

The minutes from the meeting held on 30 September 2014 were agreed as a correct record with no matters arising.

The minutes from the meeting held on 28 October 2014 were agreed as a correct record with no matters arising, subject to the following amendments:

Minute 32 – Leeds' Mental Health Framework

In relation to the supporting action plans requested, these should specifically reflect the requirements of the 'Closing the Gap' report (published in January 2014).

Minute 33 - Leeds' Child and Adolescent Mental Health Services and Targeted Mental Health in Schools

As part of the range of additional information to be made available and considered by the Scrutiny Board, this should specifically include details associated with current transitional arrangements between services for children and services for adults.

41 Chair's Update Report (November 2014)

The Head of Scrutiny and Member Development submitted a report that provided an outline of the Chair's activity since the Board's meeting in September 2014.

The Chair provided a verbal report at the meeting, drawing particular attention to the discussions / activity around the following matters:

- Provision of healthy food at Leeds' health care establishments and Leeds City Council's sports establishments.
- Muslim burials – release of deceased relatives.
- Work of the Joint Health Overview and Scrutiny Committee (JHOSC) for Yorkshire and the Humber.

Members discussed and commented on the information and update provided.

RESOLVED –

(a) To note the report and update provided at the meeting.
(b) To maintain an overview of the issues highlighted in the report and discussed at the meeting.

42 Primary Care Services in Leeds

The Head of Scrutiny and Member Development submitted a report introducing an overview of Primary Care Services in Leeds and on-going developments.

The following representatives were in attendance:

- Moira Dumma (Director – NHS England (West Yorkshire))

- Kathryn Hilliam (Head of Primary Care – NHS England (West Yorkshire))
- Nigel Gray (Chief Officer) – NHS Leeds North CCG
- Sue Robins (Director of Commissioning, Strategy and Performance) – NHS Leeds West CCG
- Matt Ward (Chief Operating Officer) – NHS Leeds South and East CCG

The Director of NHS England (West Yorkshire Area Team) gave a brief introduction to the report, which provided information on the following four areas:

- General Practice
- Dental Services
- Community Pharmacy
- Community Optometry

The Scrutiny Board agreed to consider the details of the report in line with the above four areas and a number of matters were raised and discussed. A summary of the issues discussed is set out below:

General Practice (GP)

- The overall strategy for GP services was around keeping and maintaining patients out of hospital care.
- There would be a return to more 'placed based commissioning' of services through co-commissioning arrangements between NHS England and Clinical Commissioning Groups (CCGs).
- The role of GP services in addressing health inequalities and general implications around equality and diversity.
- The use of local intelligence to inform service development and commissioning.
- Available models and proposals around co-commissioning, alongside related matters such as overall governance arrangements and issues around potential conflicts of interest.
- Issues around available GP appointments and access to services.
- The changing nature of GP services and the current pilot (with Leeds West CCG) looking at the availability and delivery of the range of services under the umbrella of General Practice.
- Challenges for GP services in general, but specifically in Leeds – including the current age profile and methods of operation.
- The collection and use of patient feedback and general involvement of patients in designing services.
- Governance and accountability arrangements, including the introduction of Care Quality Commission (CQC) inspections of GP services.

Dental Services

- Equality of access to dentistry services.
- Concerns regarding factual inaccuracies within the report presented and that oral health in Leeds was poor and not the best in Yorkshire and the Humber – as portrayed.
- It was important that the Health and Wellbeing Board (the body that had previously been provided with and considered the published report) was presented with an updated and accurate report regarding dentistry.
- Building capacity and methods for achieving this – including the links with appropriate training and development opportunities.

Community Pharmacy

- Clarification that with the abolition of Primary Care Trusts (PCTs) the commissioning of community pharmacy services had moved the NHS England through its network of Area Teams.
- The potential role of community pharmacies in building capacity across primary care, through extended roles and the delivery of different services.
- Workforce issues and the role of Health Education England associated with capacity building.
- The importance of providing the right physical environment when considering the delivery of extended services within a community pharmacy setting.

Community Optometry

- Opportunities for developing and delivering enhanced optometry services.
- The availability and access to audiology services.

As a matter of a general nature, assurance was sought that commissioners were ensuring Health and Wellbeing Board members were aware of any potential issues around access, quality and patient safety across the range of primary care services, particularly in those areas likely to be subject to CQC inspections and monitoring.

RESOLVED –

(a) To note the report and the information presented and discussed at the meeting.
(b) That the Health and Wellbeing Board be invited to receive and consider an updated and more accurate report regarding oral health and the provision of dentistry services across Leeds.
(c) To reflect on the issues discussed at the meeting when considering primary care at future meetings during the current municipal year.

On conclusion of the discussion, the Chair thanked those in attendance for their contribution to the discussion.

(Councillor James Lewis and Councillor Shirley Varley left the meeting at 10:45am and 12:10pm, respectively, during consideration of this item).

43 Work Schedule

The Head of Scrutiny and Member Development submitted a report setting out the progress and ongoing development of the Scrutiny Board's work schedule for the current municipal year.

Draft minutes from the Executive Board meeting held on 19 November 2014 were also presented, as agreed earlier in the meeting (minute 37 refers).

Members discussed the issues presented in the report and specifically considered the additional details around Primary Care Services the Board should consider later in the year. A number of matters were identified and discussed, including:

- The contribution of Primary Care in addressing health inequalities.
- More specific details of how Primary Care services are developing and being delivered locally, with specific examples where available.
- The provision of regular reports on the provision of Primary Care services and the involvement of providers/ practitioners at future Scrutiny Board meetings.
- The need for timely consideration of the regional Oral Health Needs Assessment and Leeds' developing Oral Health Strategy.

RESOLVED –

(a) To note the content of the report and its appendices.
(b) To amend the work schedule to reflect the issues raised and discussion at the meeting.

44 Date and Time of the Next Meeting

Tuesday, 16 December 2014 at 10:00am (with a pre-meeting for members of the Scrutiny Board from 9:30am).

(The meeting concluded at 12:20pm)

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 16 December 2014

Subject: Request for Scrutiny

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☒ Yes	☐ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. The following Requests for Scrutiny have been received for consideration by the Scrutiny Board:

    a. The potential risk to patients being created by the Board of the Yorkshire Ambulance Service NHS Trust.
    b. Use of the Council's resources in the delivery of a range of Adult Social Care services.

    <u>Yorkshire Ambulance Service NHS Trust (YAS)</u>

2. A letter from the Unite Union is presented at Appendix A. Following discussions with the Leader and Deputy Leader of Council, the Executive Member for Health and Wellbeing has refereed this matter to scrutiny for consideration.

3. Given the circular nature of the letter from Unite and to ensure a coordinated response (if appropriate), contact has been made with the scrutiny functions of other top tier local authorities where YAS currently delivers services.

4. In responding to this request, members might want to consider:

    a. Holding a dedicated (and possibly extra) Scrutiny Board meeting in January 2015.

b. Inviting a range of stakeholders to such a meeting, including Unite, YAS and Service Commissioners (including local Clinical Commissioning Groups (CCGs).
c. Requesting a report detailing the performance of YAS – covering Leeds and the Yorkshire region more generally.
d. Requesting details of any local Quality Assurance/ Surveillance meetings, alongside general performance management arrangements and any remedial actions agreed in recent months. .

Yorkshire Ambulance Service NHS Trust (YAS)

5. A Request for Scrutiny has been received from Mr. Andy Atkins regarding the delivery of a range of Adult Social Care services – specifically, Community Support Service, Skills Independent Living Service and Extra Care Housing.

6. Information relevant to and in support of this request has been obtained under the Freedom of Information Act. Details will be provided to members of the Scrutiny Board ahead of the meeting.

7. Mr Atkins has been invited to attend the Scrutiny Board meeting to present his request and provide any additional details as required.

Other considerations

8. The decision whether or not to further investigate matters raised by a request for scrutiny is the sole responsibility of the Scrutiny Board. As such, any decision in this regard is final and there is no right of appeal.

9. When considering the request for Scrutiny, the Scrutiny Board may wish to consider:

- If further information is required before considering whether further scrutiny should be undertaken;
- If a similar or related issue is already being examined by Scrutiny or has been considered by Scrutiny recently;
- If the matter raised is of sufficient significance and has the potential for scrutiny to produce realistic recommendations that could be implemented and lead to tangible improvements;
- The impact on the Board's current workload;
- The time available to undertake further scrutiny;
- The level of resources required to carry out further scrutiny;
- Whether an Inquiry should be undertaken.

Recommendations

10. The Scrutiny Board is asked to:

(i) Consider the Requests for Scrutiny;
(ii) Determine if the Scrutiny Board wishes to undertake further scrutiny on the matters raised; and
(iii) Agree any next steps.

Background papers[1]

11. None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Unite the Union
128 Theobalds Road
London WC1X 8TN

Tel: 020 7611 2500
Fax: 020 7611 2555

CENTRAL OFFICE

2nd December 2014

I am writing to you as General Secretary of Britain and Ireland's largest trade union, Unite.

Regrettably I have to inform you of the potential risk to patients being created by the Board of the Yorkshire Ambulance Service Trust.

Unite members, paramedics on the frontline of service delivery, have exposed:

- Failure to meet national targets for emergency response
- Changes to the manning of ambulances that will put lives at risk
- Proposed cuts to the ambulance fleet despite rising demand
- Alleged manipulation of call-out data to meet targets

As a result of the failure of the YAS Board to heed the warnings of frontline staff and my members' unwillingness to be silenced on issues of patient safety, YAS has attempted to gag my Union by withdrawing our right to be consulted and disciplining Unite representatives on alleged 'trumped-up' charges.

As a key stakeholder with a responsibility to the public and in view of the Trust's imminent final application for Foundation Trust status, I am requesting your agreement for an urgent meeting with my Union to discuss the issues in more detail and to see how we can work together in the best interests of patient safety.

Can you contact my office (Lynne Goodwin: email lynne.goodwin@unitetheunion.org, Tel: 020 7611 2592) as soon as possible.

Yours sincerely,

Len McCluskey

Len McCluskey
General Secretary

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Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 16 December 2014

Subject: Chairs Update Report – December 2014

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to outline some of the areas of work and activity of the Chair of the Scrutiny Board since the Scrutiny Board meeting in November 2014.

2 Main issues

2.1 Invariably, scrutiny activity often takes place outside of the formal monthly Scrutiny Board meetings. Such activity can take the form of working groups (as detailed in the work schedule report, elsewhere on the agenda), but can also take the form of specific activity and actions of the Chair of the Scrutiny Board.

2.2 The purpose of this report is to provide an opportunity to formally update the Scrutiny Board on activity since the last meeting, including any specific outcomes. It also provides an opportunity for members of the Scrutiny Board to identify and agree any further scrutiny activity that may be necessary.

2.3 Since the last Scrutiny Board meeting, the Chair and Principal Scrutiny Adviser have been involved in a series of meetings and/or discussions covering a wide range of issues/ areas, including:

- Provision of healthy food at Leeds' health care establishments and Leeds City Council's sports establishments (written responses attached at Appendix 1).
- Work of the Joint Health Overview and Scrutiny Committee (JHOSC) for Yorkshire and the Humber. The formal submission in response the public consultation around the new congenital heart disease review is attached at Appendix 2.

- Ongoing discussions regarding links between Housing Leeds and Leeds Local Medical Committee (LMC);
- Ongoing liaison with HealthWatch Leeds

2.4 Members' attention is drawn to the response from Leisure Services regarding the provision of healthy food at sports centres. This reflects the approach taken by the service, but does not represent or form any council policy statement: rather it provides a practical approach given the environment in which the service operates.

2.5 The Chair and Principal Scrutiny Adviser will provide a verbal update at the Scrutiny Board meeting, as required.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and the verbal update provided at the meeting.
b) Identify any specific matters that may require further scrutiny input/ activity.

4. Background papers[1]

4.1 None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Position Statement in relation to the availability and provision of healthy food options at health care establishments across the City, November 2014.

The Director of Public Health and colleagues have addressed the above matter with Brian Young, Head of Facilities (Contracts) at Leeds Teaching Hospitals Trust (LTH).

The sale of food and drink is an important issue for LTH and they work closely with their retailers to take positive steps to ensure their hospitals provide a wide range of products, including healthier options for their patients, visitors and staff.

Some examples of the progress made by LTH include:

- Fresh fruit is included in the 'meal deal'
- Fruit and water is included in the 'up-sale league table'
- Bottled water is provided at a lower cost than all sugary drinks
- Water remains the most popular drink choice within their hospitals.

Leeds Teaching Hospitals Trust is constantly reviewing opportunities to reduce the range of sugary drinks and snacks and this forms part of all tendering processes. Recent tender specifications for retail catering and vending contracts include the following stipulations to prospective contractors:

"Services proposed for the retail outlets and restaurants must match the customer's expectations of a consistently varied, balanced, healthy, nutritious and attractive offer."

"Enhancing the impulse purchase experience of our patients, staff and visitors is extremely important to the Trust and as such the offer needs to fit in with our health and wellbeing strategy. We aim to provide the customers affordable branded healthy options for them to choose, that they recognise and enjoy".

Public Health is a priority for LTH which is working closely with Public Health to encourage staff, visitors and patients to make healthy choices which are right for each stage of life and are supported by campaigns such as Smart Swaps and Nutrition and Hydration Week. A new Public Health Strategy for the LTH has been developed which includes actions to address obesity. The LTH Public Health Strategy will be raised at the next Health & Wellbeing Board.

As Leeds hospital premises also include those provided by Leeds and York Partnership NHS Foundation Trust (LYPFT), The Director of Public Health and colleagues have discussed the matter with Helen Wiseman (Strategic Lead for Allied Health Professionals) at LYPFT.

LYPFT provides services from a number of premises through the Leeds area, the main inpatient services are delivered from PFI estate. Two of these locations have café facilities within them, but these have been closed for some time. LYPFT and their PFI partners are currently working with a social enterprise organisation to re-open these facilities. LYPFT are working closely with the social enterprise to provide a wide range of products, including healthier options. All of this includes the

promotion and availability of healthy choice sandwiches and meals, and an alternative snack and beverage range to the traditional ‘sugary’ options.
Staff catering outlets and vending machines operated by LYPFT and PFI operators all offer fruit, fruit juices, bottled water, ‘healthy food ranges,’ and alternative snack options with price ranges that ‘favour’ these options. LYPFT and its partners constantly review product ranges and work closely with dieticians to ensure a good balance of health products are available for our outlets.

Position Statement in relation to the provision of food and drinks in Leeds City Council Leisure Centres November 2014.

The sale of food and beverage is an important part of the effective and efficient operation of Sport and Active Lifestyles Service. The service works closely with its suppliers to take appropriate positive steps to ensure that the food and drink options supplied to customers and staff are diverse and reflect the needs of those engaging in physical activity during their leisure time.

The service works in partnership with two catering operations that delivers a café function at four of the services leisure centres. The operators provide a range of food and drink options including those that would be considered `healthy. ` The operators work closely with their customers to ensure that their range of product and the prices charged are appropriate to support a sustainable business and livelihood for the operators all of which are local Leeds based organisations. This included the development of a range of healthy menu choices at Holt Park Active with colleagues from Adult Social Care.

In addition the service provides its own in house café / catering function at the John Charles Centre for sport, adopting the same principles as those outlined above. The range of meal choice is significant and includes by way of example; fruit, freshly prepared meals, freshly prepared sandwiches and wraps, low sugar drinks and water.

To compliment this provision, the service also operates a full range of vending solutions across its estate of leisure centres. This operation uses suppliers who have been formally procured through the Leeds City Council procurement pathway to provide a range of vending products. This contract is currently out to tender and it is our intention to work with the new supplier to further develop wherever reasonably practicable the range and quality of the products offered to our customers.

In addition the network of leisure centres across the city support a range of communication initiative's to reinforce public health messages. This has included for example the smart swaps healthy eating campaign as well as information relating to smoking cessation. Using the centres as a marketing collateral tool is something that the service will look to expand through the development of the Leeds Let's Get Active project in addition to closer working with colleagues in public health.

The service is keen to develop the supply of food and beverage to customers through the network of cafes and vending solutions. Our approach is very much to develop our offer so that it is attractive to customers as well as supporting a sustainable and efficient business model for both the operators and the wider Sport and Active Lifestyle Service.

APPENDIX 1

APPENDIX 2

The new review of Congenital Heart Disease (CHD) in England

Consultation response

Introduction

The purpose of this paper is to set out the views of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the proposed Congenital Heart Disease (CHD) Standards and Service Specification, launched for public consultation by NHS England on 15 September 2014.

This response sets out the main observations of the joint committee following a series of meetings, discussions with key stakeholders (including commissioners, service providers and patient representatives) and consideration of a range of information.

Background

The Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – the JHOSC – is a single representative body for the 15 top-tier local authorities across Yorkshire and the Humber. The JHOSC was initially established (in March 2011) to consider the Safe and Sustainable Review of Children's Congenital Cardiac Services in England, the associated proposals and respond to the options presented for public consultation.

The JHOSC previously produced two reports in relation to the Safe and Sustainable Review of Children's Congenital Cardiac Services in England. The first, published in October 2011, was submitted as a formal response to the options presented for public consultation. The second report, published in November 2012, formed the basis of a formal referral to the Secretary of State for Health following a decision on the proposed future model of care and designation of surgical centres in July 2012.

The work, reports and findings of the JHOSC were fundamental to the findings and recommendations of the Independent Reconfiguration Panel (IRP) report (passed to the Secretary of State for Health in April 2013) and subsequently the Secretary of State's decision to halt the Safe and Sustainable Review.

A number of issues raised by the JHOSC's reports remain relevant to the new CHD review and warrant further consideration by NHS England, particularly in relation to the following areas:

- Co-location of services;
- Caseloads;
- Population density;
- Vulnerable groups;
- Travel and access to services;
- The impact on children, families and friends;
- Established congenital cardiac networks; and,
- Adults with congenital cardiac disease.

Specifically, the JHOSC would not wish to see any dilution of the standards around co-location and recognition that the 'gold standard' remains physical co-location on a single site.

The JHOSC's previous reports are available using the following links: October 2011 and November 2012 (and appendices).

Main Observations

Overview

The following details outline the JHOSC's main observations, following a series of meetings, discussions with key stakeholders (including commissioners, service providers and patient representatives) and consideration of a range of information.

To help inform its view of the proposed standards, the JHOSC sought a range of different inputs. Specifically, it had hoped to consider a detailed gap analysis from Leeds Teaching Hospitals NHS Trust – detailing the Trust's level of compliance with the proposed standards and some analysis of the actions required to attain any unmet standards. Despite receiving assurances from the Trust that there was currently a high degree of compliance with the proposed standards, the JHOSC was disappointed that the detailed gap analysis was not available prior to the deadline for consultation responses.

The JHOSC was interested to understand the timescales and implications associated with implementing the agreed standards. When attending the JHOSC meeting, representatives from NHS England described the derogation process – whereby there would be an agreed temporary delay in meeting key service requirements in full, supported by full implementation over a time limited period according to provider capacity and capability. The JHOSC was concerned about the transparency of this process and is keen to ensure it was not used as a mechanism to circumnavigate consultation about potential service reconfiguration in the future.

In early October 2014, NHS England published its commissioning intentions for Specialised Services – which includes some specific comments on CHD services. This presented the clearest information thus far – stating that the form and function of CHD services will be considered over 12 months – commencing in March/ April 2015. Clearly this has implications for the on-going work of the JHOSC and it is important that NHS England fulfils its statutory duty by maintaining a dialogue with the JHOSC as work progresses.

The JHOSC identified a number of specific areas it wished to comment on. These are detailed below.

Stakeholder involvement

In considering stakeholder engagement, it is important to consider and reflect on the following extracts from the report of the Independent Reconfiguration Panel (IRP).

> ***'NHS England must ensure that any process leading to the final decision on these services properly involves all stakeholders throughout in the necessary work, reflecting their priorities and feedback in designing a comprehensive model of care to be implemented and the consequent service changes required.'***
>
> ***'NHS England should use the lessons from this*** **[Safe and Sustainable]** ***review and create with its partners a more resource and time effective process for achieving genuine involvement and engagement in its commissioning of specialist services.'***

Regrettably, the JHOSC believes that NHS England fallen short on some aspects of the IRP recommendations – particularly in relation to the involvement, engagement and consultation with Black and Minority Ethnic (BME) communities.

The JHOSC expressed concern regarding NHS England's decision not to translate its consultation documents into other languages (other than Welsh). This led to a rapid re-think and some translation of the consultation booklet took place. However, in this regard, the JHOSC believes the new CHD review has repeated some of the well documented failings of the previous Safe and Sustainable review.

The JHOSC has significant concerns more generally regarding the involvement and engagement of Black and Minority Ethnic (BME) communities – in particular Pakistani and South Asian communities, where the prevalence of CHD is known to be proportionally higher than in other communities. Regardless of the approach around translating consultation documents, as 'known' service users, the JHOSC believes NHS England should have had more general regard for the active involvement and engagement of BME communities (as part of the established sub-group structure) throughout the development of proposed service standards and the new CHD process in general.

There was also concern regarding the ownership of the consultation process, with NHS England seemingly leaving the local charity to organise local events across the region. With limited notification around the commencement of the 12-week consultation period, this provided very limited opportunity in terms of planning and delivering such events. It is likely this was replicated elsewhere in England.

The JHOSC was also concerned to hear that Embrace (the regional, dedicated neonatal and paediatric transport service) had not been asked to participate in any specific groups or workstreams of the new CHD review. Again, the JHOSC does not believe this adequately reflects the recommendations of the IRP.

Implications of the proposed standards

In terms of implications of the proposed standards, the JHOSC believes the following extract from the IRP's report is an important consideration:

> ***'…the Panel has concluded the JCPCT's decision to implement option B (DMBC – Recommendation 17) was based on flawed analysis of incomplete proposals and their health impact, leaving too many questions about sustainability unanswered and to be dealt with as implementation risks.'***

The JHOSC believes that in considering the proposed standards, it is equally important to consider the likely impact and implications of implementing and achieving those standards: It is difficult to whole-heartedly support proposals when the potential impact remains unclear and uncertain.

The JHOSC heard that, from a patient transport perspective, the proposed specifications and standards do not raise any issues and that the patient transport provider currently meets the service specification and standards (as drafted). However, the JHOSC was also advised that a re-assessment against the standards would be required should there be any changes to the current configuration and provision of services across Yorkshire and the Humber. This supports the JHOSC's view that while the majority of proposed standards might be seen as helping achieve

the aims of the review, it is equally important to consider any impacts associated with implementation before unreservedly endorsing any proposals.

The JHOSC also heard and supports the view that there is insufficient evidence that outcomes will improve with surgical centres undertaking 400 – 500 procedures per annum. This issue was also discussed in the IRP report. The JHOSC is concerned that standards relating to minimum levels of procedures and/or surgeons will lead to closure of some existing centres sometime in the relatively near future. However, with the current rate of increase in the population of adult patients with congenital heart disease (due to better survival rates etc.), there is concern that any closure of surgical centres in the short-term would most likely lead to problems with national capacity in the longer-term. This supports and reinforces the JHOSCs previous view that surgical centres in both Leeds and Newcastle should be retained in order to meet the needs of a growing cohort of service users.

In relation to the discussions on derogation, there appeared to be some confusion – and certainly a lack of clarity – about how this might be applied to the implementation of the agreed standards. For example, the standard relating to the number of surgeons required at a surgical centre was identified as an 'immediate standard', whereas evidence from Leeds Teaching Hospitals NHS Trust suggested there would be a 3-year window to recruit a fourth surgeon.

There has been considerable debate regarding the number of surgeons necessary for a sustainable surgical centre. This debate has continued from the previous Safe and Sustainable Review through to the new CHD review. While it could be argued that a minimum of four surgeons might be preferable, there seems to be little evidence to support this as a fundamental requirement. Furthermore, the JHOSC heard the availability of specialist cardiac surgeons remained a national issue and had been adversely affected by the Safe and Sustainable Review. The JHOSC seriously questions whether four surgeons per surgical centre is realistic and achievable, and believes this is likely to be a key issue during the implementation phase of the review and beyond. In light of this remaining an issue for some considerable time, the JHOSC's view is that the standards should require a minimum of three surgeons per surgical centre.

The JHOSC also has some general concerns regarding those standards relating to staffing and particular roles – specifically where providers are not able to directly control the availability of suitably qualified staff. There is clearly likely to be a time lag between individuals undertaking the necessary training and being able to work within a clinical environment.

Finance and affordability

In considering finance and affordability, the JHOSC again reflected on elements from the IRP report and recommendations – as follows:

> ***'For the current service and any proposed options for change, the function, form, activities and location of specialist surgical centres, children's cardiology centres, district children's cardiology services, outreach clinics and retrieval services must be modelled and affordability retested.'***

The JHOSC is concerned at the level of available detail and the robustness of financial modelling undertaken prior to consultation. The JHOSC heard from NHS England that

there was no funding identified to assist with the implementation of the proposed standards. Indeed, NHS England's financial assessment concludes that any additional costs associated with providers implementing the new standards should be met through the national tariff – with greater income generated through increased activity, rather than an increase in the rate of tariff. It is suggested that the national tariff includes an element for investment, which is reinforced in Part 4 of the consultation document (pages 50-52).

This raised a number of specific issues and concerns for the JHOSC, as follows:

(a) The evidence from NHS England appears to be odds with feedback from other stakeholders. The JHOSC heard from the Chief Executive of Leeds Teaching Hospitals NHS Trust, who stated that the availability of resources was an important issue and some of the draft standards required significant investment. It was anticipated this would necessitate discussions with commissioners about any necessary additional investment (a particular example raised was around funding for a hybrid theatre). As such, much greater clarity is needed around the financial impact and affordability of the standards, and specifically how additional costs will be met.

(b) The JHOSC has previously considered the historical levels of funding/ investment for specialised services across England. This showed that historical funding across Yorkshire and the Humber was relatively low in comparison to most other areas of the country. The legacy of such historical spending patterns is likely to have led to a lower level of investment in specific areas across service providers. As such, there is likely to be different affordability gaps across different providers. The JHOSC understands that similar concerns were raised in the joint network meeting (summarised in Appendix 2). This further supports the need for greater clarity around the financial impact and affordability of the standards, and how additional costs will be met.

(c) Another specific consideration regarding affordability relates to the ability of individual providers to generate (or borrow) capital for investment. This ability can also be directly influenced by the 'Foundation Trust (FT) status' of individual providers. Additional freedoms and flexibilities around resources are often cited as significant benefit of FT status. Therefore, the financial implications of meeting the proposed standards are likely to be directly influenced by the FT status of individual providers. The JHOSC believes that NHS England (as the service commissioner) has a duty to consider the needs of the population – first and foremost – and this again supports the need for greater clarity around the financial impact and affordability of the standards.

The JHOSC was also advised that resource issues had been highlighted at the Providers Group meetings and were an issue across different units. It was also stated that the financial modelling was unclear. It is clearly important that NHS England clarifies issues associated with resources and implementation.

Networks

The importance and strength of network arrangements is a key feature of the new CHD review – as it was under the previous Safe and Sustainable review. In its previous reports, the JHOSC was pleased to be able to highlight the strength of the network across Yorkshire and the Humber. However, the JHOSC was disappointed to learn that since NHS England formed in April 2013, the dedicated managerial support for the network ceased to exist. The JHOSC understands the network had previously

been funded by a collaborative funding arrangement between Primary Care Trusts (PCTs) across Yorkshire and the Humber. This is particularly disappointing given the following comments and observations in the IRP report:

> ***'…the establishment of a formal network board would be the driver for developing the congenital heart network in the north of England and that clinical colleagues from the existing Yorkshire and Humber network would be key to its development.'***

The JHOSC recognised that the previous Safe and sustainable Review had created tensions between existing surgical centres. In the North of England, despite the suggestions that relationships were improving, the JHOSC believes tensions between Leeds and Newcastle remain. Relationships have certainly not been helped by the on-going and protracted review of services at Leeds Teaching Hospitals NHS Trust, following the temporary suspension of services in March/ April 2013. While that review has now been concluded, repairing the damaged relationship between Leeds and Newcastle is likely to take some considerable time. This is particularly pertinent when considering the central role of networks – particularly in terms of the development of a network of surgical centres.

It should be noted that the JHOSC has maintained an overview of the review of services at Leeds Teaching Hospitals NHS Trust, following the temporary suspension of services in March/ April 2013. The JHOSC aims to produce a report setting out its observations of the process and any recommendations for improvement in early 2015.

Additional information

Some specific information provided to the JHOSC is attached at Appendix 1 (Feedback from a joint network meeting) and Appendix 2 (Feedback from local engagement events organised by Children's Heart Surgery Fund (CHSF)). While it is envisaged this feedback will be provided directly as part of other consultation responses, it is attached and repeated here for completeness.

Summary

In general, the JHOSC recognises and welcomes NHS England's more open and transparent approach in relation to the new CHD review. However, a number of concerns remain (as detailed above) and it is hoped these will be taken into account and addressed as the review moves forward.

In early October 2014, NHS England published its commissioning intentions for Specialised Services. This included some specific comments around CHD services – stating that the form and function of CHD services will be considered over 12 months – commencing in March/ April 2015. Clearly this has implications for the on-going work of the JHOSC and it is important that NHS England fulfils its statutory duty by maintaining a dialogue with the JHOSC as work progresses.

The JHOSC will consider whether it wishes NHS England to provide a specific response to the issues identified in this paper.

Cllr Debra Coupar (Chair)
Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)

Report to the Joint Health Overview and Scrutiny Committee (JHOSC) for Yorkshire and the Humber – 28 November 2014

Feedback from a joint network meeting

At the JHOSC meeting on 3 November 2014, members heard that a clinical network meeting was due to consider the proposed service specifications and draft standards at a meeting on 10 November 2014.

It should be noted that minutes from the network meeting are not routinely taken, as they tend to be more educational type meetings with presentations and discussion. It should also be noted that, prior to the NHS England being founded in April 2013, a formal network board existed and was supported through a collective of Yorkshire and Humber Primary Care Trusts.

The Network meeting was joint meeting between the Leeds Network and the Leicester Network. The Trusts represented at the meeting included:

- LTHT
- Leicester University Hospital Trust
- Nottingham Children's Hospital
- Sheffield Children's Hospital
- York Hospital
- Chesterfield District General Hospital
- Hull Hospital

Based on feedback from Leeds Teaching Hospitals NHS Trust's lead cardiologist, Dr Elspeth Brown, the points below set out the main areas of discussion/ outcomes from that meeting:

- Generally it was felt the standards were sensible and described a good service.

- There were concerns that there is no evidence for 400 or 500 cases per centre (as discussed in the IRP report) and this standard would at present lead to centres having to close. There was concern that with the current rate of increase in the population of adult patients with congenital heart disease (due to better survival) closure of centres now would lead to problems with national capacity in the future.

- The new standards define a network structure with a network manager and administrative support. The description of the network represents an Operational Delivery Network and it should be funded as such.

- Historical funding for specialised services was discussed and it was felt that historic differences in funding should be recognised as part of any implementation.

Report to the Joint Health Overview and Scrutiny Committee (JHOSC) for Yorkshire and the Humber – 28 November 2014

Feedback from local engagement events organised by Children's Heart Surgery Fund (CHSF)

The most discussed issues so far have concerned **staffing and skills**, **the network approach**, **transition**, **communication with parents**, and **fetal diagnosis**.

These subjects seemed to prompt many personal stories, mostly being around the lack of understanding at regional hospitals. Nearly all patients said once they arrive at Leeds they were dealt with professionally and appropriately. In contrast, they felt very vulnerable at local centres due to lack of cardiac knowledge. Parents also expressed concern about referral times.

Parents said they wanted an instant referral, stating 3-7 days was too long as the bad news is hard enough to bare and not knowing the severity of the unborn baby's condition is deeply distressing from the point of knowing there is a problem.

Transition

This is a real issue for patients. Attendees have stated they felt the leap from children's services at the young age of 16 to the adult service is a leap too far.

To be put on a ward with patients who are non-congenital and a lot older than them, they felt was not only inappropriate, but also depressing.

The Network Approach

Families were quite keen to ask for re-assurance regarding the current support they receive whereby the Leeds staff visit them in the peripheral clinics for follow up appointments.

Families have spoken about how they have valued this service and would hope it would continue as Leeds for some people is just too far.

Staffing and Skills

We also received a considerable amount of questioning about the need for **4** surgeons performing 125 operations.

Some parents felt the most important issue was a surgeon's capabilities and most people seemed to think performing a reasonable amount of surgery with varied case mix was more important than the stipulated 125 number of procedures.

Many of the attendees at the Leeds meeting had done some fact finding and were quite clued up on the fact surgeons in other countries perform fewer operations, yet have very good outcomes.

People also commented on the fact we don't have an abundance of heart surgeons in this country therefore this standard is a hard one to reach considering the lack of available surgeons in this field of medicine.

Fetal Diagnosis.

This is the point where people are genuinely traumatised and had very vivid memories about the way they were treated. In fact many of the attendees talked about the 'post trauma' they felt once there child's condition had been stabilised through an operation or some sort of intervention.

Lots of people talked about the need for training in this area, and how surprised they were that this has not been readily available in some centres.

They also welcomed the use of pulse oximetry which is being trialled at the moment.

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Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-being and Adult Social Care)

Date: 16 December 2014

Subject: Scrutiny Inquiry: Leeds' Child and Adolescent Mental Health Services and Targeted Mental Health in Schools

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. In July 2014, the Scrutiny Board identified Mental Health Services (and in particular Child and Adolescent Mental Health Services (CAMHS)) as areas for more detailed consideration by the Scrutiny Board.

2. In September 2014, the Scrutiny Board considered a range of initial information, including:

   (a) An overview of Leeds' mental health strategy / framework; and,

   (b) A summary paper in relation to Leeds' Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health in Schools (TaMHS).

3. At that meeting, members identified a range of additional information for more detailed consideration, including:

   - Performance data in relation to access, waiting times and outcomes.
   - Information around demand for services and current capacity.
   - A copy of the full report recently presented to the Integrated Commissioning Executive (ICE).
   - Information regarding the consistency of TaMHS provision across the City
   - Relevant details from the School Clusters enquiry report produced by the Scrutiny Board (Children and Families)
   - A clearer overall spending/ funding analysis for CAMHS and TaMHS services across the City, including the different tiers of provision.

4. The purpose of this paper is to introduce and present a range of additional information, including some of the details identified above.

5. The following details are attached to this report:

    - Child and Adolescent Mental Health Services Tier 4 Report – NHS England (July 2014)
    - Briefing note on the above Tier 4 Report – NHS England (September 2014)
    - TaMHS Expansion Evaluation (2011 – 2013) – Leeds City Council (January 2014)

6. Additional information may also be provided prior to the meeting and suitable representatives have been invited to attend the meeting to discuss matters in more detail.

Recommendations

7. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to:
    a. Consider the information presented and identify any specific matters that require more detailed consideration and/or any further scrutiny activity.
    b. Identify any specific matters/ areas for improvement for inclusion within its final inquiry repot.
    c. Consider and agree its next steps as part of this Scrutiny Inquiry.

Background papers[1]

8. None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report

NHS England INFORMATION READER BOX		
Directorate		
Medical	**Operations**	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**01891**
Document Name	Child and Adolescent Mental Health Services Tier 4 Report
Author	CAMHS Tier 4 Report Steering Group
Publication Date	10 July 2014
Target Audience	CCG Clinical Leads, CCG Accountable Officers, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, NHS England Regional Directors, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's Services, NHS Trust CEs
Other	Voluntary and Independent sectors, MPs, Children and Young Peoples Groups, Royal Colleges, Health Education England, Department of Health
Additional Circulation List	
Description	This is the Report for the Specialised Commissioning Oversight Group who in September 2013 commissioned an urgent stocktake of CAMHS Tier 4 inpatient services to map current service provision; consider any issues which had arisen since April 2013 when NHS England had assumed responsibility for commissioning these services. The remit included identifying specific opportunities for improvement through the national commissioning of these services after a number of concerns about Tier 4 CAMHS inpatient services had emerged in the first 6 months of national commissioning.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Kath Murphy c/o Vicky Hine, Business Manager, Direct Commissioning Area 6 D, 6th Floor, Skipton House 80 London Road, London SE1 6LH 1138248079

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Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report

First published: July 2014

Prepared by: CAMHS Tier 4 Steering Group

Contents

1 Acknowledgements

The steering group Chairs would like to acknowledge the following contributors to the report who have provided input, most often in addition to their existing clinical workloads:

Tier 4 CAMHS Clinical Reference Group (CRG) members, individually and collectively, who have conducted the background research, consulted with colleagues and developed the report's recommendations on advice about the care pathway;
Dr Margaret Murphy, Tier 4 CAMHS CRG chair, for coordinating the CRG content of the report, and for her support in aligning this with survey feedback and existing research evidence;
Dr Michaela Swayles for her contribution to the development of the guidance on self-harm and suicidal ideation;
Dr Dickon Bevington, Professor Peter Fonagy and colleagues for permission to cite their review;
The Royal College of Psychiatrists for access to the QNIC network of members and use of their standards as framework for advice; Peter Thompson and Jessica Redman in CCQI for coordination and analysis of the surveys;
Respondents to the survey (both commissioners and providers) who provided detailed information within a very tight timeframe;
NHS Benchmarking Network for permission to reproduce extracts of their findings from the CAMHS benchmark review, 2013.

Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it."

2 Background to this report

2.1 Introduction

Child and Adolescent Mental Health Services Tier 4 (CAMHS Tier 4) are a specialised service commissioned by NHS England since April 2013. This is the first time that all elements of CAMHS inpatient services have been commissioned nationally providing an opportunity to implement standards consistently across the country.

The purpose of this report is to outline the findings of an important but very much first stage review to assess and understand the current CAMHS Tier 4 services with a particular focus on a factual assessment of current provision and commissioning issues.

This initial piece of work was designed to map current service provision, to consider issues that had arisen since April 2013 and to identify specific improvements that are required as an immediate and urgent priority through national commissioning.

It was not intended to be a comprehensive review, but would make recommendations for areas of further work to be developed and carried out with the full involvement of children, young people, their families and carers, clinicians, the wider CAMHS community and other commissioners including local authorities.

2.2 Background to the report

Every Child Matters (2003), and the National Service Framework for Children, Young People and Maternity services (2004), using the four tier strategic framework for child and adolescent mental health services (CAMHS), defines what is required to ensure children and young people receive comprehensive care. This includes the provision of effective early help services which may prevent problems escalating to the point where admission to hospital becomes necessary.

Since April 2013 NHS England has been responsible for commissioning CAMHS Tier 4 services and clinical commissioning groups (CCGs) are responsible for ensuring a robust infrastructure is in place at tiers 2 & 3, including the provision of effective early help services which can prevent problems escalating to the point where admission to hospital becomes necessary.

During the first six months of the new arrangements, a number of concerns around CAMHS Tier 4 inpatient services emerged:

- Quality concerns about a small number of services;
- Closure to admissions impacting upon capacity (closure sometimes due to staffing, case mix or quality issues);

- Problems in accessing beds when needed;
- Children and young people having to travel long distances to access a bed;
- Anecdotal information suggesting some decommissioning of Tier 3 or Local Authority children's services may be impacting on demand;
- Poor environmental standards in some services;
- Disparity in education input to CAMHS Tier 4 inpatient settings;
- Continuing inequity in provision across the country.

The NHS England Specialised Commissioning Oversight Group (SCOG) commissioned this report in response to the concerns and risks being raised. The review has attempted to distinguish between those issues arising from historically diverse commissioning approaches, and those which have potentially been caused by the commissioning changes themselves.

From the outset, it was recognised that it would not be possible to address all issues relating to CAMHS, and further work would certainly be required. In particular, the interface with Tier 3 services and Local Authority children's services is important in terms of understanding the CAMHS care pathway, though the review is explicitly concerned with CAMHS Tier 4 inpatient services and addressing the immediate issues.

The review has attempted to take note of particular issues which impact upon CAMHS Tier 4 inpatient services, as well as the overall care pathway for children and young people, and has indicated where further work is needed. There was pressure to broaden the scope of the review to encompass wider issues. However, due to the need to address the pressing issues and remit this was not possible. The steering group is aware of the other initiatives within NHS England and the Department of Health which will consider the broader context. This work will contribute to the wider perspective.

Thus, the focus of this report has remained upon:

- a description of the status quo within CAMHS Tier 4 inpatient services;
- analysis of current issues revealed by surveying commissioners and providers;
- recommending actions for SCOG in response to the findings;
- offering guidance on standards developed by the CAMHS CRG for national adoption.

The further work resulting from the recommendations of this review will require broad engagement and involvement. This will include engagement and involvement with children and young people, their families and carers, clinicians, the wider CAMHS community and other commissioners including local authorities.

The Quality Network for Inpatient CAMHS (QNIC), overseen by the College Centre for Quality Improvement (CCQI) within the Royal College of Psychiatrists, has provided substantial support to the review. It offers a well-established means to achieve wider engagement with clinicians, providers, young people and their carers. This will be central to the next stage of the work to be commissioned once the immediate bed capacity issues have been addressed.

2.3 Terms of reference

The review has been overseen by a steering group, with the following remit:

- to map current CAMHS Tier 4 inpatient provision split by service type (e.g. secure, eating disorders etc.), number of beds, age range, and geographic location;
- to collate and compare for each service (type) admission criteria;
- to conduct a census and identify by age, Mental Health Act classification, gender, length of stay, out of area placements (defined by out of the originating area specialised service geographic patch);
- to identify number of beds temporarily closed to admissions from 1 September 2012, type, length of time beds closed and reason for closure – source providers triangulating response with commissioners;
- to identify any 'best practice' where local services, agencies and commissioning organisations are working together to improve the pathway;
- to request area teams (specialised) to provide information about the level and type of Tier 3 services commissioned and in place locally along with any evidence of decommissioning or intended decommissioning since 1 September 2012.

Working with the CRG:

- Determine access assessment standards (generic and by service);
- Identify 'best practice' for trial or home leave;
- Identify 'best practice' for discharge thresholds and discharge planning;
- Produce guidance on managing suicidal ideation;
- Identify environmental standards for inpatient units;
- Consider and comment on the potential impact on demand and capacity by introducing these standards.

2.4 The organisation and context of CAMHS

The 'commissioning footprint' (i.e. the size of the population over which a service is most effectively and efficiently provided) varies according to the type of service, but also increases with progression through the tiers.

The structure and operation of CAMHS can appear complex at first as the organisation differs from both traditional secondary care mental health services for adults and the majority of general physical health services for children and young people (specifically in regard to multi-agency relationships and interdependencies). The structure of CAMHS is often best explained in terms of how a child or young person accesses the service, with four 'tiers' of service provision. There are differences in the levels of support and types of intervention offered in the different tiers and also in how each of the tiers is commissioned.

Tier 1 (Universal services)
These are services whose primary remit is not that of providing a mental health service, but as part of their duties they are involved in both assessing and/or supporting children and young people who have mental health problems. Universal services include GPs, health visitors, schools, early years' provision and others. Universal services are commissioned by CCGs and Local Authorities and schools themselves, and may be provided by a range of agencies.

Tier 2 (Targeted services)
These include services for children and young people with milder problems which may be delivered by professionals who are based in schools or in children's centres. Targeted services also include those provided to specific groups of children and young people who are at increased risk of developing mental health problems (e.g. youth offending teams and looked after children's teams, paediatric psychologists based in acute care settings). Targeted services are commissioned by CCGs and Local Authorities and schools, and are provided by a range of agencies. Arrangements vary across the country and according to the nature of the service.

Tier 3 (***Specialist services***)
These are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions. Access to the team is often via referral from a GP, but referrals may also be accepted from schools and other agencies, and in some cases self-referral. These services are commissioned by CCGs although there may be a contribution from Local Authorities. The latter varies cross the country.

Tier 4 (Specialised CAMHS)
These include day and inpatient services and some highly specialist outpatient services including services for children/young people with gender dysphoria ; CAMHS for children and young people who are deaf; highly specialised autism spectrum disorder (ASD) services; and highly specialised obsessive compulsive disorder services. These services have, since April 2013, been commissioned directly by NHS England.

Within the inpatient element of CAMHS Tier 4 there are several different types of service. Service specifications were developed for these services as part of the 2013/14 NHS standard contract. The general adolescent services specification is an overarching core specification which includes additional requirements for adolescent psychiatric intensive care units, low secure inpatient units, eating disorder services, and inpatient learning disability services. There are separate specifications covering children's inpatient units, specialist ASD services and secure forensic mental health services for young people.

The majority of units are those termed Tier 4 CAMHS General Adolescent Units; these units admit young people aged 13-18 years with a range of problems. In some areas Tier 4 General Adolescent Units have a further sub-specialisation into services which aim to offer short-term crisis admissions; a few Tier 4 General Purpose Adolescent Units have an attached or integral high dependency area.

Although the majority of young people with anorexia nervosa requiring admission are treated in CAMHS Tier 4 General Adolescent Units, there are a small number of specialist CAMHS Tier 4 Adolescent Eating Disorder Units – these may be linked to a CAMHS Tier 4 General Adolescent Unit or function as a stand-alone service.

There are a small number of CAMHS Tier 4 Children's Units admitting under 13s.

There are also a small number of CAMHS Tier 4 Learning Disability Units catering for varying ages and degrees of disability, although these services tend to focus on young people with moderate to severe learning disabilities.

There are a small number of units which are categorised as Low Secure or Psychiatric Intensive Care Units. To date, the separation and functioning of these units has been poorly defined. The CAMHS Tier 4 CRG produced initial specifications for use in 2013/14 and recommended further work by a dedicated CRG focusing on secure CAMHS provision. This work is currently being undertaken by the Secure CAMHS CRG.

All of the aforementioned service types were largely commissioned by Primary Care Trusts (PCTs) prior to 2013. There is a national network of Medium Secure Adolescent Units. These were nationally planned and commissioned prior to April 2013. There is also one inpatient unit in London for young people who are deaf which, prior to April 2013, was also nationally commissioned and which now comes under the remit of the CRG for Services for the Deaf, as do the community CAMHS services for the deaf.

The combined bed total of these different services is circa. 1264 beds.

Previous reviews of CAMHS Tier 4

There have been a number of reviews of CAMHS Tier 4 inpatient provision over the past 15 years, often occurring in response to concerns about access and the level of provision. The last detailed national review of CAMHS Tier 4 inpatient services was carried out in 1999. The National Inpatient Child and Adolescent Psychiatry Study - NICAPS (Royal College of Psychiatrists' Research Unit, 1999), after the Health Select Committee in 1997, had concluded:

> '...the current pattern of provision does not match the pattern of need; provision is patchy and inadequate…We find it unacceptable…that the Department of Health does not know the number or geographical distribution of beds for patients with eating disorders or the number of those beds which are designated for children and adolescents.."

It was also noted in the NICAPS review that there had been a decrease in inpatient CAMHS provision in the years leading up to the review. There were also substantial

numbers of young people admitted to adult wards. The NICAPS review found significant national variation in the distribution of inpatient CAMHS. Further research into the distribution of inpatient CAMHS (O'Herlihy A, 2007) found that bed numbers in England had increased by 284 between 1999 and 2006 to a total of 1128. However, regions with the highest number of beds in 1999 had increased more than areas with the lowest number of beds in 1999, thereby widening the geographical disparity.

In 2007 the Department of Health commissioned an analysis of the various local/regional reviews of CAMHS Tier 4 which had taken place across the country (Care Services Improvement Partnership, Kurtz, Dr Z, 2007). The report identified the underlying reasons for the regional reviews as:

- increasing referrals to inpatient CAMH services, particularly significantly increased numbers of emergency referrals;
- a national shortage of adolescent inpatient beds and a particular lack in developmentally appropriate provision for those aged 16 to 18;
- the inability of services to always respond in a timely way to requests for urgent admission and the consequent usage of paediatric and adult psychiatry wards as an interim resource;
- significant gaps in provision including long-term therapeutic provision and post-discharge services;
- significant problems in recruiting staff, especially nursing staff;
- inter-agency confusion, in particular about the needs of children with conduct disorder and challenging behaviours.

The report identified the underlying reasons for the various regional / local reviews which had taken place as:

- There was a major need for regularly updated and consistent data for use in provider management and service development, and in commissioning and evaluation.
- There was uneven distribution of, and access to (not necessarily the same thing) CAMHS inpatient beds.
- In-patient beds are only one aspect of the provision required and there is a need to consider other types of provision including crisis services, outreach, and intensive home treatment services. There is a crucial relationship between Tier 4 and Tier 3 services in effectively meeting the needs of children and young people.
- The importance of commissioning and its underdevelopment.

Broader CAMHS context

Although the focus of the current review is CAMHS Tier 4, it is useful to comment on the broader CAMHS context. As with all mental health services, progression up or down a care pathway depends not only on individual patient factors (and in the case

of children and young people family/carer factors) but is also determined by the availability of services / interventions at different points in the care pathway.

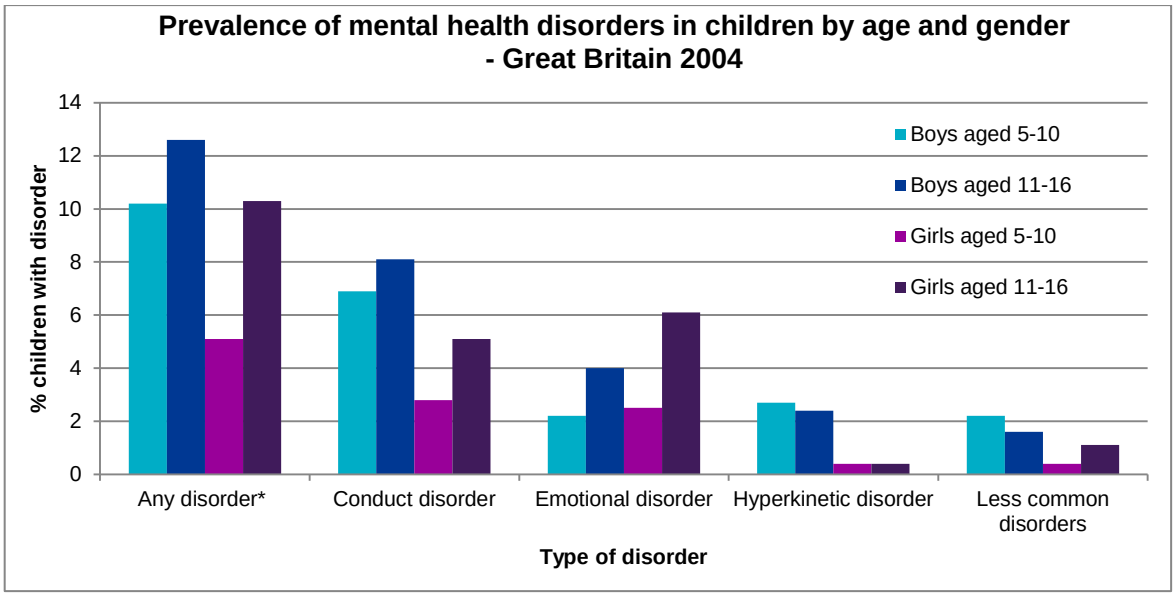
As noted earlier, the different elements of the care pathway may have different commissioners. The Chief Medical Officer in her 2013 report “Our children deserve better” (Department of Health, 2013) has highlighted that in relation to commissioning decisions there is a potential for reluctance by commissioners/agencies to invest in interventions when they themselves may not benefit from any savings accrued. This may be the case with CAMHS since the savings accrued as a result of early intervention may well fall to a different commissioner / agency than those providing the investment or the cost of a delayed discharge falls to a different commissioner /agency than those required to provide services to facilitate discharge services.

Given the multi-agency nature of services, and complex commissioning arrangements, there is also potential for a lack of integration between agencies, particularly at a time of shrinking resources. This can result in children and young people falling through the net, or alternatively escalating up the care pathway and experiencing greater distress and potentially requiring more expensive services.

As noted above in the descriptors of the CAMHS tiers, there is considerable variation across the country in terms of structure and funding of Tier 1-3 services.

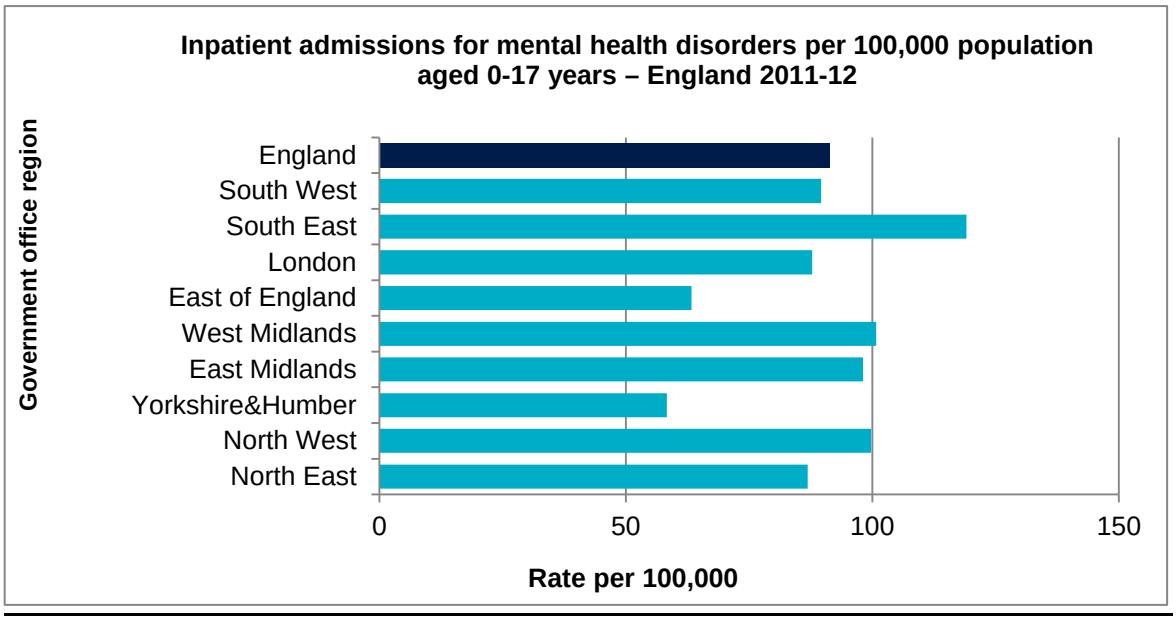
CCGs and Local Authorities decide what they wish to spend on individual services. The charity Young Minds (Young Minds, 2011/12) reported on the basis of Freedom of Information requests that there has been disinvestment in CAMHS, particularly in Local Authority expenditure. Evidence of disinvestment in recent years is also borne out in the NHS Benchmarking Review of CAMHS 2013 (NHS Benchmarking Network, 2013).

The best available estimates of the prevalence of mental disorders amongst children and young people are those from the Office for National Statistics surveys in 1999 and 2004 (Office for National Statistics, published 2000 and 2005 respectively). These found one in ten children aged between 5 and 16 years has a mental disorder. About half of these (5.8%) have a conduct disorder, 3.7% an emotional disorder (anxiety, depression), 1–2% have severe Attention Deficit Hyperactivity Disorder (ADHD) and 1% have neurodevelopmental disorders. The rates of disorder rise steeply in middle to late adolescence and the profile of disorder changes with increasing presentation of the types of mental illness seen in adults. Although as noted in the Chief Medical Officer’s report (Dept. of Health 2013) there is reason to believe these estimates of prevalence may be out of date.



The above chart relates to prevalence of mental health disorders in the general population of children. Given below are rates of admission for those children who access inpatient services by government office region.

There is no recent data on estimated levels of need for the different elements of CAMHS including Tier 4 services. This depends not only both on prevalence but also other factors including the range of alternative services. The only available data is that detailing actual admissions by Government Office region.



Information on access times for treatment in community CAMHS is not currently systematically available at a national level though it is understood that there is considerable geographical variation. Data from the NHS Benchmarking Report

CAMHS (NHS Benchmarking Network, 2013) found that in 2012/13 amongst its members the maximum waiting times for specialist CAMHS Tier 3 average 15 weeks across the participating providers. This has increased from 14 weeks recorded in 2011/12. Waiting times for accessing urgent CAMHS Tier 3 had a 3-week median wait. This should also be seen in the context of the lack of crisis response services in CAMHS, with less than 40% of CAMHS in the benchmarking offering rapid access through crisis pathways.

There are concerns from CAMHS Tier 4 commissioners and CAMHS Tier 4 providers that due to the lack of ability by CAMHS Tier 3 and other related community services in some areas to respond early to problems, there may be deterioration in a child/young person's problems which can lead to crisis. This may be further compounded by a lack of services offering alternatives to admission to hospital (which, in itself, for some individuals can be more harmful) thereby increasing demand for inpatient services. By this stage, admission is often not inappropriate, as it is the only safe alternative, though it could have been avoided with earlier intervention.

Commissioning specialised services has changed from a resident population basis to a national responsibility

NHS England makes decisions on how much money is spent on CAMHS Tier 4.

Prior to April 2013, CAMHS specialised commissioning was undertaken on a population basis. PCTs either directly commissioned some of these services or devolved to their regional Specialised Commissioning Group (SCG) to commission on their behalf. 'Minimum take' arrangements were a list of services agreed by SCGs (CAMHS inpatients was included) to be commissioned with effect from April 2012, in order to prepare for national commissioning. However, not all PCTs agreed to this arrangement. Some SCGs held contracts for CAMHS Tier 4 inpatient services and others were 'collaboratively commissioned' alongside their PCTs, with the PCTs negotiating and holding the contracts. In practice therefore, the arrangements and contracts inherited on 1 April 2013 by NHS England may have been negotiated, in some parts of the country, by predecessor organisations that were not specialised commissioners. There was variation in what was commissioned despite 'minimum take 'arrangements.

Previously, independent sector providers would mostly have had a contract with the SCGs in whose locality they had units – hence contracts with multiple commissioners, and no single commissioner responsible for the overall quality and safety of services in a unit.

Where SCGs had been historically commissioning CAMHS Tier 4 inpatient services, there were CAMHS case managers. Otherwise, case management predominately related to secure services and was undertaken on a resident population basis, resulting in case managers travelling throughout the country to the locality where patients were placed. There was no national commissioner approach to the

collection/recording of CAMHS Tier 4 data on admissions, discharges etc. and local information systems were developed within SCGs.

These previous arrangements led to a diverse commissioning landscape, with higher levels of scrutiny for local NHS units and lower levels of scrutiny for independent sector placements or any placements made 'out of county'. There were varying contract types in existence. Some NHS units were commissioned as part of a 'block contract' which included other mental health services from the provider, whilst others were commissioned on a cost and volume basis, and the independent sector beds were more likely to be spot purchased. Given the variety of contract types there was no benefit from 'all inclusive rates' (all inclusive would include one to one nursing observations) or volume discounts. These contractual arrangements were largely rolled forward into the new arrangements.

There is limited evidence that PCTs had worked with each other to develop the Tier 3-4 care pathway and to commission a full range of community-based services, including those services aimed at providing an alternative to admission. There were notable exceptions and some of these are cited as examples of best practice. Hence, there is considerable variation in access assessment processes, distribution of services and also diversity within the services themselves. CAMHS Tier 4 inpatient services are not available in every locality and availability regionally varies. Thus services differ, pathways differ and distance from home for inpatient services differs.

As outlined earlier, PCTs jointly commissioned specialised services from the National Definition Set across individual regions and funded their SCG accordingly. These finance arrangements varied from funding 'actual' spend to funding rolling averages. Comment has recently been made in support of previous arrangements over the current system because of a belief that the 'money followed the patient'. In reality the latter did not generally occur, because of the variety of different CAMHS contracting arrangements across the country. Nevertheless, all funding for the total of specialised commissioning expenditure did come from the PCTs who were responsible for their resident population.

In preparation for national commissioning Clinical Reference Groups (CRGs) were established to advise on what those services defined as 'specialised' for the purposes of commissioning should provide. The service specifications produced were subject to consultation. There are now two CRGs supporting CAMHS Tier 4 commissioning – the Tier 4 CAMHS CRG and Secure CAMHS CRG.

In April 2013, new commissioning arrangements were implemented with the following features:-

- NHS England is 'one' commissioner with a single contract per provider.
- NHS England is required to act as 'one body' for the population of England ensuring equity of access and consistent standards for that population.
- Independent sector providers now have one single contract with NHS England, irrespective of where their units are located and this contract is managed by a lead NHS England area team. Identification of area team contract leads was based on location followed by spend with the provider. Lead NHS England area teams are as follows:

Independent provider	Lead area team
Alpha	Cheshire, Warrington & Wirral
Cygnet	Bristol, North Somerset, Somerset and South Gloucestershire
Priory	Wessex
St Andrews	Leicestershire & Lincolnshire
Partnerships in Care	East Anglia
Danshell Group (Oakview Hospitals)	London
Huntercombe	Birmingham, Solihull & Black Country

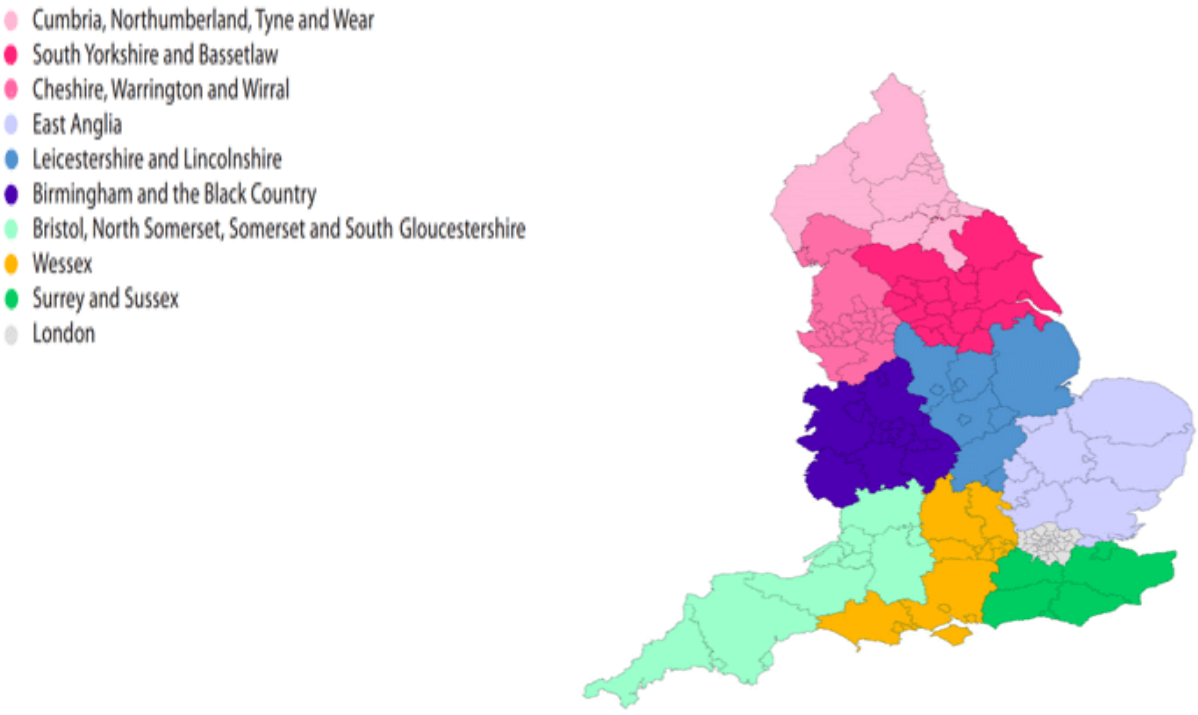
- Area teams are responsible for the quality and safety of units in their catchment area.
- Pre-existing SCG procedures have been rolled forward relating to serious incident reporting in the absence of an agreed NHS England procedure.
- New terminology to aid communication between specialised area teams was developed and is as follows:
  - *'host'*– Area team responsible for quality and safety of units 'hosted' (located) in their geographic 'specialised' boundary.
  - *'contract'*– Area team that holds contracts with provider.
  - 'originating'– the 'specialised' area team from which the patient originates and to which they are usually discharged.

Commissioning arrangements for specialised services since April 2013

Specialised commissioning is undertaken by NHS England, utilising service specifications developed nationally by the CRGs.

There are 27 area teams of NHS England, from which ten were designated to lead specialised commissioning arrangements covering all England. These ten area teams are the local offices for national commissioning of specialised services. They need to work collectively and consistently to deliver national services, ensuring equity for the population of England. The map below shows the geographic area covered by named area teams.

Area Teams with lead responsibility for commissioning CAMHS:



Contracting issues

Commissioning of services is now carried out by CCGs and NHS England. In the transfer of commissioning to the new organisations various exercises were undertaken during 2012 and estimates had to be used for much of the specialised mental health spend. Much of the mental health split was based on estimates as block contracts were commonly used with mental health providers. Some small volume specialties had not previously been contracted for by SCGs in all parts of the country meaning that defining the appropriate funding split was difficult. Hence previous spend on all NHS commissioned services was split between CCGs for their resident population and NHS England to be spent on a national basis but estimates had to be used for much of the mental health specialised spend.

NHS England then allocated funding to the ten area teams; based on contracts they were now responsible for managing. The information available up to April 2013 related to regional population spend. Unlike acute services, where coding of patients was well developed enabling commissioners and providers to identify where an individual was from as well as the reason for admission, specialised mental health services had largely relied heavily on case management and direct knowledge of individual patients. As the Health and Social Care Act does not provide a legal entitlement for NHS England to know who they are these previous systems / arrangements are no longer available to commissioners.

There are proportionately far more independent sector providers of specialised mental health services than in general hospital acute services. Many SCGs had not had CAMHS case management (largely because they had not commissioned CAMHS) and hence knowing the 'right' financial allocation for the area team in relation to the contracts in their portfolio was challenging.

Agreement to develop a process to transfer funding between area teams, where patients move between areas teams, has proved problematic, although a system has recently been agreed. If a national case management database were to be introduced, a means of reconciling patient flows would be possible at area team level.

Specialised commissioners in NHS England are currently prioritising which specialised services are to be subject to a procurement exercise. In CAMHS, existing contractual and provider arrangements are inherited and variable. It is possible to increase contract volumes on existing contracts and new provider contracts can be justified on quality and safety grounds, although bringing new market entrants into a locality without a formal process can be challenged under competition rules.

Providers who would be considered "new market entrants" and have, or are developing, services have expressed frustration that they are unable to secure commitment for use of those services.

Patient placement

Prior to April 2013, patient placement within CAMHS Tier 4 was determined through a variety of arrangements including automatic access upon referral via a particular route/pathway through to limits to the number of placements that could be made in CAMHS Tier 4 (sometimes referrals capped or a panel had to agree funding).

Since 1 April 2013, it was assumed that there were formal access assessment arrangements in place and all requests for a CAMHS Tier 4 bed were appropriate and should be funded. The assumption was that robust assessment was taking place at all levels. Attention was given by specialised commissioners to developing a notification system for cost per case or out of area placement to track patients. Thus, should a specialised area team require an individual placement outside their geographic boundary, they would proceed with the placement and notify the area team that 'hosts' that service accordingly. Out of hours arrangements were also agreed. Although common documentation was developed and shared, implementation has varied. The documentation is being reviewed and a Specialised Mental Health Commissioning Operating Handbook is being developed.

In summary, whilst the new commissioning responsibilities since April 2013 have been perceived by some as the cause of recent difficulties, there are other factors around past variation in practice and provision which have significantly influenced the situation. Arrangements that may have been in place by previous commissioners to manage demand largely disappeared on 1 April 2013. There were few if any posts in specialised area teams to place, manage or monitor the use of CAMHS Tier 4 in the

first 6 months from April 2013 (now some case managers in place temporarily). Specialised area teams inherited an arrangement whereby their CAMHS Tier 3 providers could place young people anywhere there was a bed available, without nationally agreed access criteria or funding flow arrangements being in place.

Areas which had previously worked to ensure sufficient capacity was available to them have expressed concern that the capacity in their area is now being used by other areas, for a variety of reasons, including insufficient provision elsewhere and lack of robust access assessment (which includes consideration of safe/effective alternatives to admission). This in turn impacts upon their ability to access local capacity for local young people. Thus the effects of shortfalls in provision in some areas are now over-spilling. The system put in place for commissioners to notify each other of a placement being made out of area was reliant on providers notifying commissioners of out of hour's placement. This was not universally adhered to. Information systems to track patients were not in place. They have since been developed although implementation is hampered by capacity.

The variation in historical provision is a consequence of the variation in how services have developed across the country. Thus in some areas there has been well developed strategic planning of the whole Tier 1-4 pathway, informing commissioning decisions, whereas this has been lacking in others. Sub-specialisation has largely been developed by providers rather than in response to strategic planning. Over 2013, for a variety of reasons, the availability of beds has fluctuated. New market entrants could not be guaranteed contracted activity (unless in response to local quality and safety concerns) and consequently the process of moving patients closer to home has stalled (should there be provision locally), until a formal procurement exercise can be undertaken.

In addition, where there were excellent local commissioner and specialised commissioner relationships previously in place these have been affected due to changes in personnel, capacity and/or understanding of responsibilities. This situation needs to be addressed.

2.5 Methodology adopted for the review

How the steering group approached its task

The steering group proposed a three stage approach to address the terms of reference which it had been given:-

- Describe the status quo.
- Offer advice about the care pathway.
- Make recommendations on the commissioning response to the current situation.

The steering group acknowledged the need for the review to respond to the question of whether the right beds are in the right sub-specialties in the right place. It recognised that it may need to distinguish between what is immediately achievable and what will require more time. A major task for the group was to undertake a gap analysis, recognising that across the country there are very different patterns of service usage and changes experienced at local level also differ.

The group commenced work in December and agreed the format and content of the survey on 10 January, having consulted commissioners and providers. The Steering Group met formally on three occasions through a combination of face to face meetings and teleconferences. The survey ran from 22 January to 12 February. Drafting and finalising the report was undertaken through a series of teleconferences. Draft findings were provided to SCOG in March 2014, and the final report is to be submitted to its April meeting.

In line with the remit and terms of reference for the review, the Tier 4 CAMHS CRG took responsibility for developing proposed standards and included clinicians from all categories of Tier 4 CAMHS inpatient settings. The CRG also communicated with the Secure CAMHS CRG. Lead members within the CRG took responsibility for individual pieces of work, consulting and coordinating responses, reviewing available evidence, cross-referencing other research currently underway and developing the draft guidelines which are contained later in chapter 2 of this report.

The steering group considered whether the review process required a census at a point in time or a longitudinal view. It concluded that ideally elements of both were needed in order to better understand the practical realities being experienced by commissioners and providers. It was agreed to survey issues of bed availability and occupancy longitudinally. As the provider survey was by necessity retrospective, a census approach would be difficult. Thus, the steering group decided to seek commissioner case histories to provide a snapshot of cases in real time.

Design of the survey

All specialised area team commissioners (both individually and collectively) provided input to the survey design and content, agreeing key themes needing to be addressed. Provider input into the survey design was gained through interviews with clinicians from both Tier 3 and Tier 4 inpatient services. The latter included clinicians representing both the NHS and independent sector units providing general adolescent, low secure, children's and Learning Disability services.
Comments on the emerging survey themes were sought from other providers and the Tier 4 CAMHS CRG and Secure CAMHS CRG.

The themes which emerged from the aforementioned work were developed into the commissioner and provider questionnaires, along with a pro forma to capture 10 case histories from each commissioner. In addition, commissioners were invited to submit information regarding local initiatives/good practice for possible adoption countrywide.

Receipt and collation of responses was overseen by the Royal College of Psychiatrists, College Centre for Quality Improvement (CCQI). The Tier 4 CAMHS CRG was responsible for developing guidance in line with the terms of reference.

The steering group had to balance the need for the survey to consider CAMHS Tier 4 inpatient services as comprehensively as possible, with the time limit set for its report. It was acknowledged from the outset that there would be areas requiring further investigation (some of which were already underway elsewhere) beyond the capacity of the review. For this reason, it was agreed not to include Tier 3 or section 136 suites or referring clinicians in the survey.

The scope of the review in the context of other work underway

This review was commissioned to obtain, as far as possible, an understanding of the factual position relating to CAMHS Tier 4 inpatient services and to offer specified guidance for consideration. Tier 3 commissioners working with the specialised commissioners expressed a wish to contribute to the review. Within the remit and timescale, it was agreed that Tier 3 commissioners would offer input via their relevant CAMHS Tier 4 commissioner. As the recommendations of this report later confirm, the importance of commissioning across the pathway of care means that commissioners of all aspects of CAMHS need to collaborate. The review group hopes that this report will provide a means to promote further dialogue across the CAMHS pathway.

During the period of this review, the Child and Adolescent Psychiatry Faculty of the Royal College of Psychiatrists conducted a survey of its members concerning admissions to inpatient CAMHS, which also highlights the pressures felt around the country in these services.

3 Survey results and draft guidance prepared by the CAMHS CRG

This section provides an analysis of the responses received from the commissioner and provider surveys and offers initial commentary on the insights they provide. Draft guidance covering specific aspects of CAMHS care has been prepared by the CAMHS CRG for consideration, as required in the review terms of reference. This is included at the end of this section.

3.1 Contracting issues

The type of services commissioned

There is variation, both geographically and by sub-specialty, in both Tier 3 and Tier 4 services.

The chart below summarises lead commissioning responsibilities across the whole of the CAMHS care pathway. This is an overarching schematic at a general level. It should be noted that the category "specialist Tier 3/4" relates to different services commissioned by different agencies, not three agencies commissioning the same services.

Which agency commissions what

	Service Type	Responsible Commissioning Agency			
		School	Local Authority	CCG	NHS England
Universal Services (Tier 1)	GPs practice staff				
	School nurses				
	Health Visitors				*Moving to LA*
	Social workers				
	Youth workers				
	Teachers				
Targeted (Tier 2)	Outreach into schools by CAMHS				
	School counsellors				
	Educational Psychologists				
	Community based counselling				
	YOT Health workers				
	Parenting Programmes			*In specialist*	

	Service Type	Responsible Commissioning Agency			
		School	Local Authority	CCG	NHS England
				CAMHS	
Specialist (Tier 3)	Looked after children/adoption			*In specialist CAMHS*	
	Specialist CAMHS (T3) community		*Social workers/Edpsych /MST*		
Specialist (Tier 3/4)	Specialist Outreach services to prevent admission/speed discharge		*Social workers*	*In some areas commissioned locally*	In some areas Specialised Commissioners
Highly Specialist (Tier 4)	In -patient or regional specialist community e.g. deaf CAMHS				

Darker shade reflects most likely responsible commissioner; Lighter indicates variation based on local agreements

The area teams of NHS England which lead specialised commissioning on behalf of all 27 area teams are described throughout this section as follows:

Cumbria, Northumberland, Tyne and Wear	CNTW
South Yorkshire and Bassetlaw	SYB
Cheshire, Warrington and Wirral	CWW
East Anglia	EA
Leicestershire and Lincolnshire	LL
Birmingham and the Black Country	BSBC
Bristol, North Somerset, Somerset and South Gloucestershire	BNSSSGW
Wessex	SS
Surrey and Sussex	L
London	

Area team commissioners were requested to describe what services were commissioned at Tiers 3 and 4 both pre-and post-April 2013, liaising with the commissioners of CAMHS Tier 3 as necessary.

The review was seeking to understand if commissioners were aware whether, as asserted by some, the volume and level of available services had changed after April 2013 which may have impacted on demand or capacity.

In most cases, CAMHS Tier 4 commissioned by NHS England are identical to those inherited under previous arrangements although during 2012/13 there were some changes by previous commissioners:

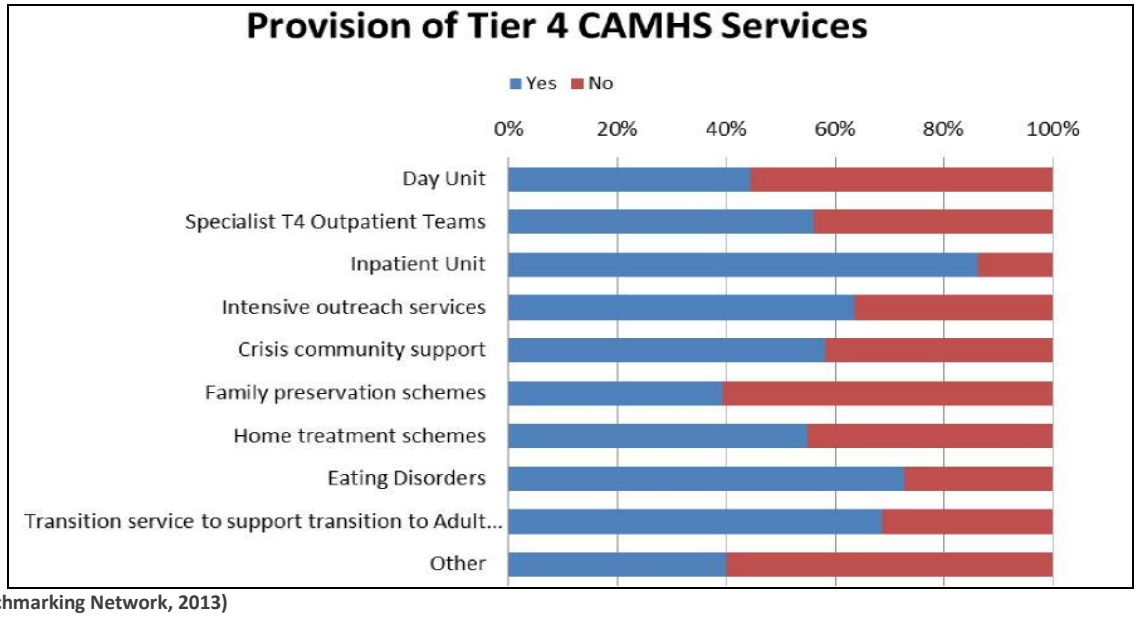
- South Yorkshire and Bassetlaw PCTs consulted during 2012/13 on changing the CAMHS Service in Hull West End Unit from a five day service to more local community based services.
- Bristol, North Somerset, Somerset & South Gloucestershire – Wessex House temporarily closed due to staffing issues.
- Birmingham Children's Unit temporarily closed due to re-provision

Service models

The NHS Benchmarking survey (NHS Benchmarking Network, 2013) reported the following pattern of service provision by CAMHS Tier 4 providers amongst its members:

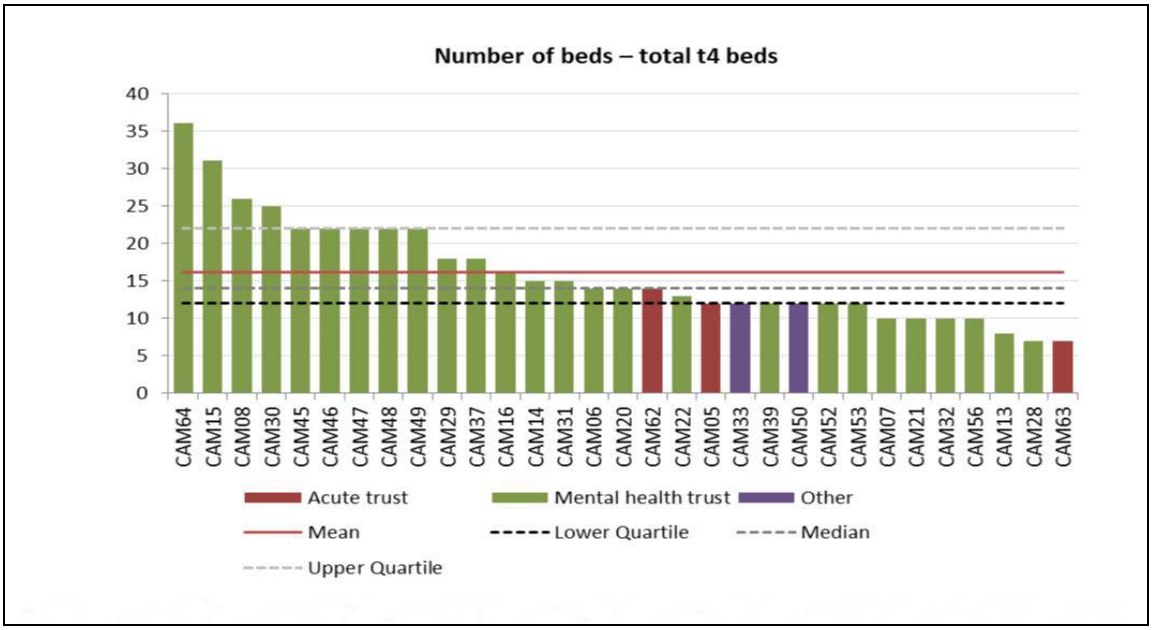
- *Around half of the contributors to the CAMHS benchmarking project provide Tier 4 services.*
- *CAMHS Tier 4 contain interesting service models that are much wider than a core of specialist inpatient services. Targeted services are evident within Tier 4 portfolios.*
- *Services that have high levels of provision and are delivered by over 60% of providers include; in-patient beds, eating disorders services, transition services, and intensive outreach which is offered by 63% of providers.*
- *More niche services that are delivered on an infrequent basis include; day units, community based crisis support, family preservation schemes, and home treatment services.*

(NHS Benchmarking Network, 2013)



(NHS Benchmarking Network, 2013)

- A total of 31 services reported providing in-patient beds. The number of beds provided ranges from 7 to 36.
- The mean level of beds provided is 16 and the median is 14



(NHS Benchmarking Network, 2013

What is the contractual basis for CAMHS placements?

Commissioner responses describe contracting arrangements varying across the country, both pre- and post-April 2013, including the full spectrum of contract types. This essentially reflects the wide variety of arrangements which existed pre-April 2013. There is now an opportunity to align these contractual arrangements into a more rationalised national approach.

Specialised commissioners have worked together to develop patient placement principles which are aligned across the country and based upon placing the patient as close to home as possible. This review has confirmed that the practical implementation of these principles varies across the country as outlined in the earlier chapter. Since April 2013 a number of specialised commissioners have closed some units to admissions because of serious concerns about their ability to meet necessary quality standards. Although this has impacted on capacity this has been a positive step in aligning quality expectations nationally. Specialised commissioners have also worked closely with the Care Quality Commission in sharing concerns or actions. The recommendations of this review should assist commissioners in further developing quality standards to be used in contracts and the proposed procurement of services.

3.2 Changes to funded places in Tier 4

Some specialised commissioners had described how in the past PCTs had undertaken 'invest to save schemes' investing in Tier 3 services in order to avoid the need for admission, provide more appropriate care locally and make financial savings from beds. The new commissioning arrangements did not provide any savings to CCGs hence commissioners' concern about the potential investment in aspects of Tier 3 services, particularly services aimed at reducing the need for admission and potential over reliance on Tier 4. Others indicated that previously planned changes in service provision to invest in Tier 3 were potentially under threat, through funding withdrawal. To have gleaned detailed evidence of the extent of this would have required a survey of Tier 3 commissioners which was beyond the scope of this review.

> "The current commissioning arrangements can be perceived as creating a perverse incentive regarding admission. [CITY] Outreach service which is commissioned locally by the CCG's is successful in reducing admissions. This cost saving is not realised by the CCG as the inpatient unit is commissioned by the SCG. This presents a serious risk of the outreach service being decommissioned." (General CAMHS provider)

On reviewing the provider and commissioner returns no major changes to funded beds were described (apart from those described earlier). East Anglia commissioners highlighted that the need to comply with quality expectations in the NHS England national specifications had led to refurbishment in some units thus reducing available beds temporarily whilst refurbishment was carried out. Since the survey was issued, and in response to demand currently being experienced, NHS England has asked local contracted CAMHS Tier 4 providers to consider what potential existed to increase bed availability when the need arose.

3.3 Case management

Case manager resource

Prior to the review, area team commissioners were describing the importance of case management to the successful commissioning of CAMHS. Some described reductions in case management resources prior to transferring commissioning to NHS England. Arrangements were in hand at the commencement of the review for case managers to be available to commissioning teams. Funding arrangements for these varied. Commissioners were asked to describe the number by 'whole time equivalent' (WTE) of posts, when they were appointed, whether they are recurrently funded and whether they are clinical or non-clinical.

Arrangements pre-April 2013

Varying levels of resource were available with most CAMHS commissioners (SCG and PCT) having access to case management resource. Some areas were better resourced than others.

Arrangements post April 2013

All commissioners now have access to some case manager resource, though in areas which previously had designated CAMHS case managers this is typically less than under the previous arrangements. The resource varies between one WTE and two WTE. Most were appointed around September/October 2013 and almost all are funded non-recurrently. Some are "borrowed" from other services including secure and adult services or are seconded from providers. Case managers are predominantly clinical staff. All area teams are now delivering robust case management. However, the significant variation in the availability of beds within area teams directly impacts upon their ability to manage and meet demand within the patch.

Provider comments
"Case managers from out of area not knowing referral pathways and not liaising with local case managers prior to referral process".
"Adult Case Managers no longer attend Care Programme Approach meetings. This has had an impact on transitions to adult services".
"Contact with the local case manager from the host commissioning point is very good".
"The introduction of an NHS commissioning case manager is a major step forward".

This group of staff appears to be key to keeping the system moving and this resource is currently fragile (non-recurrently funded) and highly variable across the country. Case Managers have an important role in helping patients to navigate the care pathway, and keeping care as local as possible and could help to address some of the current difficulties in relationships between Tiers which are now the responsibility of different commissioners.

3.4 Staffing issues

CAMHS Tier 4 units identified nurse recruitment and training, particularly post-qualifying training in CAMHS, as an issue in the delivery of CAMHS Tier 4 inpatient services. As commissioning of these services is now national, consideration could be

given by NHS England, in conjunction with Health Education England, to how best issues around the development of the nursing workforce can be addressed.

The NHS Benchmarking Review (NHS Benchmarking Network, 2013) noted that the CAMHS Tier 4 Multi-Disciplinary Team (MDT) is less diverse and has a far less rich skill mix than Tiers 1- 3.

> *Nurses and support workers together account for 73% of the tier for workforce. CAMHS nursing has many band 5 and 3 staff present with proportionately fewer qualified nurses than Tier 1-3 services.*

10 units specified that inexperienced staff is a common issue.

"…there seems to be a lack of availability of experienced applicants".

"…junior clinicians left to manage risky and complex cases".

4 units noted that it is difficult to recruit specialist staff.

"National difficulties in recruiting staff with specialist skills across the MDT".

"The key challenges for inpatient CAMHS include being able to attract and retain experienced, qualified nursing staff…" (Provider responses)

3.5 Network or other support arrangements across/ between levels of commissioning

Some commissioners described a deterioration in local relationships with Tier 3 commissioners after April 2013. Others said that previous arrangements for liaison between the levels of service had been sustained. Commissioners were asked to describe any local arrangements in place which were felt to be helpful in ensuring good communication across the care pathway. Some had previously had separate Tier3 and Tier 4 network arrangements.

Current arrangements are largely influenced by the extent of engagement between the tiers prior to April 2013. There are examples of pre-existing networks being sustained (Cheshire Warrington and Wirral, Birmingham Solihull and the Black Country). In other cases, commissioners are developing new hosting arrangements to replace pre-April 13 arrangements (Cumbria Northumberland Tyne & Wear and South Yorkshire and Bassetlaw). All commissioners describe some arrangements for interface with Tier 3 colleagues, with the exact nature varying across the country. Where network arrangements do not exist, difficulties are being experienced and pathways of care appear to have become fragmented. Several area teams have

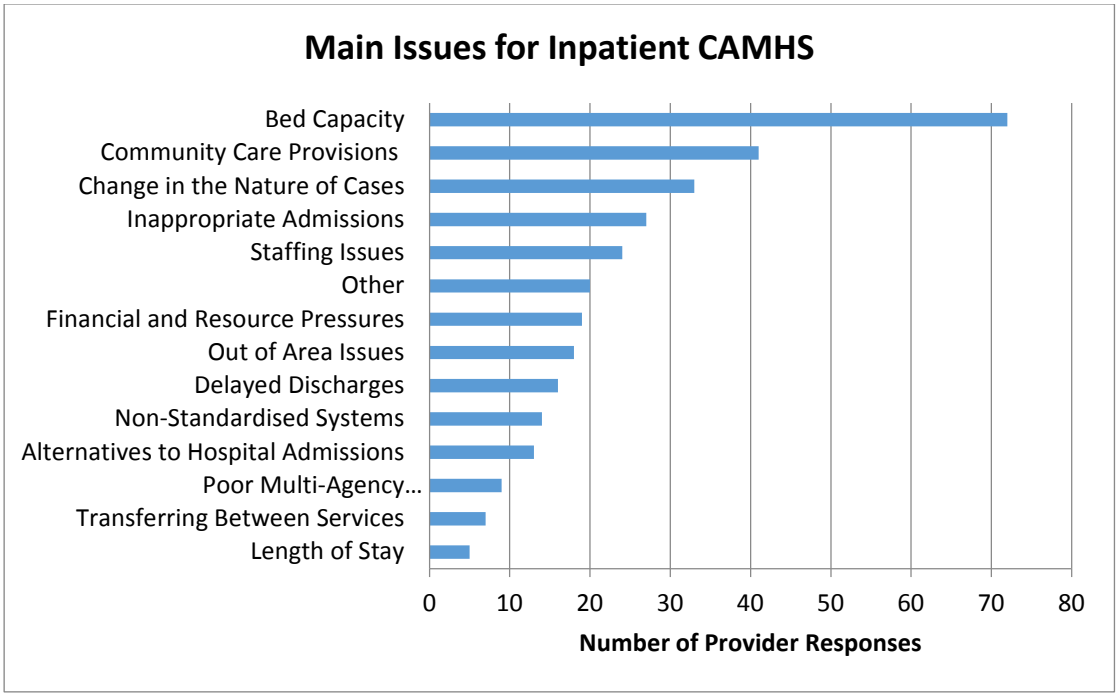
shared with the review examples of local initiatives. It would be helpful to develop mechanisms for sharing these for wider adoption.

> "Patient journey would be improved significantly by improvement in links between social services and NHS England and if funding were not separated"
>
> "Would be helpful to have joint commissioning arrangements for Tier 3 and Tier 4 CAMHS. Pre-admission assessments should be optional, and emergency admissions still permitted. More direct commissioner oversight of services."
>
> "There are not the same relationships within local boroughs where previously PCT commissioners would have ensured there was sign up and robust management from all partner agencies in managing issues that arose".
>
> "...we are unaware of other area's procedures, at times they may have no care co-ordinator and trying to get a service to take up this role can be more difficult than when local and all working for the same Trust".
>
> "We cannot have the same level of relationships with the referrers that we used to have, which really benefitted the patients".
>
> "More partnership working with the commissioning arrangements".
>
> "The arrangement with the SCG's enables more effective relationship building".
>
> (Provider responses)

3.6 Access to CAMHS

Current issues described by providers

The provider survey asked units to describe what they felt were the major issues in CAMHS presently being experienced. Their responses are summarised below:



Provider free text responses regarding main issues
What do you believe are the main issues for inpatient CAMHS at the moment?
"Reduced availability of long term care providers in this area."
"Threat of tendering of services" (comment submitted by two different units).
"Reliance on PICU which is not facilitating longer treatment periods where necessary." (Comment submitted by eight different units under the same trust)
"Reduced willingness of paediatric wards to provide a few days respite care in crisis."
"Increased family breakdown."
"Resources required to manage the process of performance indicators."
"Preserving the high quality of care that is offered to the most severely unwell children in the country."

"Poor services for young people within this age range."

"Social networking and media interaction."

"...commissioning insecurity due to confusion in the commissioning arrangements."

"Lack of clarity as to what commissioners require from our services going forward."

"Increased acuity caused by lifestyle/social circumstances i.e. acuity of referred client."

3.7 Referral and assessment arrangements

A clear comparison at specialised commissioner level is not possible as this data is held by providers. Most area team commissioners do not hold comparative information on referrals pre-and post-April 2013. Moreover, as local protocols vary, commissioners may hold data on admissions rather than referrals. As indicated there is significant variation in historical arrangements across the country, and this includes those identified in assessing young people to determine whether they require an in-patient service and those who are then expected to find the bed. In some cases providers undertake the initial trawl for beds.

Significant variation in the pre- and post-April 2013 referral rates were reported by the following:

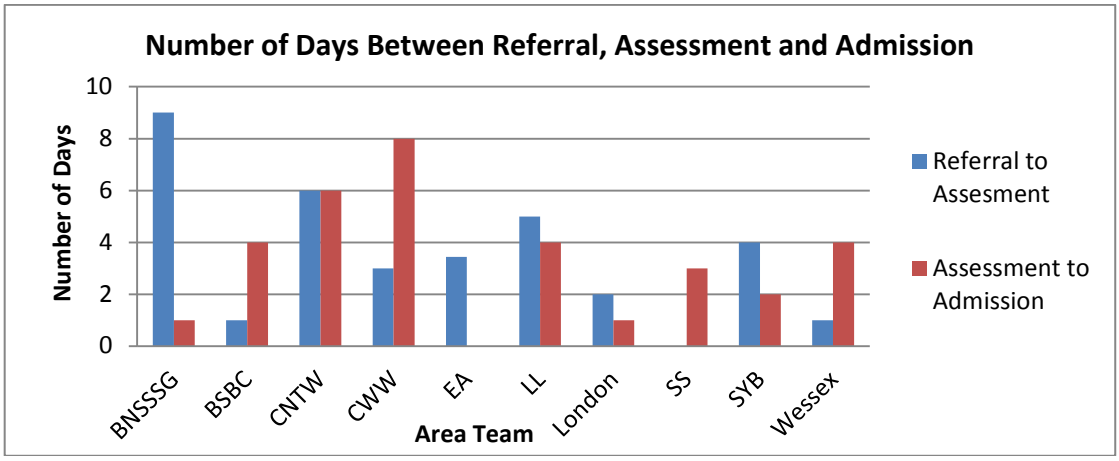
- East Anglia-22 per month pre-April 13 and 69 per month post-April 13. It has been suggested by some providers they were limited by the commissioning PCT in the number of referrals that could be made to Tier 4 services. If this is the case, it would explain the sudden increase post April 2013.
- South Yorkshire and Bassetlaw-29 per month pre-April 13 and 39 per month post April 13 (referrals into services contracted by SYB).
- Surrey and Sussex reported a threefold increase in eating disorder referrals (previously 2 per month) following discontinuation of enhanced pathway.

As outlined earlier, prior to April 2013 there was variation around the country in how referrals were handled, depending upon locally developed arrangements and the services available in Tiers 1-3. The review asked each Tier 4 commissioner to confirm the following:

- who conducts the assessment;
- whether standard documentation for referral and assessment was used;
- whether there was a written referral pathway which is regionally applied;
- whether there is a written assessment pro forma which is regionally applied.

At this stage, there is no national standardised documentation other than placement forms as part of the specialised commissioning mental health standardised protocol for placement. This section of the survey sought to establish whether there is best practice which could be applied more widely or whether there is merit in developing a national protocol. Examples of standardised documentation and / or protocols were supplied by some commissioners. These are listed later in this report under shared good practice.

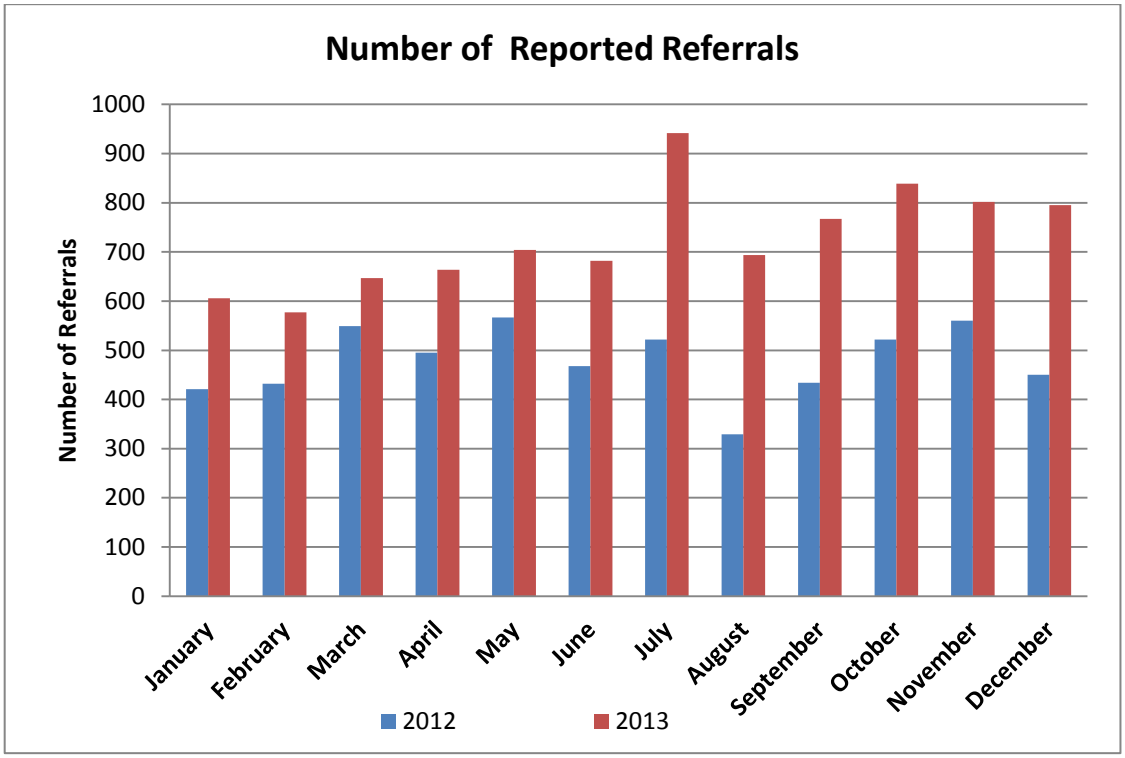
The commissioner case histories give an indication of the progress of referrals through to admission.



Area Team	Days Taken to Notify Commissioners of Referral (0 = same day)	Additional Notes
BNSSSG	5	N/A
BSBC	0	N/A
CNTW	7	N/A
CWW	0	N/A
EA	0	N/A
LL	-1	In 1 case, commissioner was notified before referral.
London	0	In 1 case, commissioner was notified before referral.
SS	2	N/A
SYB	-1	In 3 cases, commissioner was notified before referral.
Wessex	1	N/A

Average number of referrals per month

Suggestions had been made that the number of referrals to Tier 4 services had increased after April 2013. Providers and commissioners were asked to supply information on this.



The provider returns show a sudden increase in referrals commencing in July 2013. Although the number has settled to a lower level, it has remained consistently higher than the pre-July levels. The data also shows evidence of an increase in referrals in 2013 prior to April.

Since most commissioners do not have referral information recorded on a consistent basis, it is not possible to state definitively the change in demand for CAMHS Tier 4 inpatient services. Providers clearly report a year on year increase in referrals received, though they also say they have become aware of multiple referrals being made in respect of the same patient as commissioners (or providers who have undertaken the assessment) search for a bed. Handling these referrals, which may result in assessment appointments which are subsequently cancelled because a bed has been found elsewhere, adds to pressure on Tier 4 clinicians through unnecessary appointments. This was highlighted to the review team by two providers interviewed during preparation of the provider questionnaire.

Provider free text responses: What were the most common reasons for inappropriate referrals?

"Parents not in full agreement with the referral."

"Young people being referred with Informal status."

"Referral is from a school, or relates to school focused problems only."

"Nowhere to live."

"Crisis presentation and pressure to get off adult/paed ward."

"Referrals being deemed to require longer term placement."

"Informal status."

"Bed managers and referrers often do not refer to the specific designation of our service and seem to have referred to all services they can make contact with."

"Distance from home to unit."

"The increased complexity of mental health issues not eating disorder related." (Comment submitted by Eating Disorder Unit)

"Patients who were clearly not consenting but were not detained."

"No discharge destination."

"Not being detained."

What were the main reasons for referrals not being accepted?
"Refurbishment purposes." "Need for immediate or request for 7 day bed when none available (e.g. Child in A&E and cannot go home)" "Service not operating as 7 day service." "Too unwell i.e. YP at too low a weight to be managed safely." (Comment submitted by Eating Disorder Unit) "Patient too complex to contain." "Need for long-term placement." "Transferred to a different unit for NG tube feeding." (Comment submitted by Eating Disorder Unit) "We offer many young people treatment on our day programme as a way of offering intensive treatment without admission and reducing length of stay. We cannot do this with patients from a distance." "Unrealistic goals for inpatient care."
Changes observed since new commissioning arrangements
"Numbers of young people with LD and challenging behaviour are being referred to specialist MSU for Forensic Adolescent LD". "More inappropriate and/or incomplete referrals from out of area". "Increased requests to take 13-14 year olds who do not fit developmentally into an adolescent service". "It appears clinicians are effectively left to go through a list of units in the country with little guidance as to their appropriateness for the particular referral".

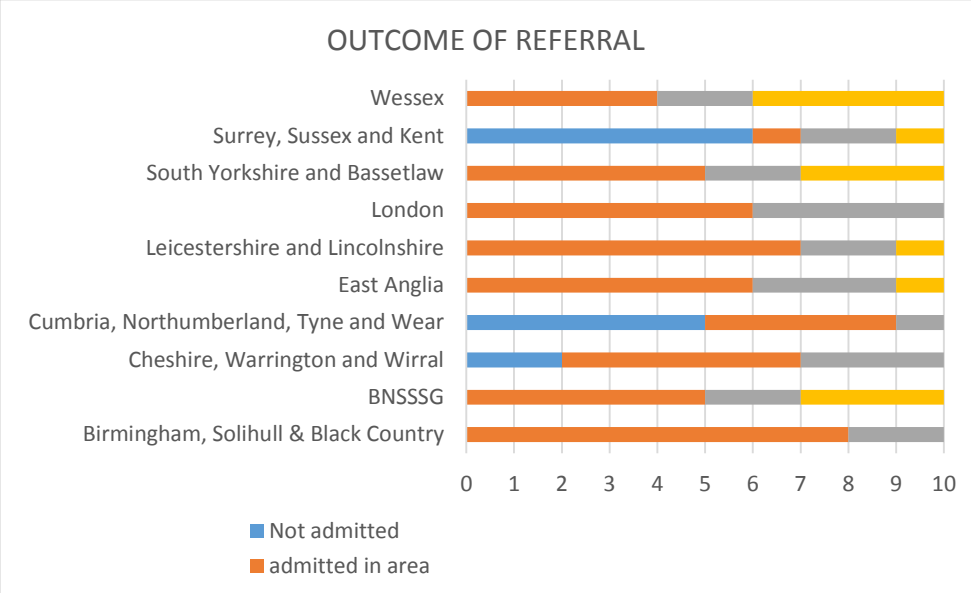
The comments relating to 'informal status' are thought to relate to young people being referred to secure units who are not considered to meet the criteria for detention under the Mental Health Act and hence criteria for secure care and/or young people not agreeing to admission.

Information from commissioner case histories about referrals

Each of the specialised area team commissioners was asked to provide information relating to the five most recent referrals prior to the survey date and the next five after the date. This has provided a snapshot of 100 case studies across the country. The analysis of these case histories is shown below.

Commissioner survey responses confirm that area teams are not aware of all referrals. Therefore, other than areas which have reported referrals not leading to admission, conclusions cannot be drawn from the case studies about how many referrals actually led to admission. That not all referrals result in admission was reported by the NICAPS study (Royal College of Psychiatrists' Research Unit, 1999) which found that for every four patients referred to in-patient units, approximately three were assessed and two admitted. In the current surveys patients were commonly referred to more than one unit (either serially or in parallel) before admission was achieved. It isn't possible to determine the number or proportion of patients who were not admitted to any unit.

The outcome of referrals in the chart below shows higher levels of out- of -area admissions are seen in those areas with low numbers of local beds.



Whether there is a written, area-applied referral pathway

In half of the commissioning areas, there is a clear agreed pathway. In two other areas a pathway is under development. In the remainder, arrangements vary across the patch, usually on historical lines. It is also noted that individual provider services may have their own referral pathways.

Whether standard documentation is used

There is roughly an even split between area team specialised commissioners who do have their own standard documentation for referral and assessment and those who do not. Standardised documentation does not currently include referral and assessment arrangements. Nationally agreed referral and assessment documentation would aid providers and communication between area teams.

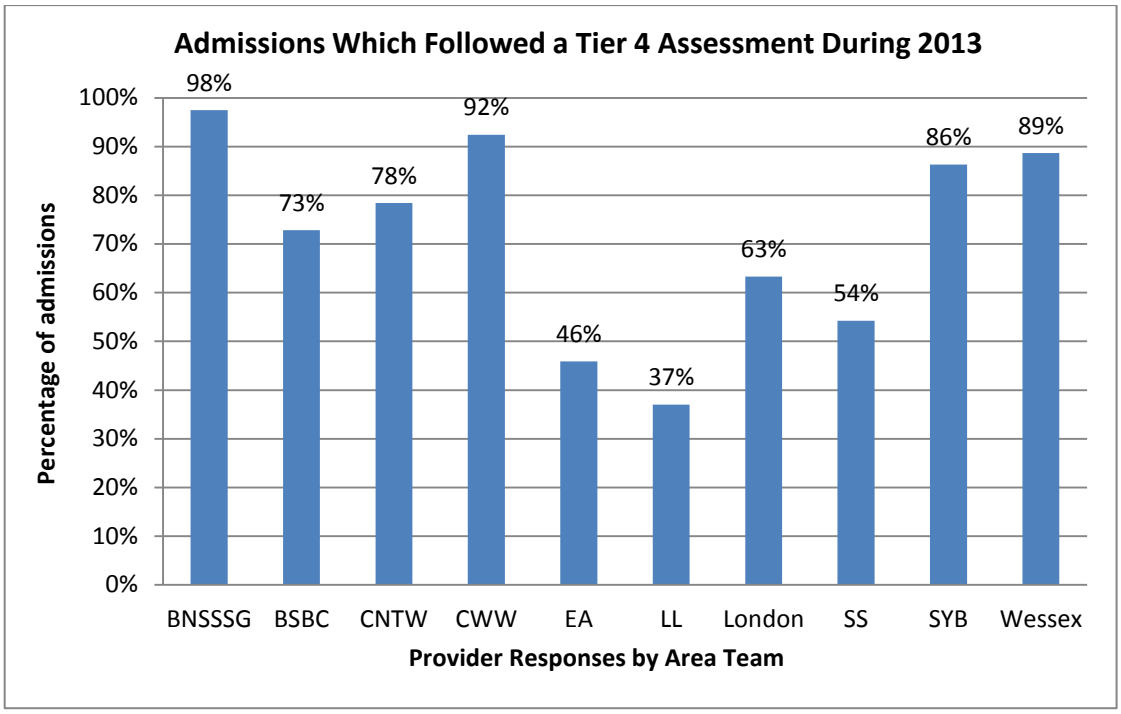
> "...the lack of common referral paperwork duplicates the work involved in finding a bed as several sets of the same information has to be repeated as each provider has a separate referral form."
> (provider comment)

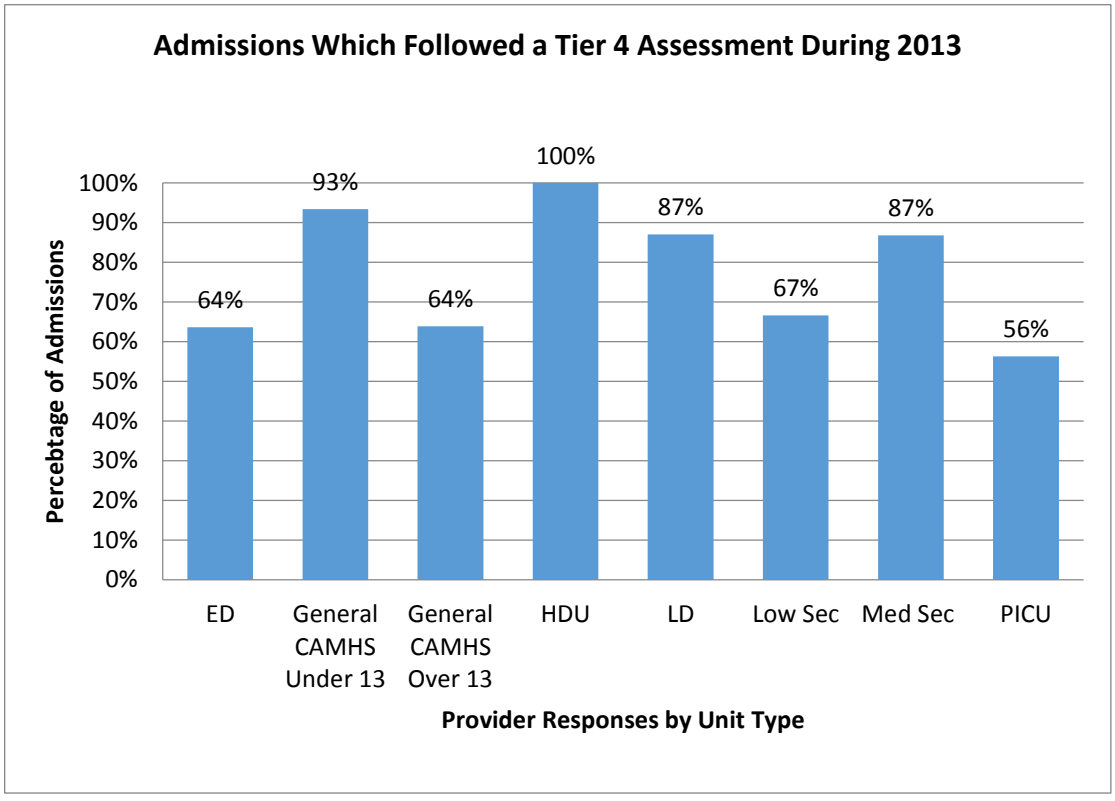
Who conducts the assessment

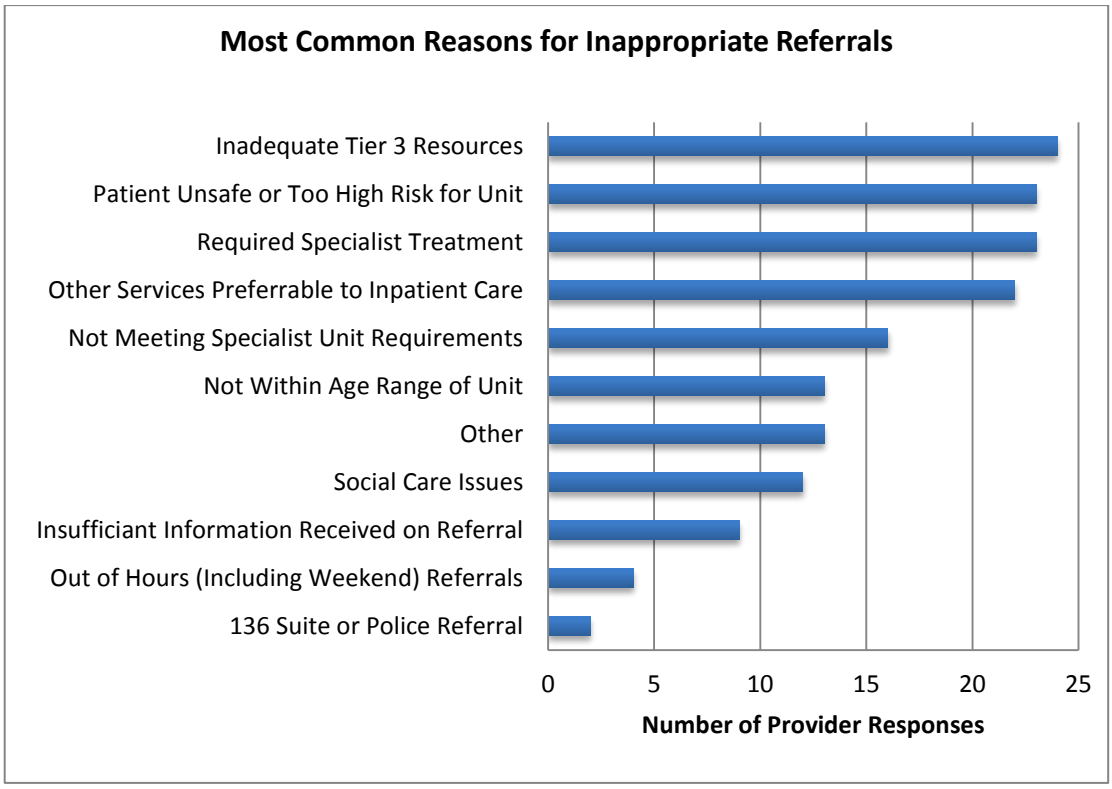
In a number of areas pre-admission assessments are carried out by the receiving Tier 4 service, and may be conducted out by a multidisciplinary team (which can include a psychiatrist) or a consultant psychiatrist. In some areas when the pre-admission assessment is not possible because of the out-of-hours emergency nature of the referral there is a formal process of a post-admission review of the continuing need for by the Tier 4 team. By contrast, in some areas the referring CAMHS Tier 3 team carry out an assessment and there is no additional pre – admission Tier 4 assessment to determine the appropriateness of in-patient care.

In some areas referrals to Tier 4 can only be made by a consultant psychiatrist in Tier 3 services and in others referrals can be made by any member of the multidisciplinary CAMHS Tier 3 team; there are instances of eating disorder referrals permitted by paediatricians in acute hospitals. In one instance a commissioner reported having been advised by their providers of receiving referrals where there had not been a psychiatric assessment as well as referrals by-passing case managers.

According to the 75 provider units who submitted an answer, an average of 71% of all admissions followed a Tier 4 assessment however as can be seen there is wide variation.


Admissions Which Followed a Tier 4 Assessment During 2013
Percentage of admissions
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
98%
73%
78%
92%
46%
37%
63%
54%
86%
89%
BNSSSG
BSBC
CNTW
CWW
EA
LL
London
SS
SYB
Wessex
Provider Responses by Area Team


Admissions Which Followed a Tier 4 Assessment During 2013
Percebtage of Admissions
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
64%
93%
64%
100%
87%
67%
87%
56%
ED
General CAMHS Under 13
General CAMHS Over 13
HDU
LD
Low Sec
Med Sec
PICU
Provider Responses by Unit Type



Of the units which reported "not meeting Specialist Unit Requirements", there were 5 Low Secure, 5 Medium Secure, 4 Eating Disorder, a PICU and an under 13 CAMHS Unit.

3.8 Commissioner approval arrangements and out-of-hours arrangements

The review wanted to understand the extent to which commissioners approved placements, and whether arrangements differed out-of-hours. A number of problems had been described by commissioners whereby they were unaware of admissions of patients from their area, in some instances only finding out by chance. There had also been a suggestion that procedures were not necessarily followed. The providers interviewed by CCQI to inform designing the survey design described instances of multiple units receiving referrals for the same patient, placing additional pressure on already stretched clinical resource.

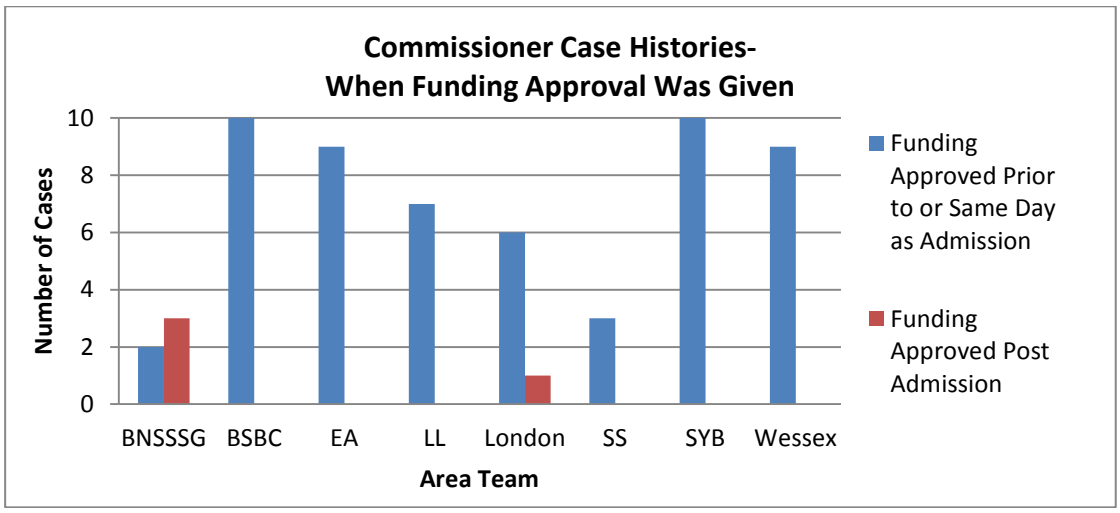
Arrangements prior to April 2013 varied across the country, with some commissioners exercising prior approval policies. In some instances prior approval was only for non-contracted beds or out- of -area placements. For out-of-hours admissions, approval (where required) was usually within a specified time limit after admission.

Since April 2013, prior commissioner approval is not required where placement is within area, though providers must notify commissioners. Approval is required for out-of-area or cost per case placements, though a number of commissioners report

that this requirement is not always adhered to. Some area teams have added to those arrangements in respect of the actual gatekeeping/assessment expectations for example additional approval requirements:

- Cheshire Warrington and Wirral-prior approval for all specialist independent sector placements
- Cumbria Northumberland, Tyne & Wear requires prior approval

The variation in area team approval arrangements and the reported instances of simultaneous referrals of a patient to multiple units is an issue which could be addressed through the creation of a standardised approach across all area teams. Some area team commissioners have reported that where protocols exist, they are not always adhered to. Whilst the need to find a bed as quickly as possible is understandable, this variation in practice could be generating some of the extra pressures in the system.



3.9 Commissioner access assessment arrangements and referral refusal rate

The review was asked to consider the use of admission criteria. Some commissioners had suggested that the existence of gatekeeping/access assessment arrangements were important for ensuring appropriate access to CAMHS Tier 4 inpatient services. Commissioners were asked to describe any access assessment arrangements in place and what level of referrals were accepted/refused (if known).

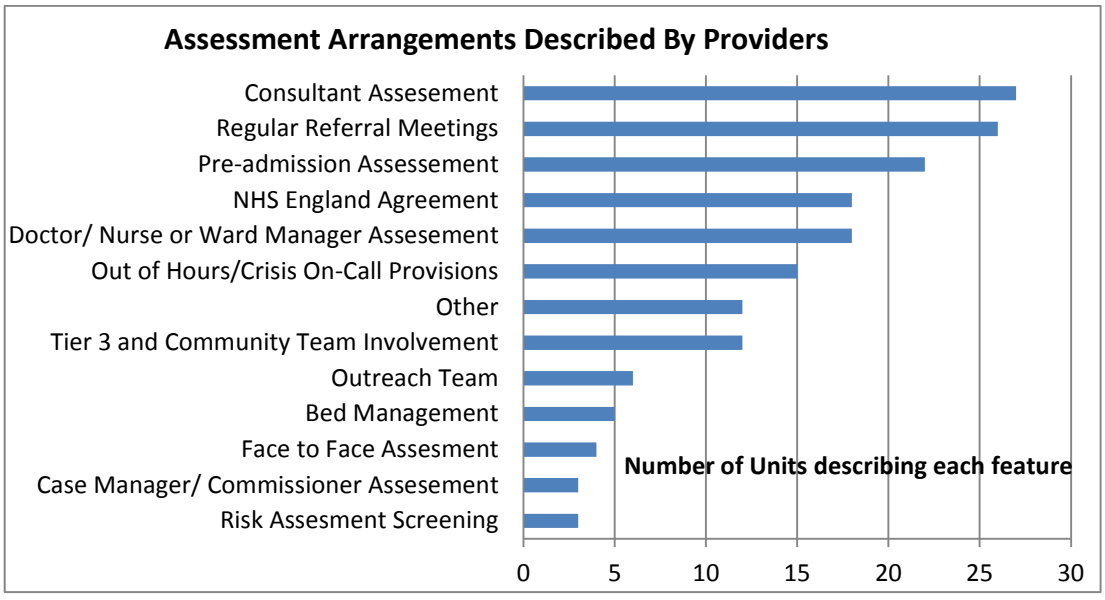
Most commissioners do not have formal gatekeeping/access assessment arrangements in place. A number of commissioners have no involvement pre-admission when admissions are of patients admitted are within their 'home' area. Most said they are notified when out- of- area placement is needed. A number described previous arrangements where local prior commissioner approval processes existed though these have not continued under the new arrangements.

Where access assessment is embedded in local arrangements, the assessment is undertaken by the CAMHS Tier 4 unit, frequently in discussion with the Tier 3 services. In two instances (Cumbria, Northumberland Tyne & Wear and Birmingham, Solihull and the Black Country) structured arrangements have been in place for some years and have benefited from continuity. Several commissioners emphasised the importance of case management to harnessing activity, facilitating appropriate discharge and reducing lengths of stay.

Most commissioners did not know the proportion of referrals which were turned down and therefore a national overview is not possible. The following information was provided:

- South Yorkshire and Bassetlaw- 29 admissions were refused in 2012/13
- Birmingham, Solihull and the Black Country-an audit in 2012 reported 45% of referrals were diverted through the assessment mechanism
- Surrey and Sussex-no refusals known
- Wessex-refusal rates ranged from 0% to 61% depending on the provider

Providers were asked to describe their own access assessment arrangements, with the following responses received, these may not be mutually exclusive and providers may have several different mechanisms in place:



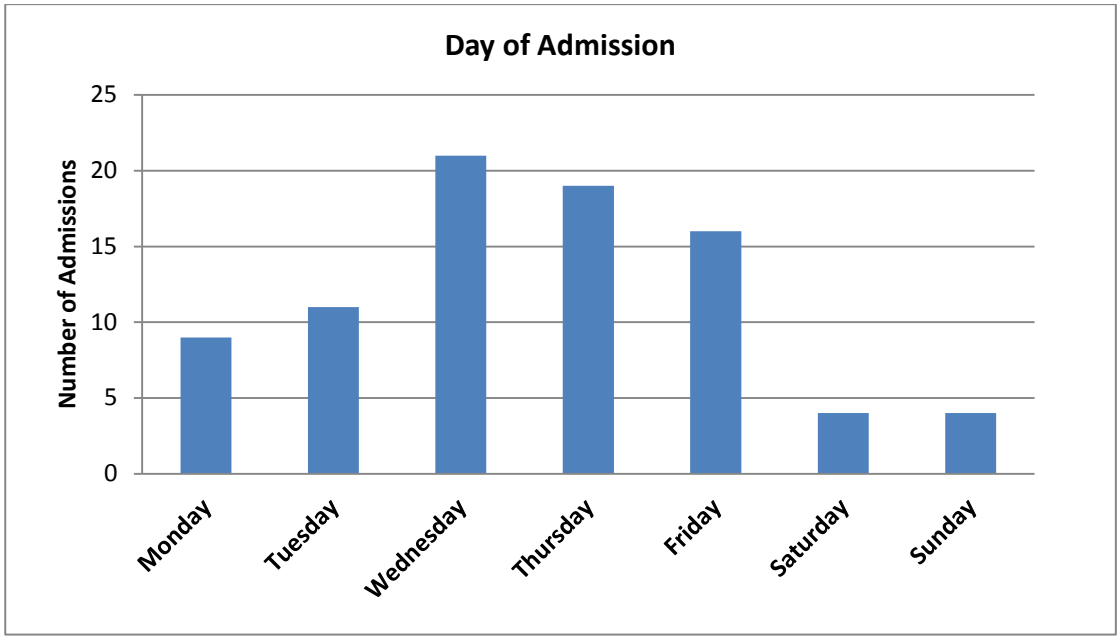
One unit reported no formal assessment arrangements were in place which they cited as causing an issue with inappropriate referrals.

Provider responses on changes observed since commissioner changes implemented
"Gatekeeping threshold reduced". "The changes in commissioning arrangements have made it more difficult to gatekeep beds effectively". "Suggested removal of gatekeeping in [COUNTY] would be detrimental". "The unprecedented use of adult beds...along with the requirement for an added Tier 4 gatekeeping assessment have placed significant strains on the relationships of the in-patient service with CAMHS".

It appears to be generally acknowledged that consistently applied assessment arrangements are helpful in ensuring that CAMHS Tier 4 inpatient services are accessed appropriately. Equity of access to CAMHS Tier 4 inpatient services would be more consistently achieved through standardised access assessments (see section 2.23). It appears that some of the controls that existed prior to April 2013 have lapsed and that these appear to have contributed to some of the pressures being experienced in the system.

3.10 Admissions

Day of admission (from commissioner case histories)

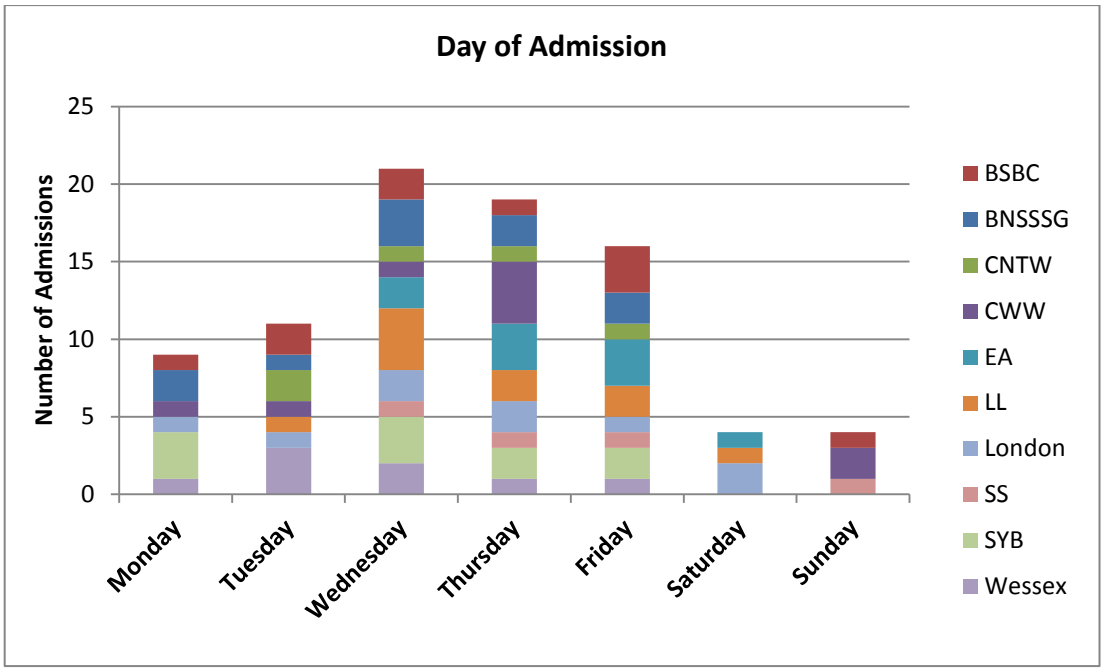


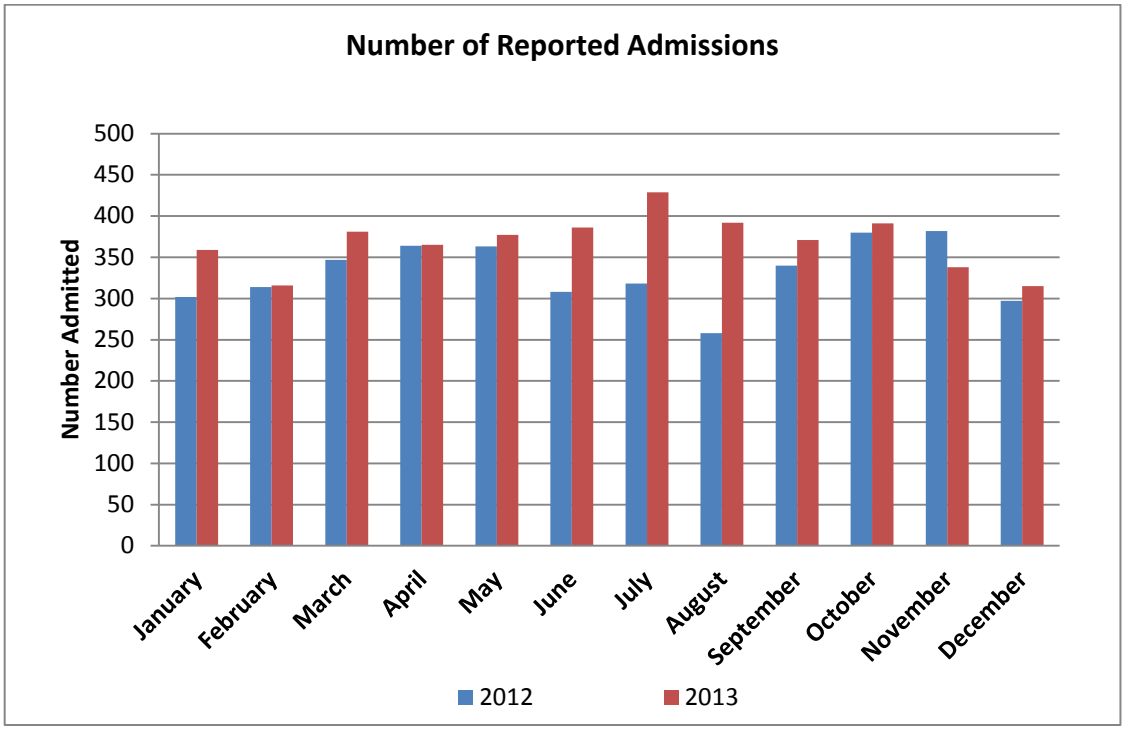
"NHS England can be extremely helpful when planning / agreeing admission to out of area beds".

"The admission process is simplified and streamlined".

"A decrease of pre-admission Tier 3 input".

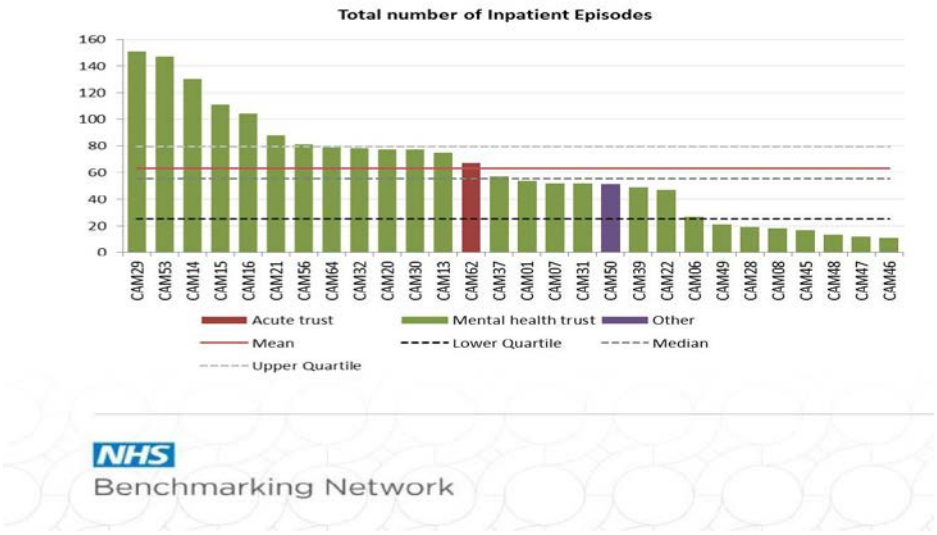
"The threshold for requesting admission seems to have lowered and referrers seem to simply seek more and more distant placements in crisis situations rather than look at local plans".


Day of Admission
Number of Admissions
25
20
15
10
5
0
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday
BSBC
BNSSSG
CNTW
CWW
EA
LL
London
SS
SYB
Wessex


Number of Reported Admissions
Number Admitted
500
450
400
350
300
250
200
150
100
50
0
January
February
March
April
May
June
July
August
September
October
November
December
2012
2013

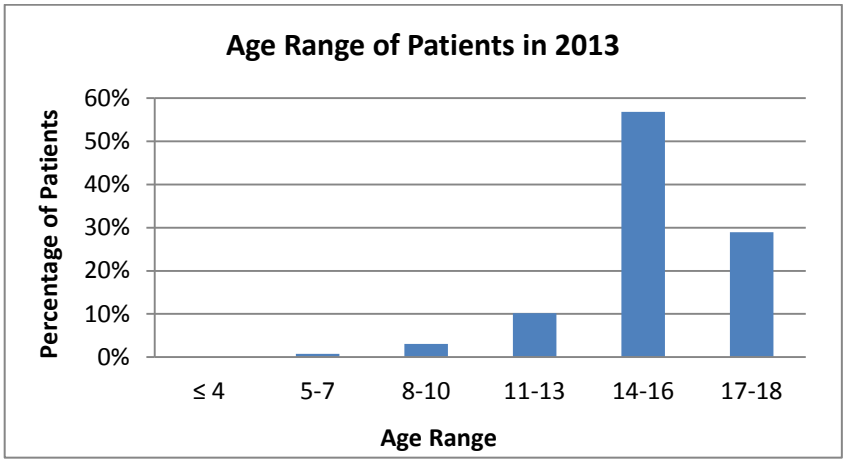
The CAMHS benchmarking report (NHS Benchmarking Network, 2013) shows the following on number of inpatient episodes for Tier 4 services:

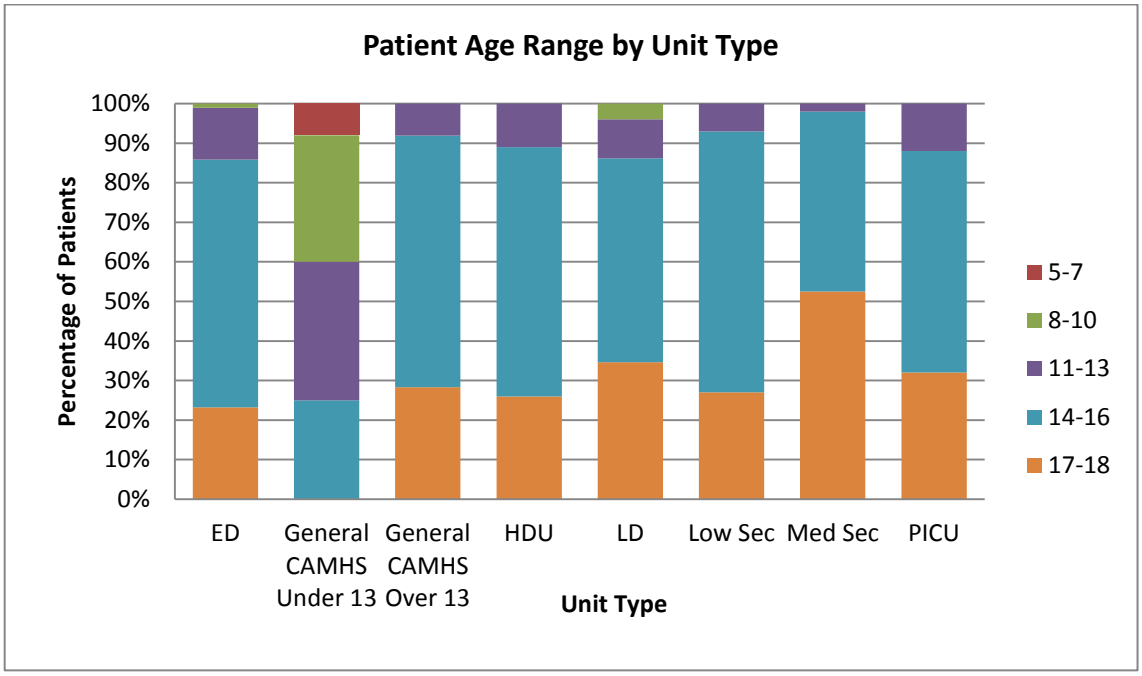
- Tier 4 inpatient activity cannot be benchmarked in terms of catchment population served as definitive catchment populations cannot be calculated due to crossover between catchments, the role of the private sector as a prominent provider to the NHS, and the commercial nature under which many NHS Tier 4 beds are purchased.
- The mean average number of admissions for each Tier 4 unit in 2012/13 was 63, which should be compared against the mean average for beds provided of 16.
- The range in admissions approximates the level of bed provision and ranges from 11 admissions to 151 admissions.



Patient profile

Age groups of patients admitted in 2013:





Four individual children's units had 14-16 year olds admitted.

Admission profiles

Planned and unplanned admission

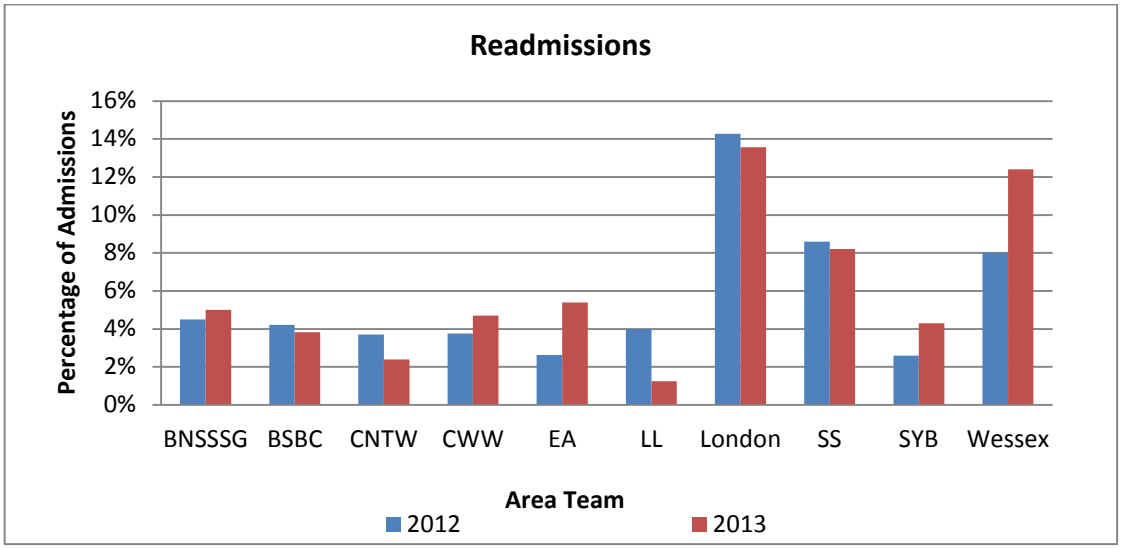
A potential indicator of an increased mismatch between capacity and demand in the system may be a rise in unplanned admissions. Providers were asked to report on planned and unplanned admissions during 2012 and 2013. In the units who

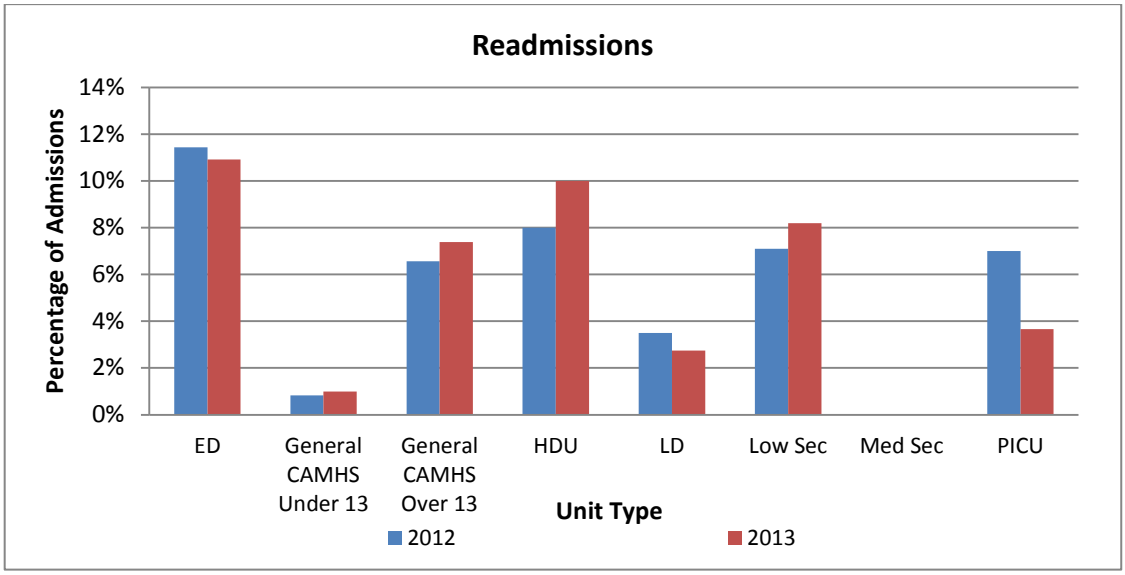
responded the ratio of planned to unplanned admissions showed no significant variation year on year (67% in 2012, -68% in 2013 planned).

There is no universally agreed definition of a planned admission but it is often taken to mean an admission which has occurred following an assessment by the CAMHS Tier 4 team.

Readmissions

The provider survey defined readmissions as a young person who had previously been admitted to a Tier 4 in patient service within the previous four months.



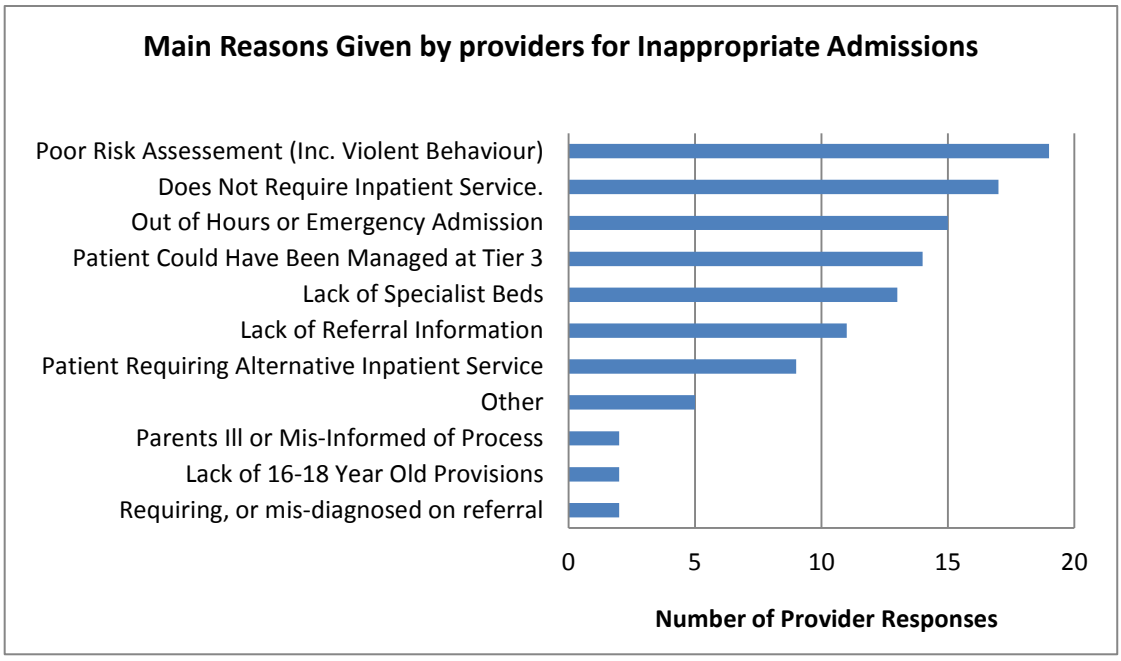


Providers were asked to report on the percentage of patients who had clear aims on admission. Of the 90 units that provided an answer, an average of 95% of admitted

patients had clear aims. There was no marked difference across area teams or specialties.

Inappropriate admissions

Providers gave examples of instances where patients who had been admitted were subsequently deemed to be inappropriate. The main reasons described are shown below. It should be noted there are potential overlaps between categories (for example, the categories does not require an in-patient service and could have been managed by Tier 3)



What are the main reasons for inappropriate admissions in your experience?

"Defensive practice of community professionals and a lack of training or awareness of CAMHS issues (in adult services)."

"Non-clinicians trying to say somebody 'has to be admitted'."

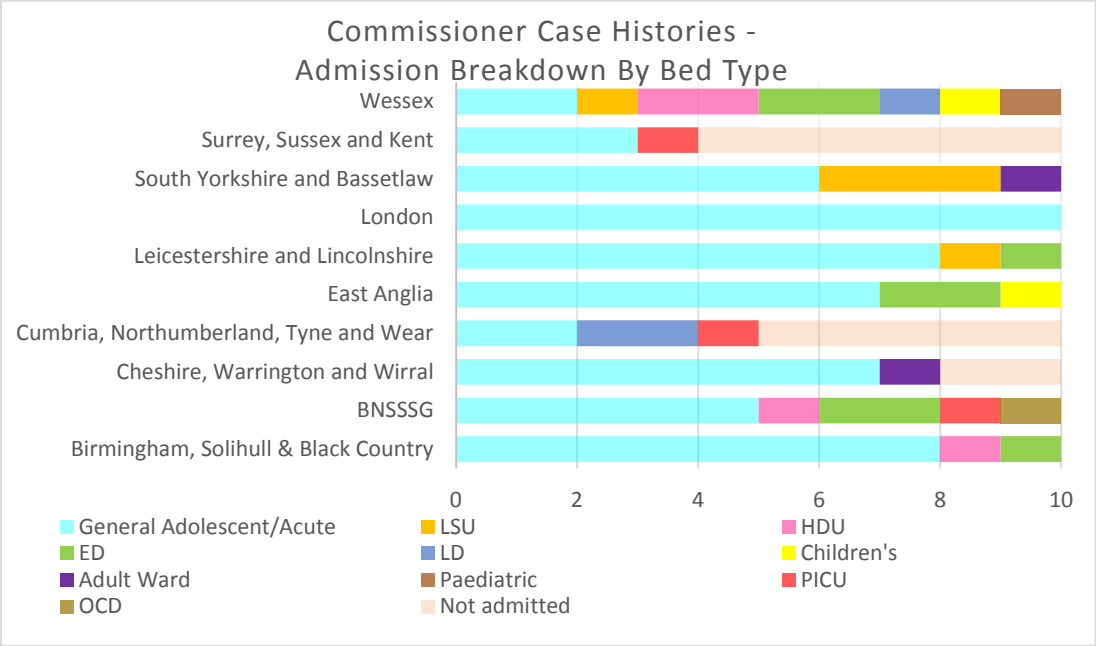
"Some young people actively seek admission through deliberate self-harm/peer encouragement from current in-patients."

"Mixed diagnosis and complex care needs." (provider responses)

Admissions by bed type from the commissioner case histories

Analysis of the commissioner case history admissions is shown below.

Although this is a small cohort representing a short time period it provides a snapshot of activity from the commissioner perspective. 87 patients were admitted, the majority into general adolescent units and two went into an adult ward. The remainder of admissions are distributed across the sub- specialties.



3.11 Admissions of young people into adult wards

Recent publicity about young people being placed in adult wards has been a cause of concern.

From 1 April Quality Surveillance Groups (QSGs) were established in all area teams (not just area teams that commission specialised services) to provide an opportunity for the exchange of information that may indicate an early warning of problems. They also provide assurance that appropriate actions are being taken when problems arise.

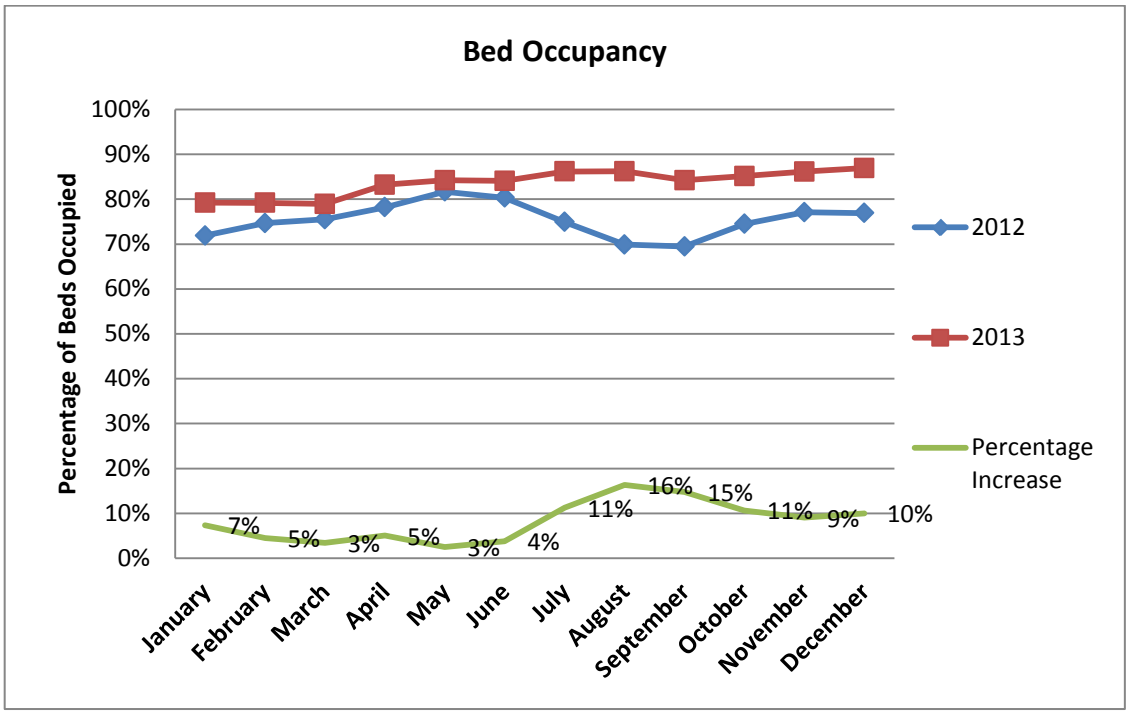
Admission of a young person aged under 16 years to an adult ward is currently classed as a “serious incident” and is currently reportable under the STEIS system. A young person aged between 16 and 18 admitted to an adult ward is a “reportable incident”. The former requires in-depth investigation and consideration by the regional Quality and Safety Group. It is understood the definition of the types of incidents reported via STEIS is under review. If in future the admission of a young person to an adult wards is no longer classified as an incident, then NHS England will have no consistent mechanism for gathering this information and another mechanism will need to be arranged.

From the commissioner case histories, there are only two examples of young people being admitted to adult wards. Only one commissioner reported knowing all instances of young people in adult wards because they have an arrangement with the nursing and quality team at the region. The steering group review co-chair asked the four NHS England regional QSGs for information on CAMHS issues they had discussed. The main issues raised were around general lack of availability of beds leading to longer distance admissions. Two regional QSGs specifically reported discussing adolescent admissions to adult wards: Midlands and East region held a system wide meeting following 11 instances of young people being admitted to adult beds relating to one unit; North region identified two instances.

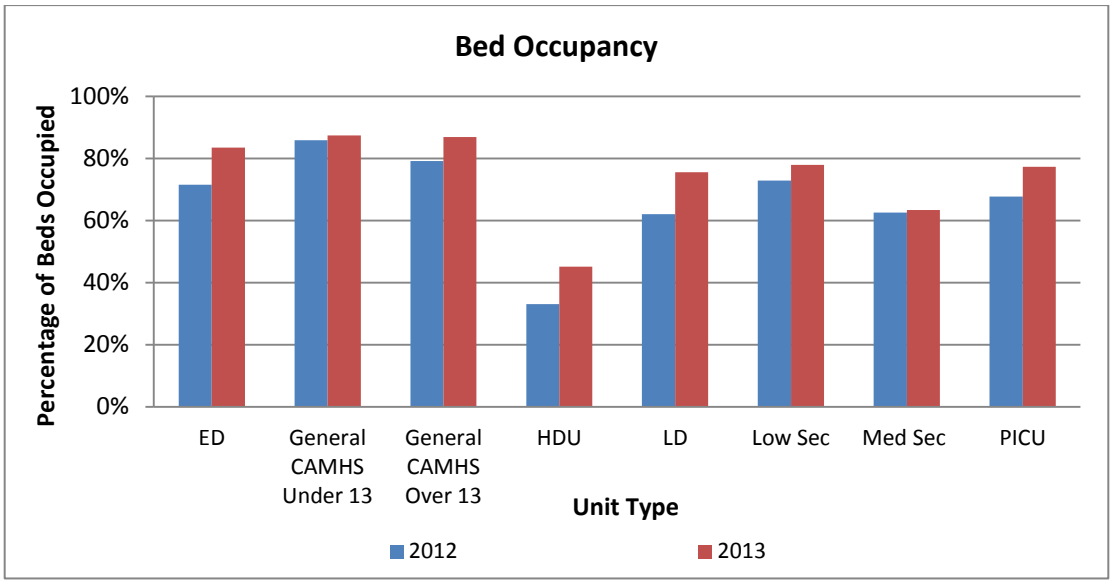
Bed occupancy and length of stay

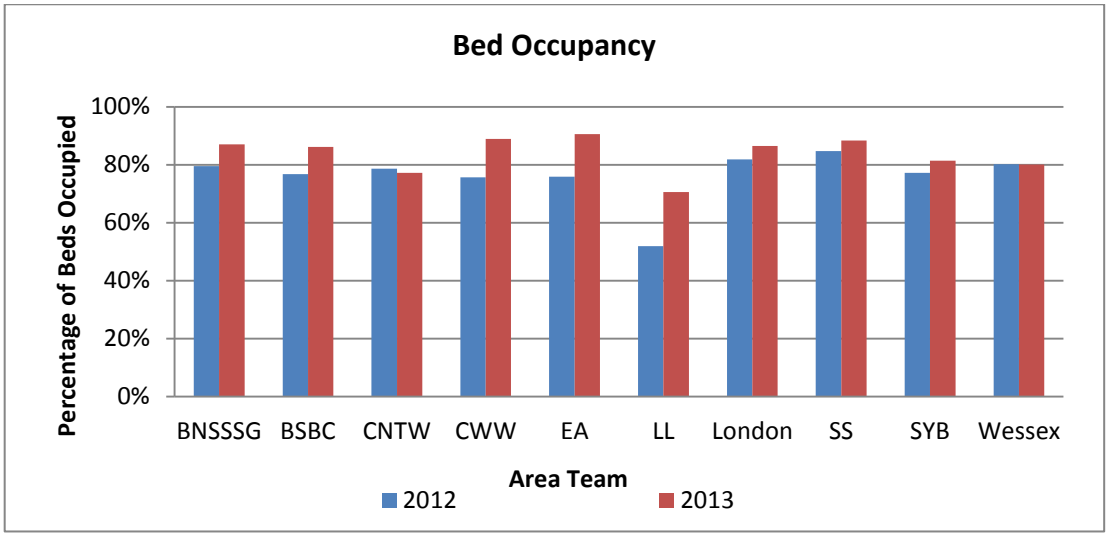
Monthly bed occupancy

In 2012 providers saw a seasonal dip in bed occupancy over the summer months. This was not repeated in 2013 with a sharp increase of 16% in admissions seen in August.



The rise in occupancy was experienced across all specialties, most markedly in learning disabilities which had a 15% year on year increase.





All area teams, with the exception of Wessex and CNTW experienced increased average occupancy. LL had a 19% increase (from 52% to 71%) and East Anglia had a 15% increase (from 76% to 91%).

Bed availability

Beds commissioned

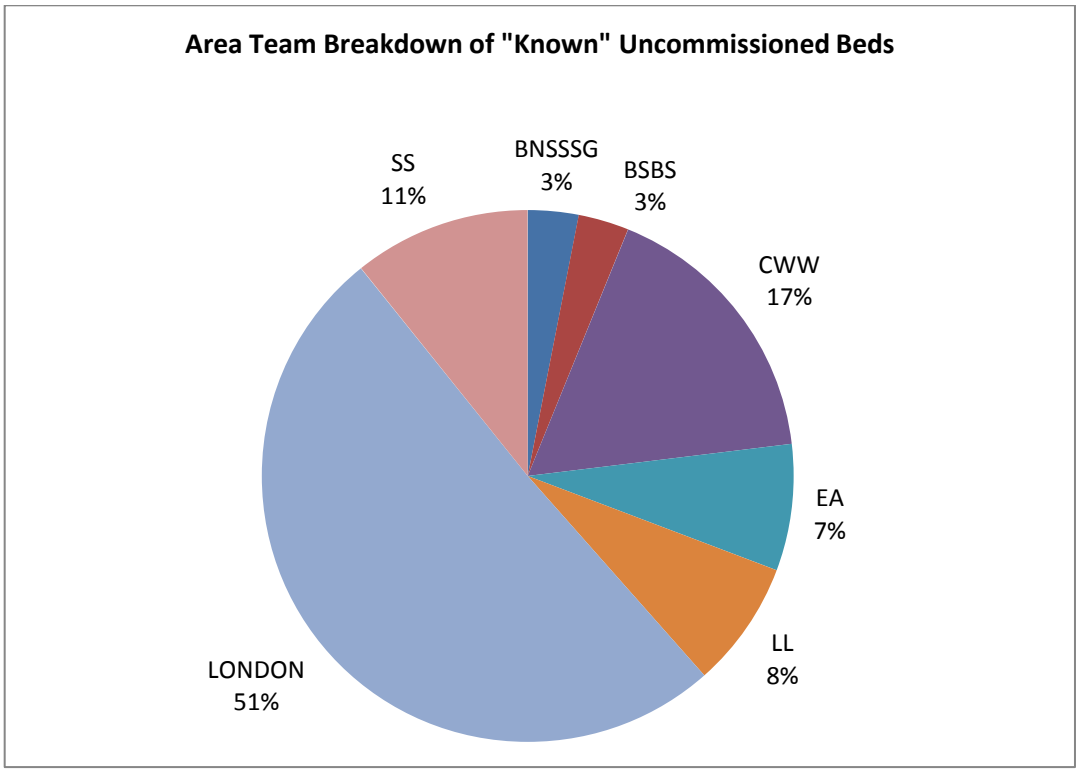
A proportion of the bed estate for CAMHS Tier 4 services is not covered by contracts for services. As at January 2014, NHS England commissioned 1264 beds, based upon the weekly sitrep as completed by providers. This is broken down as follows:

- 618 General (Adolescent or Children's Units)
- 232 Eating disorder

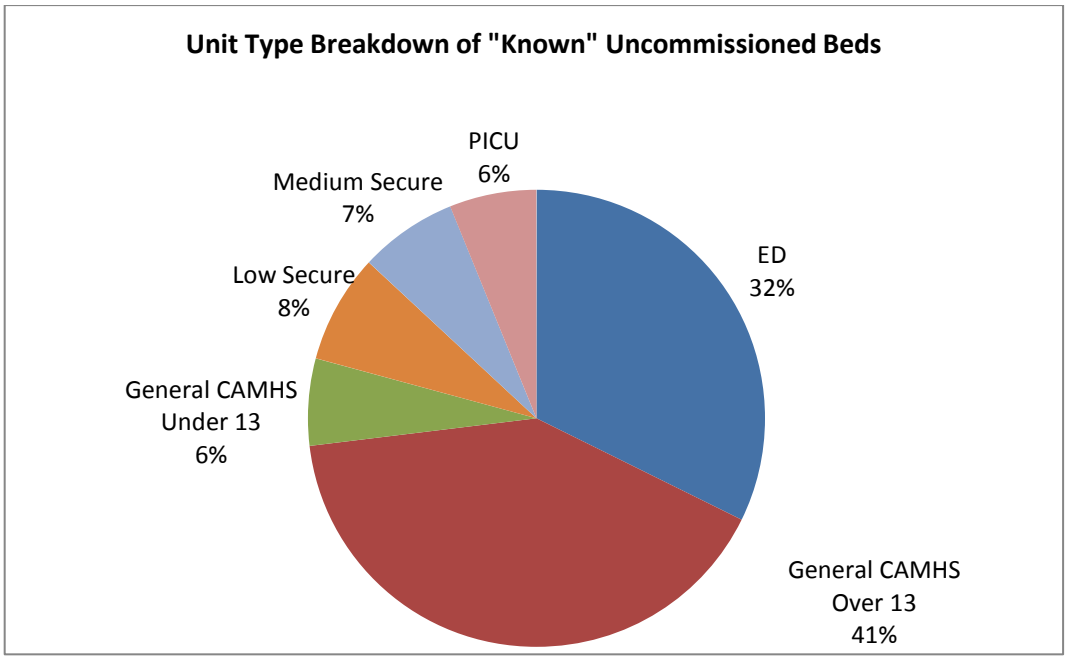
- 141 Low secure
- 92 Learning disability
- 92 PICU
- 47 HDU
- 42 Medium secure

Due to spot purchasing arrangements, the exact number will fluctuate marginally. The breakdown of bed types reported to commissioners on a weekly basis varies from that indicated in the provider survey responses. This may be due to providers including their sub-specialty beds within their general CAMHS figure or vice versa. More work is needed to clarify the exact position.

The provider survey asked units to identify how many of their available beds were not commissioned. Providers reported a total of 1383 available beds. Providers were asked to report on uncommissioned beds (i.e. beds not included in commissioner contracts) 78% of providers responded, identifying a total of 65 beds. A comparison of total beds versus NHS England commissioned beds would suggest that there should be 119 uncommissioned beds. The geographical distribution of known uncommissioned beds is shown in the chart below.



From the provider responses, the uncommissioned beds were located in 7 of the 10 specialised area teams.

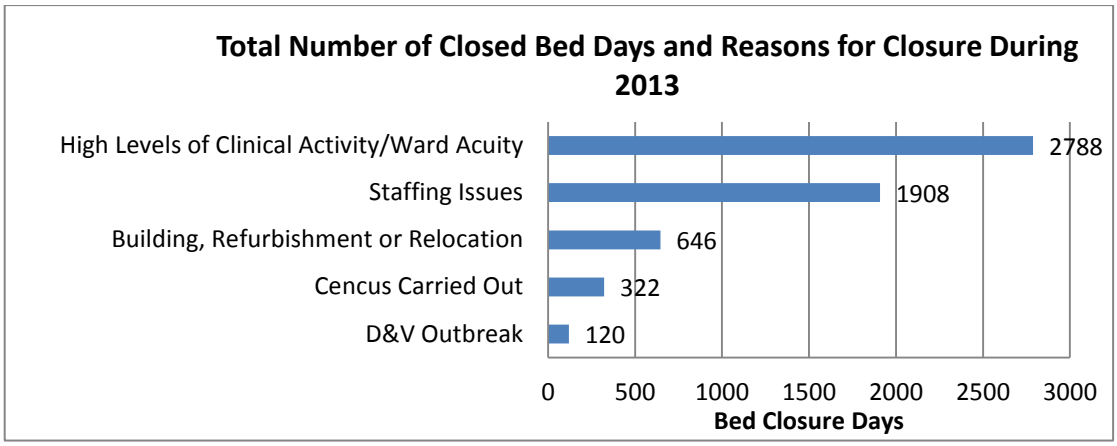


Of the total known number of uncommissioned beds (65), 51% were NHS beds spread across 14 units, with the remaining 49% of Independent beds spread across 5 units. It is not known whether the beds identified met the service specification and can be staffed. Area teams may wish to explore this further. If these beds are able to be included in existing contracts, the need for immediate procurement for additional capacity could be better assessed.

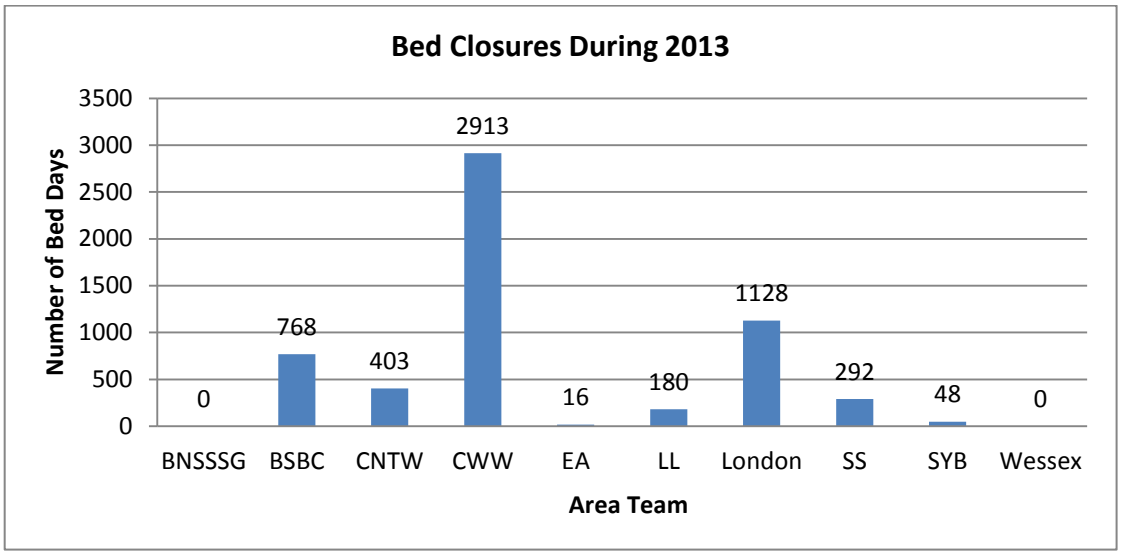
Provider Comments
"Many desperate bed requests from all over the country". "We are probably getting more requests for beds for older children and for 7 day placements..." "...better organisation of regional use of beds, clearer picture of bed usage..."

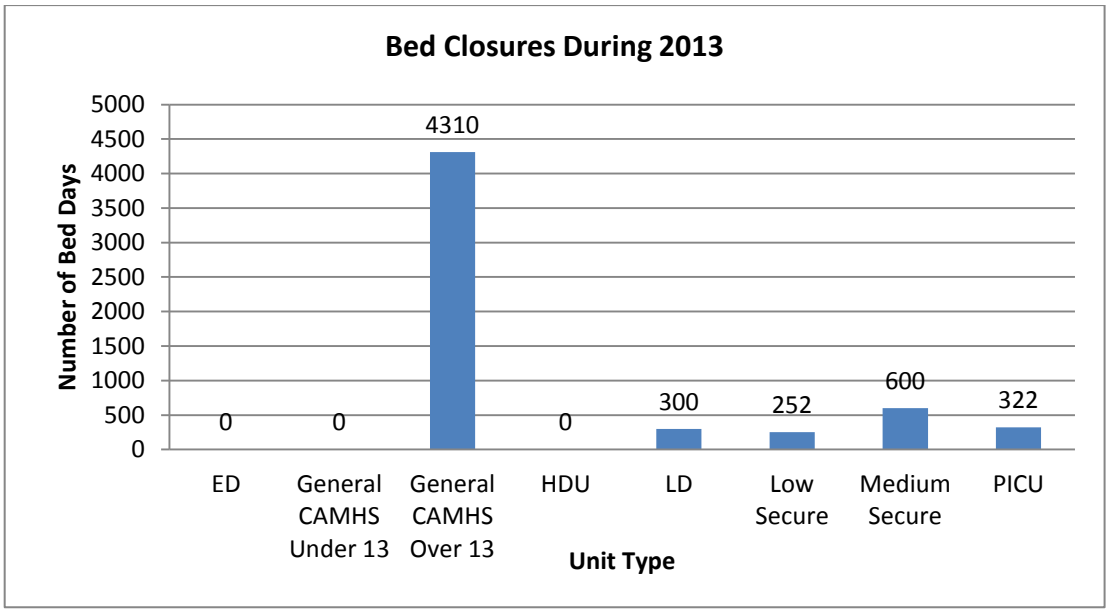
Periods of bed closure

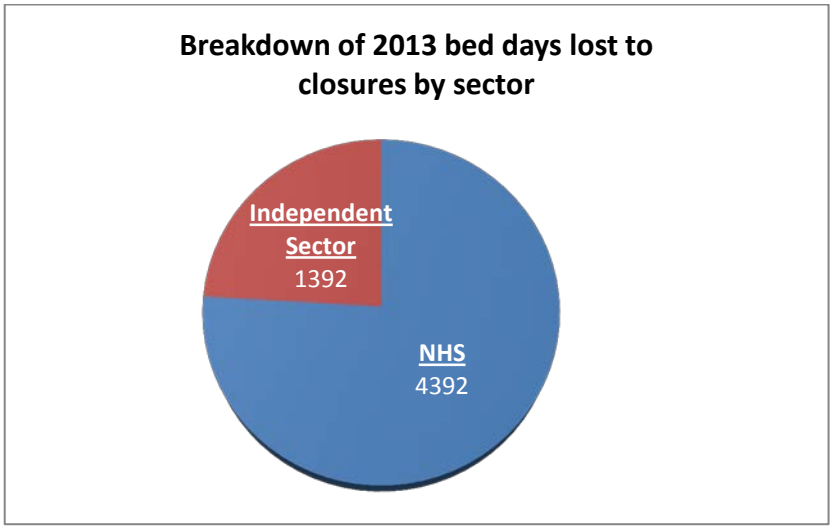
Any bed closures after January 2014 are not included in the survey. During 2013, 42% of the 99 wards who gave an answer experienced bed closures at some point during the year. A total of 5784 bed days were lost to closures during 2013, 1781 of which related to a segregation care plan in one unit.



- 11 units reported multiple instances of closure throughout the year, and 4 units reported that the closure was ongoing at the date when the survey was returned.
- A PICU Unit in CWW described 233 bed days being closed due to a census taking place in November though no further explanation is given regarding the nature of the census.
- A General Unit in CWW had 1781 bed days closed due to a segregation care plan.

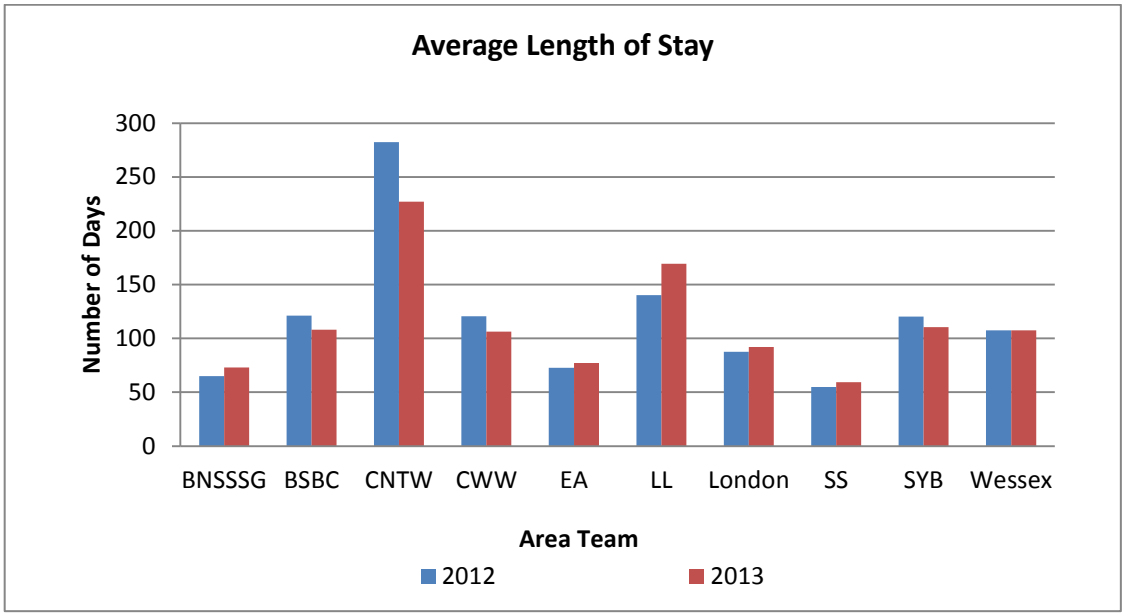


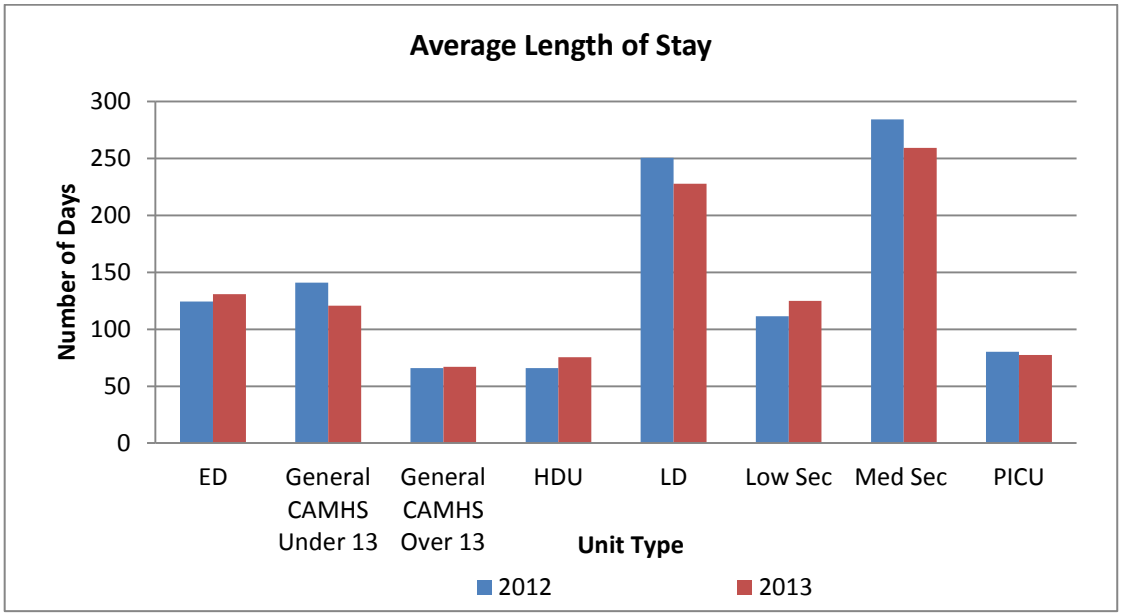

Bed Closures During 2013
Number of Bed Days
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
0
0
4310
0
300
252
600
322
ED
General CAMHS Under 13
General CAMHS Over 13
HDU
LD
Low Secure
Medium Secure
PICU
Unit Type


Breakdown of 2013 bed days lost to closures by sector
Independent Sector
1392
NHS
4392

Average length of stay 2012 to 2013 comparison

The average length of stay across all units did not differ significantly between 2012 and 2013 (123 days compared with 116). Average lengths of stay are notably longer in both years in the CNTW area team, and for learning disability and secure services across the country.

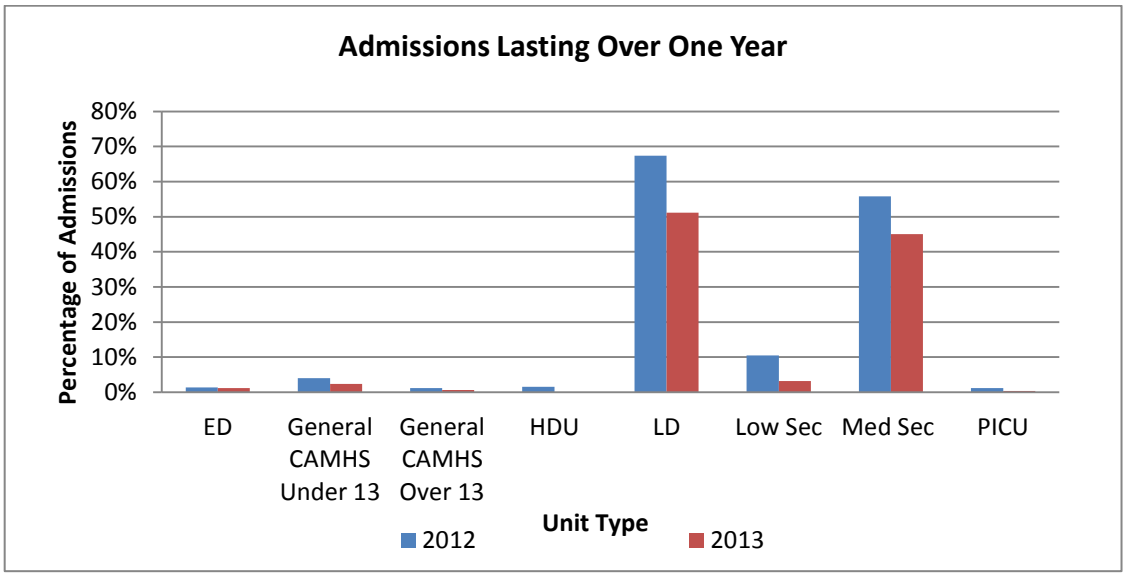


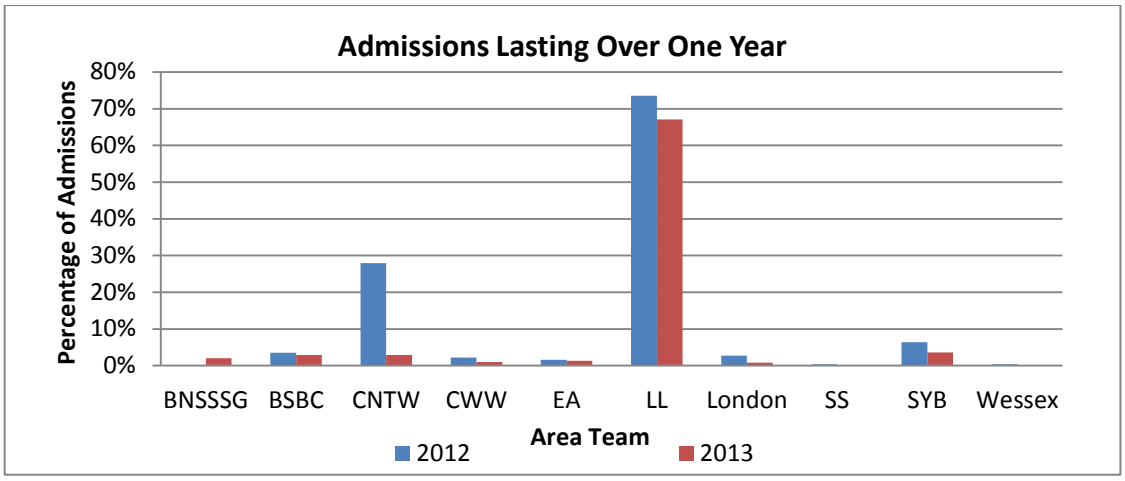


Provider comments
"The commissioning team have been very helpful at expediting discharges and reducing the length of hospitalisation, especially for the difficult to place patients". "In-patient episodes have been longer with better results..."

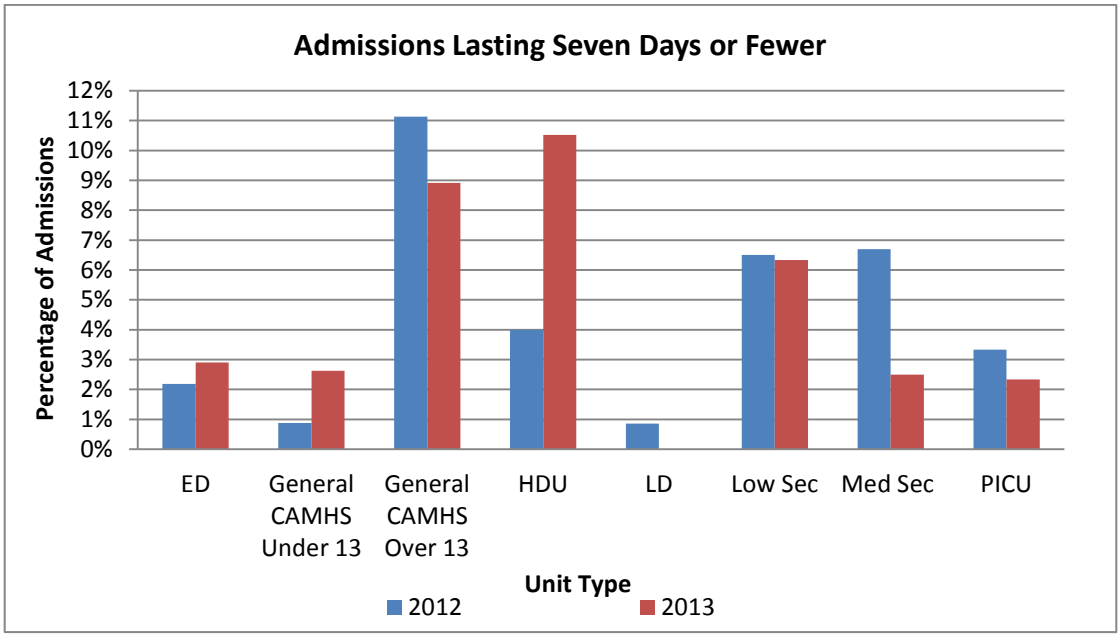
Long and short lengths of stay

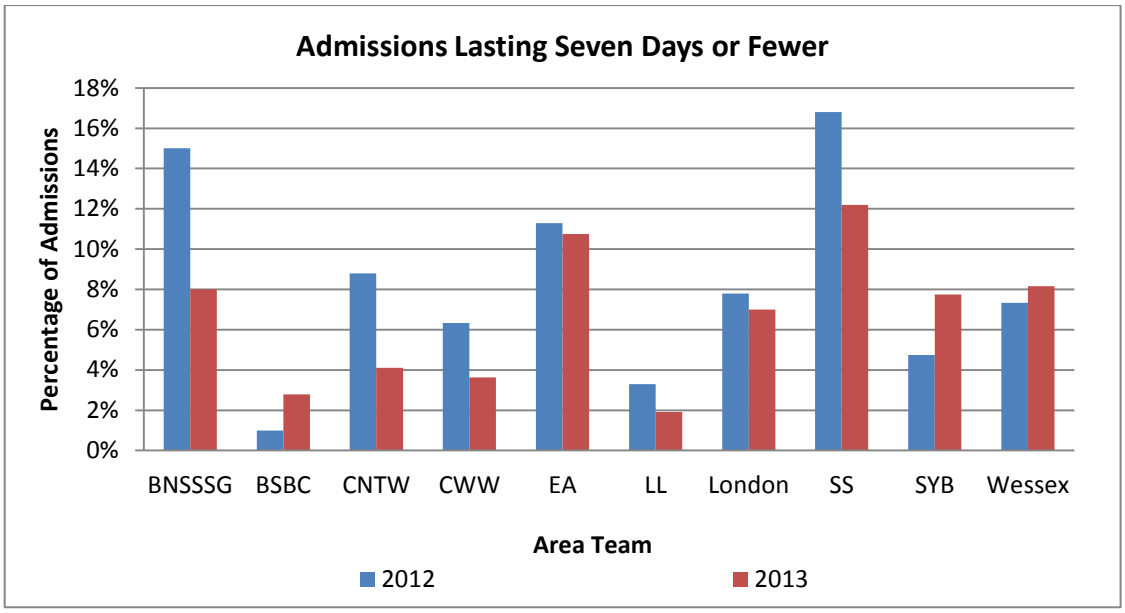
The provider survey also asked separately about particularly long or short lengths of stay, as these can have a skewing effect on reported figures. It has to be remembered that although the graphs are illustrating units by the specialised commissioning area in which they are located, those units will have children and young people from other areas. The year on year comparison varies by specialty. Notably, there was a 7% increase in HDU and a 4% reduction in medium secure short lengths of stay. BNSSSG and SS experienced markedly greater reductions in short stays (7% and 5% respectively). For lengths of stay over a year, Leicestershire & Lincolnshire area tam is an outlier and LD and Medium Secure services are markedly higher than other specialties.





The high percentage in LL relates to one independent sector provider of Medium Secure and LD care. The relatively high percentage for 2012 in CNTW relates to one LD unit reporting that all of its patient admissions lasted over one year.





3.12 Discharges

Before the review, a number of commissioners had raised the issue of delayed discharges impacting upon capacity within the system. In some areas this was felt particularly to be related to social care issues relating to Looked After Children. A view was expressed that not enough emphasis is given to discharge arrangements, particularly relating to complex care arrangements and the handling of risk as patients are discharged.

Commissioners were asked to quantify delayed discharges. Providers were asked to identify proportion of delayed discharges and reasons for them.

Reporting arrangements vary across the country. There is not a clearly agreed definition of a delayed discharge and therefore care is needed in comparing rates described across the country. From the information provided by commissioners it is not possible to say whether the rate has increased since April 2013. Two commissioners (Cheshire Warrington and Wirral and Birmingham, Solihull and Black Country) highlighted delayed discharges as a particular issue. Leicestershire and Lincolnshire area team is piloting a systematic approach to delayed discharges; South Yorkshire & Bassetlaw area team is considering adopting this approach.

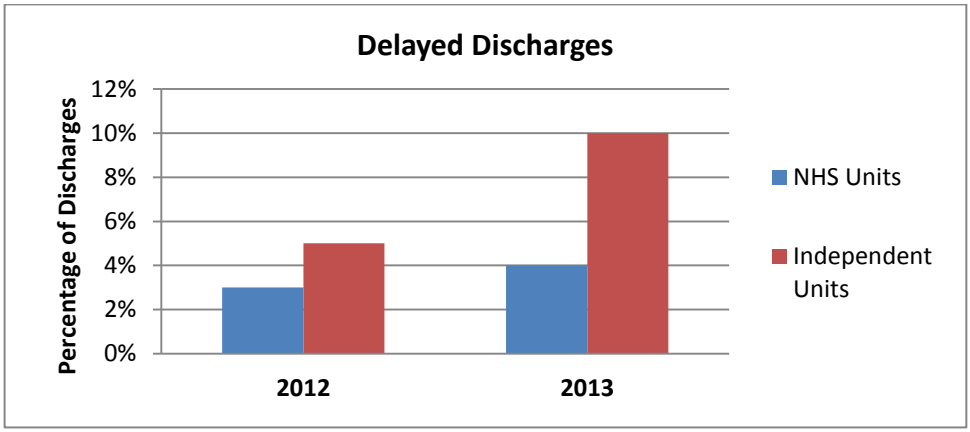
Commissioners were asked about the number of delayed discharges in their area per month. The following levels were reported:

- South Yorkshire and Bassetlaw - 9
- Birmingham, Solihull & the Black Country – 15 (excluding 2 NHS local units)
- East Anglia- 3
- London – 6

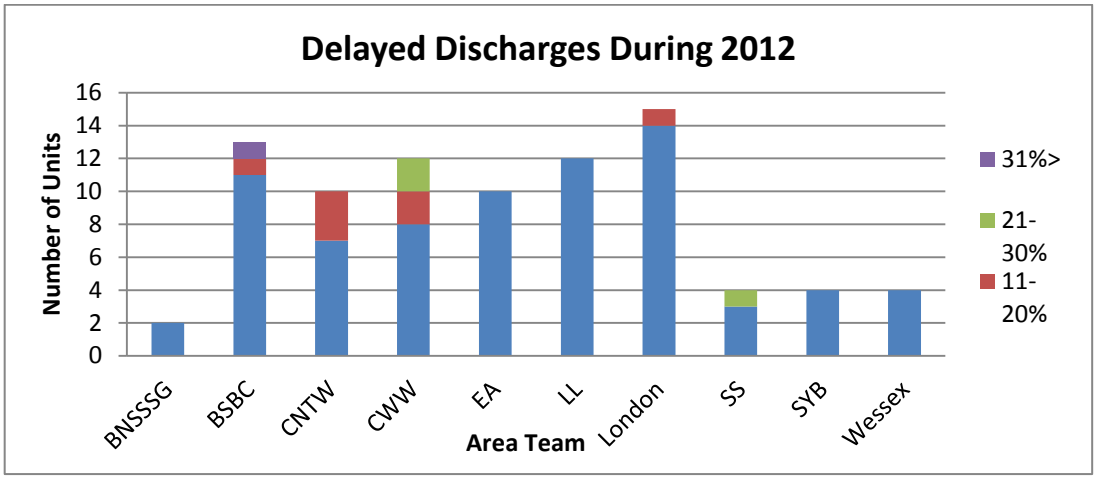
It has not been possible to quantify to what extent issues around social care were a contributory factor (as has been suggested) since this was beyond the direct remit of the review.

Any further work to better understand how pressures are being experienced across the system should include involvement of local authorities.

Of the 92 units that replied an average of 4% of discharges were delayed in 2012. During 2013 101 units reported that 6% of discharges were delayed. Provider responses describe an across the board increase in delayed discharges. In the Independent sector units the rise was from an average of 5% in 2012 to an average of 10% in 2013.

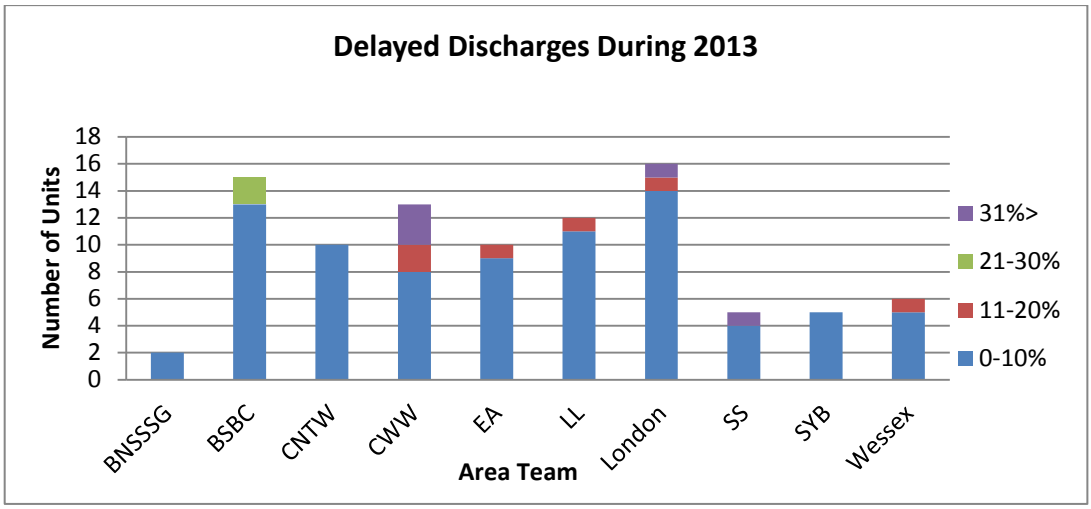


More units reported over 20% delayed discharges in 2013 than in 2012. With the exception of one unit in 2012, all of these were independent sector providers. In 2012 only one unit reported greater than 30% delayed whereas in 2013 five units did. In the units reporting higher percentages there is a predominance of PICU and low secure units in both years' figures and more instances in Cheshire Warrington and Wirral in both years.



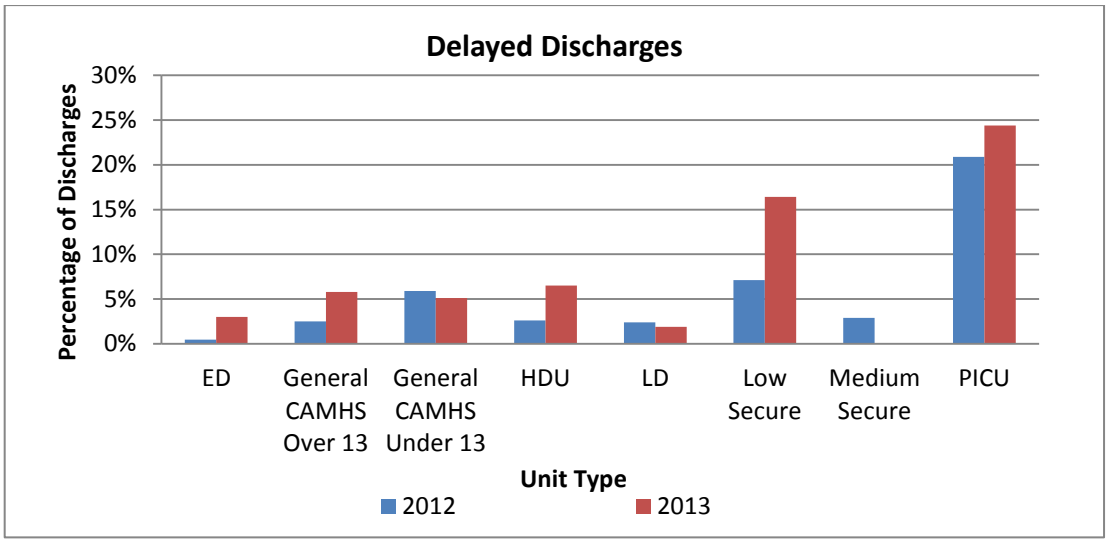
Breakdown of units reporting over 20% delayed discharges during 2012:

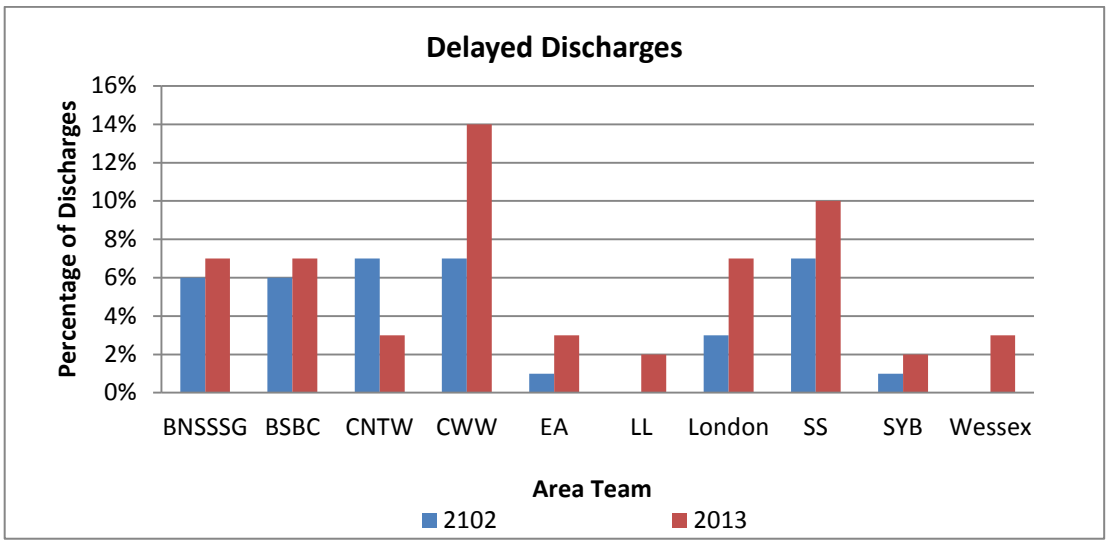
Area Team	Unit Type	Sector	% of delayed discharges
BSBC	PICU	Independent	40%
CWW	Under 13 General CAMHS	NHS	23%
	Low Secure	Independent	22%
SS	PICU	Independent	29%

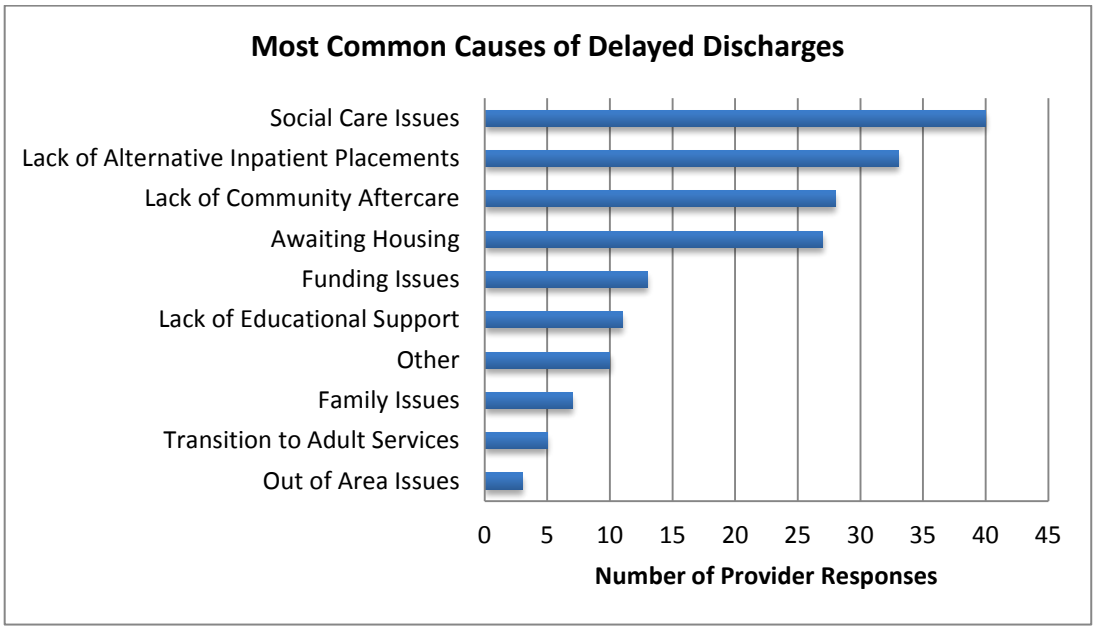


Breakdown of units reporting over 30% delayed discharges during 2013

Area Team	Unit Type	Sector	% of delayed discharges
BSBC	General Adolescent	Independent	30%
	PICU	Independent	30%
CWW	PICU	Independent	40%
	General Adolescent	Independent	35%
	Low Secure	Independent	55%
London	Low Secure	Independent	35%
SS	PICU	Independent	35%


Delayed Discharges
Percentage of Discharges
30%
25%
20%
15%
10%
5%
0%
ED
General CAMHS Over 13
General CAMHS Under 13
HDU
LD
Low Secure
Medium Secure
PICU
Unit Type
2012
2013


Delayed Discharges
Percentage of Discharges
16%
14%
12%
10%
8%
6%
4%
2%
0%
BNSSSG
BSBC
CNTW
CWW
EA
LL
London
SS
SYB
Wessex
Area Team
2102
2013


Most Common Causes of Delayed Discharges
Social Care Issues
Lack of Alternative Inpatient Placements
Lack of Community Aftercare
Awaiting Housing
Funding Issues
Lack of Educational Support
Other
Family Issues
Transition to Adult Services
Out of Area Issues
0
5
10
15
20
25
30
35
40
45
Number of Provider Responses

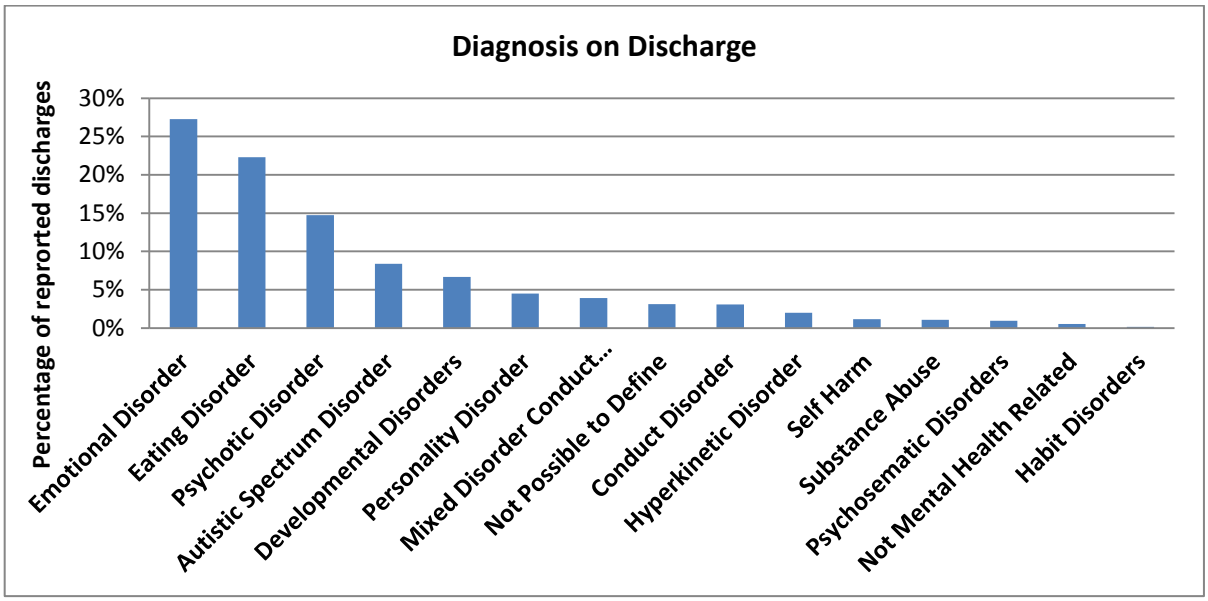
Social care issues were described as the most common cause of delayed discharges. From the commissioner case histories 13% of the cases were looked after children.

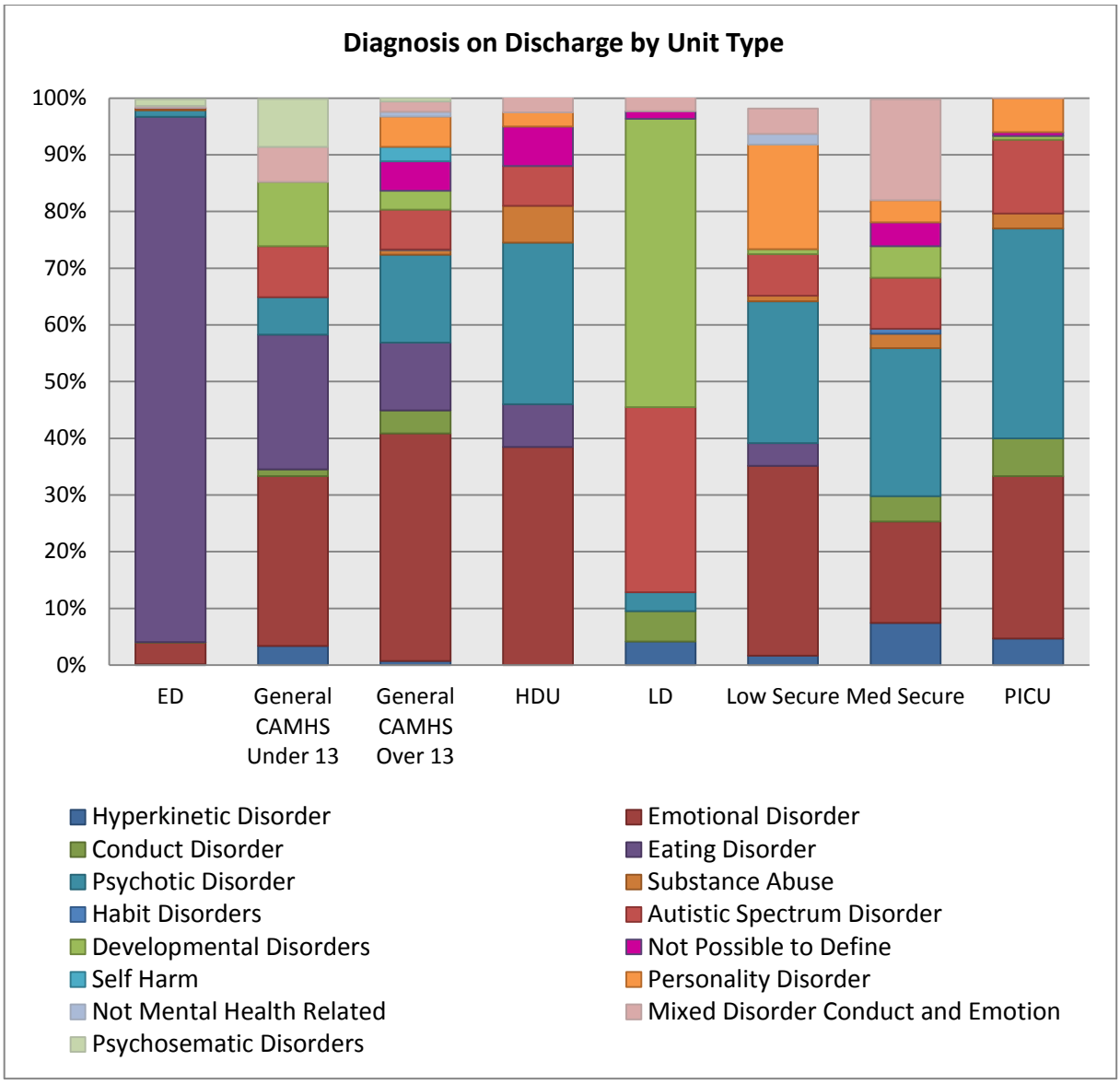
Case history information – number of cases	Yes	No	Don't know
Young Person had had a previous Tier 4 admission	38	60	2
Young Person was known to social services	47	53	3
Looked After Child	13	87	

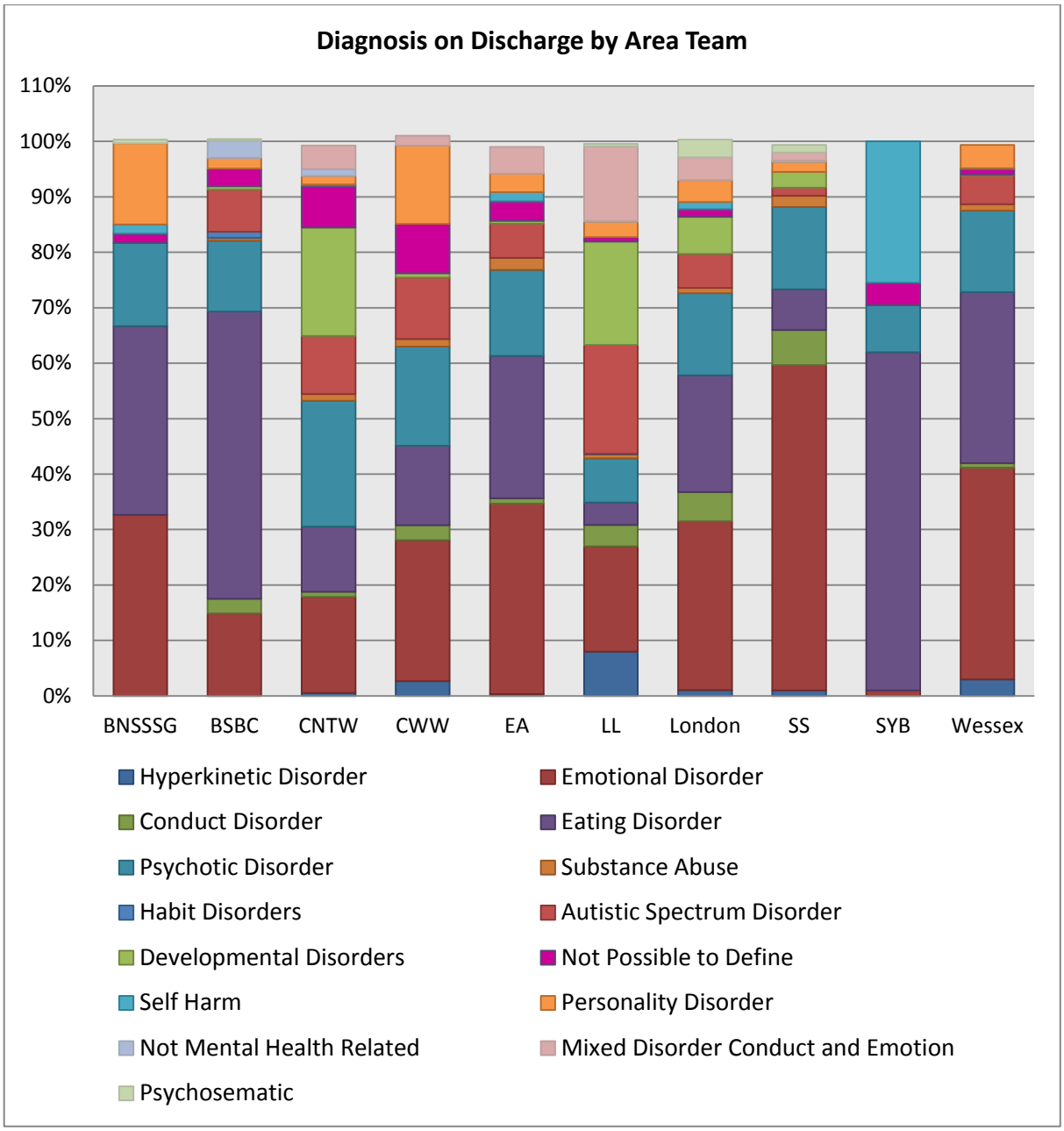
Provider free text responses on delayed discharges
What are the most common causes of delayed discharges?
"Unclear/lack of a recovery pathway." "Wider systems withdrawing following admission." "Multiple panels, with different agencies with different time scales, present 'red tape' challenges to identify appropriate and specialist placements." "Placements breaking down." "Waiting for packages of support to be set up especially if a long term placement is needed." "Delay in transfer to PICU." "Allocating care co-ordinators."
Provider responses on commissioning changes
"NHS England assist in delayed discharge - being involved in discussions around dual or tripartite funding agreements". "The commissioning team have been very helpful at expediting discharges"... "Greater difficulties with discharge back to community". "...more requests to self-discharge"

Primary diagnosis of patients on discharge in 2013

As providers varied in how they responded to this question - some used International Classification of Diseases (ICD) codes and others broad categories, - we have grouped responses into broad categories; self-harm was used as a category by a small number of providers, it is likely that self-harm was a significant factor leading to admission for patients in other categories thus this should not be taken as an indication of the rate of self-harm in this population.




Diagnosis on Discharge by Unit Type
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
ED
General CAMHS Under 13
General CAMHS Over 13
HDU
LD
Low Secure
Med Secure
PICU
Hyperkinetic Disorder
Conduct Disorder
Psychotic Disorder
Habit Disorders
Developmental Disorders
Self Harm
Not Mental Health Related
Psychosematic Disorders
Emotional Disorder
Eating Disorder
Substance Abuse
Autistic Spectrum Disorder
Not Possible to Define
Personality Disorder
Mixed Disorder Conduct and Emotion



Note:

- BSBC – 5 Eating disorder units making up 50% of all units who provided an answer.
- SYB – Only 2 units provided an answer, one of which was an ED unit.
- One Low Secure Unit in CNTW based their findings on one patient which gave a 100% reading for a psychotic disorder.

3.13 Level and type of Tier 3 services commissioned and in place

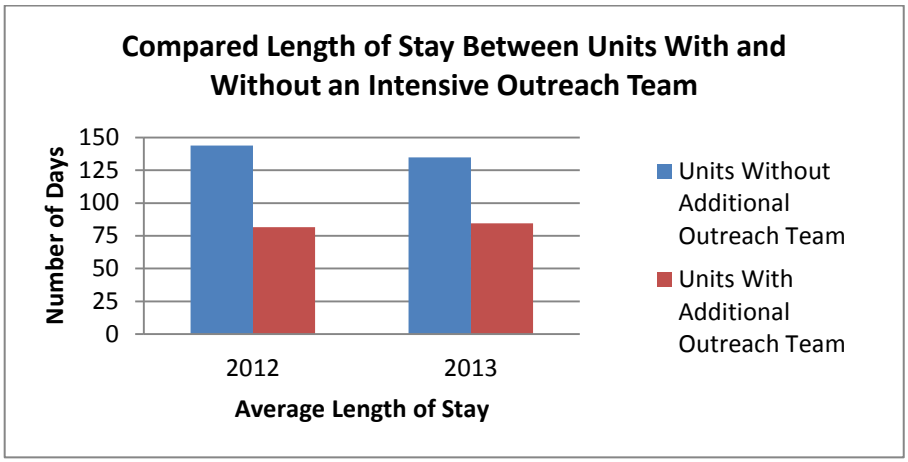
The remit of the review was to focus on CAMHS Tier 4 inpatient services. Tier 4 commissioner responses to the review were developed in consultation with Tier 3 commissioners. The information received confirms the change in lead commissioner arrangements and gives an overview of some additional services commissioned locally. Without approaching Tier 3 commissioners directly it has not been possible to provide an accurate description of the pattern of services. It was recognised that the outset that there are many issues surrounding CAMHS which require further investigation and discussion. The interface with Tier 3 services is one of these. Additional work is required between commissioners of Tiers 3 and 4 CAMHS, and this is addressed later in this report.

The provider survey asked for information about the interface with CAMHS Tier 3 services in relation to arranging discharges and managing complex cases. Responses on arranging discharge were mixed with 42% reporting reduced ability at Tier 3 CAMHS, 38% describing it as variable and 20% confirming CAMHS Tier 3 ability to arrange discharge. Regarding management of complex cases 63% noted reduced ability at CAMHS Tier 3, 32% commented that ability was variable and 6% stating that Tier 3 had the ability to manage complex cases.

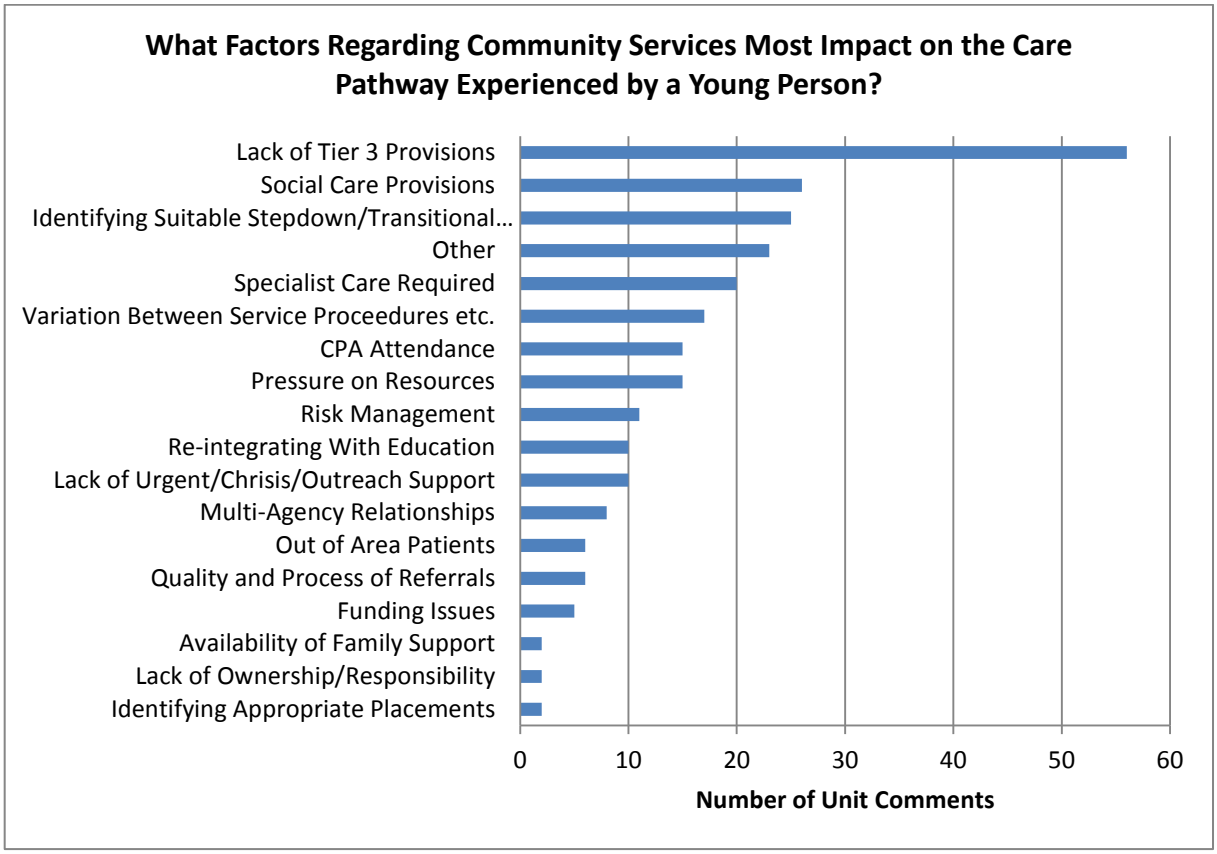
3.14 Care pathway

Intensive outreach teams

Providers were asked about the availability of intensive outreach teams. Units with access to these services show a consistently lower length of stay. Of the 96 units that supplied an answer, 64% reported that they did not have an intensive outreach team.



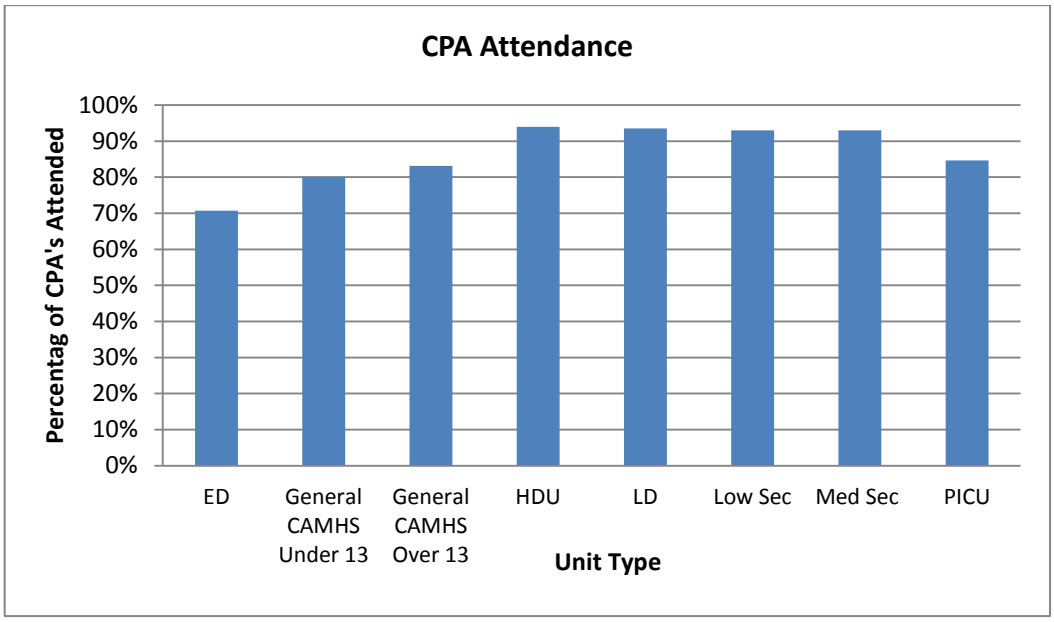
Community service impact on the care pathway experience

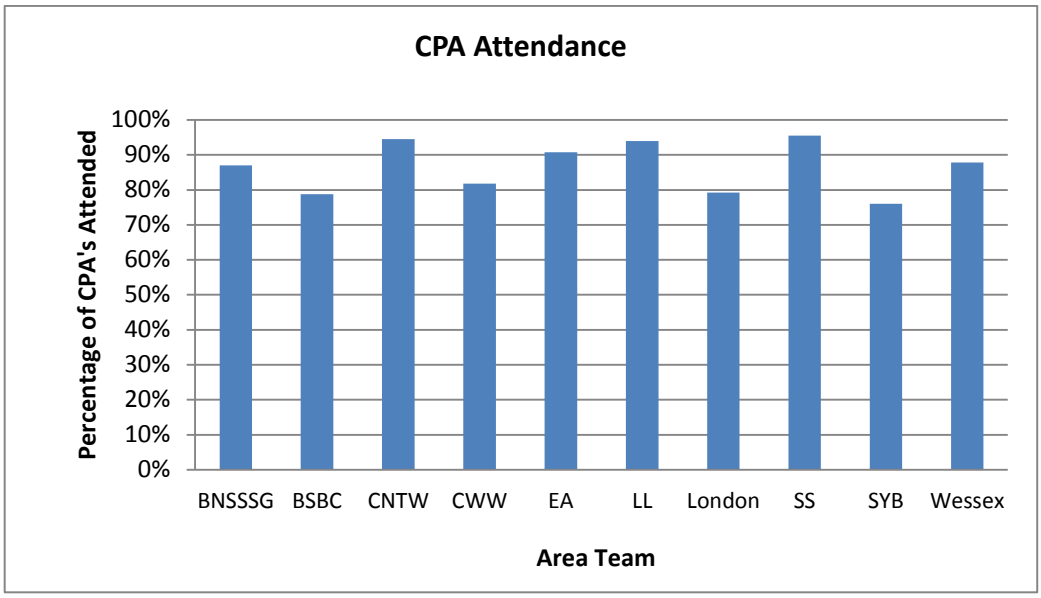


Provider free text responses on the impact of community services
"Harder to co-ordinate community resources prior to discharge..."
"...less involvement with the CAMHS community teams".
"...less pressure from community CAMHS teams and social care agencies for discharge from the unit".
"...the capacity of the local area team is limited and so response time to queries has been quite slow. However, this has been improving in the last month"
"...Challenge to community for alternatives to admission".

What factors regarding community services most impact on the care pathway experienced by a young person?
"On discharge - client is not able to be referred to a specific ED CAMHS team." (Comment submitted by Eating Disorder Unit) "Not available to pick up a young person within 7 days of discharge due to clinical caseload." "Capacity to access complexity." "Difficulties getting a key-worker for patients admitted without a period of outpatient work first, and difficulties arranging for a psychologist to continue the individual psychology post discharge." "Lack of MDT involvement in patients care..." "Vacant post or high levels of sickness in local CAMHS teams, can impact on young people's care journeys." "Sometimes, there is no adequate MDT input from CAMHS." "Geographical distance for Tier 3 services to travel." "Another key factor is the absence of a care co-ordinator in a team or a gap in consultant case holder." "Inability to pick up the case." "Speed of external assessments (this is usually good)." "Caseload." "...no availability of co-worker to support psychiatrist, lack of engagement once they are inpatients..." "Limited capacity of specialist eating disorder outpatient services or no service commissioned in some areas." (Comment submitted by Eating Disorder Unit) "Poor staffing levels." "...access to individual psychological therapies."

Community mental health team attendance at CPAs in 2013





Geographical considerations

Historically, the distribution of CAMHS beds has been uneven around the country. Research into the distribution of in-patient CAMHS in 2007 (O'Herlihy A, 2007) found that:

> Total bed numbers in England were found to have increased by 284; 69%of the increase is due to the independent sector, whose market share has risen from 25% in 1999 to 36% in 2006. Regions with the highest number of beds in 1999 have increased bed numbers more than areas with the lowest number of beds in 1999 (8.3 v. 3.6 beds per million population). In units that admit only children under the age of 14, there has been a 30% reduction in beds available (123 to 86).

CAMH bed numbers and type managed by the NHS and the independent sector in England between 1999 and 2006

	All beds			NHS beds			Independent sector beds		
	1999	2006	Change, %	1999	2006	Change, %	1999	2006	Change, %
Unit type									
General[1]	620	739	19	549	570	4	71	169	138
Eating disorder	73	113	55	18	20	11	55	93	69
Psychiatric forensic	16	68	325	16	68	325	0	0	0
Psychiatric secure	56	115	105	0	10	-	56	105	88
Learning disability	79	93	18	49	53	8	30	40	33
Age group									
Children only (<14 years)	123	86	-30	123	86	-30	0	0	0
Children and adolescents (4-16 years)[2]	50	104	108	50	48	-4	0	56	-
Adolescents (12-18 years)	671	938	40	459	587	28	212	351	66

- General units include a child and adolescent unit for young people who are deaf, a general adolescent unit that specialises in treating young people who self-harm and a combined paediatric and psychiatric service.
- The increase in beds for children and adolescents is accounted for by two eating disorder units managed by the independent sector. One is a new unit

that admits those between the ages of 8 and 18.The other is an existing unit that reduced its lower admission age threshold in 2003.

Total CAMH and general bed numbers per million population in English regions

Region[2]	Beds per million population, CAMH (general)[1] 1999	2006	Change, %	Total beds managed by the independent sector, % 1999	2006
North East	27.8 (11.9)	36.2 (12.7)	30 (7)	0	0
London	26.5 (19.5)	44.2 (28.6)	67 (47)	27	41
East Midlands	24.9 (9.7)	29.7 (10.2)	19 (5)	61	66
South East	23.2 (18.6)	25.5 (20.9)	10 (12)	41	52
East of England	11.9 (10.0)	12.6 (10.8)	6 (8)	19	15
Yorkshire/Humber	11.3 (11.3)	9.1 (9.1)	-19 (-19)	0	0
South West	11.1 (8.1)	12.8 (10.5)	15 (30)	0	21
West Midlands	10.4 (10.4)	25.8 (12.5)	148 (20)	16	38
North West	9.8 (8.3)	12.0 (10.5)	22 (27)	0	25
All England	17.2 (12.6)	23.0 (15)	34 (19)	25	36

- Units that admit children and/or adolescents with a wide range of diagnoses and problems are categorised as ‘general’.
- English regions are based on boundaries set in 2003; the areas are ranked in order of the total beds per million total population in1999.

There is no nationally agreed ratio of beds to population, though the CSIP review (Care Services Improvement Partnership, Kurtz, Dr Z, 2007) stated:

> There is no absolute standard for bed numbers, based upon evidence for either population needs or the effectiveness of in-patient (IP) provision. A proxy measure of 20-40 IP beds per 1,000,000 total population is generally used, as suggested by the Royal College of Psychiatrists (Cotgrove et al, 2004).

Referring to the O'Herlihy review, the CSIP report stated:

> This study shows that four regions of England are still well below the minimum of 20 beds per million population, while the total bed numbers in England have increased by 284.

Also, the appropriate ratio would be influenced by the population mix and geography of an area, as well as the mix of children and young people admitted (for instance, until recently 17 year olds were admitted to adult wards, whereas now they are included in the CAMHS inpatient population). Work to assess the appropriate number and ratio of beds could be requested from Public Health England.

3.15 Maps of current Tier 4 inpatient provision by service type

As part of the review, the steering group commissioned maps of the current known distribution of general adolescent and specialised CAMHS beds and the split between NHS and independent sector providers. The units shown comprise the QNIC membership cross-referenced against the list of units used by NHS England in its weekly census of bed availability.

As has been mentioned earlier in this report, there are some uncommissioned beds i.e. not contracted and therefore this may not be 100% complete. The specified age range of units varies. The majority of general beds can be defined in categories of under or over age 13, though there are exceptions where the ages span these categories. The map illustrating the location of general beds has split the services by under and over age 13 years. As the exact distribution of beds becomes clearer, these maps will be subject to validation and revision.

The maps show a concentration of units around major centres of population, with a reasonable distribution of adolescent units. Units for under 13's and sub specialty units are less evenly distributed. There are some units providing for more specialised pathways of care which are concentrated in fewer areas. Additionally some general units have associated sub specialty beds. This is particularly the case with eating disorder beds.

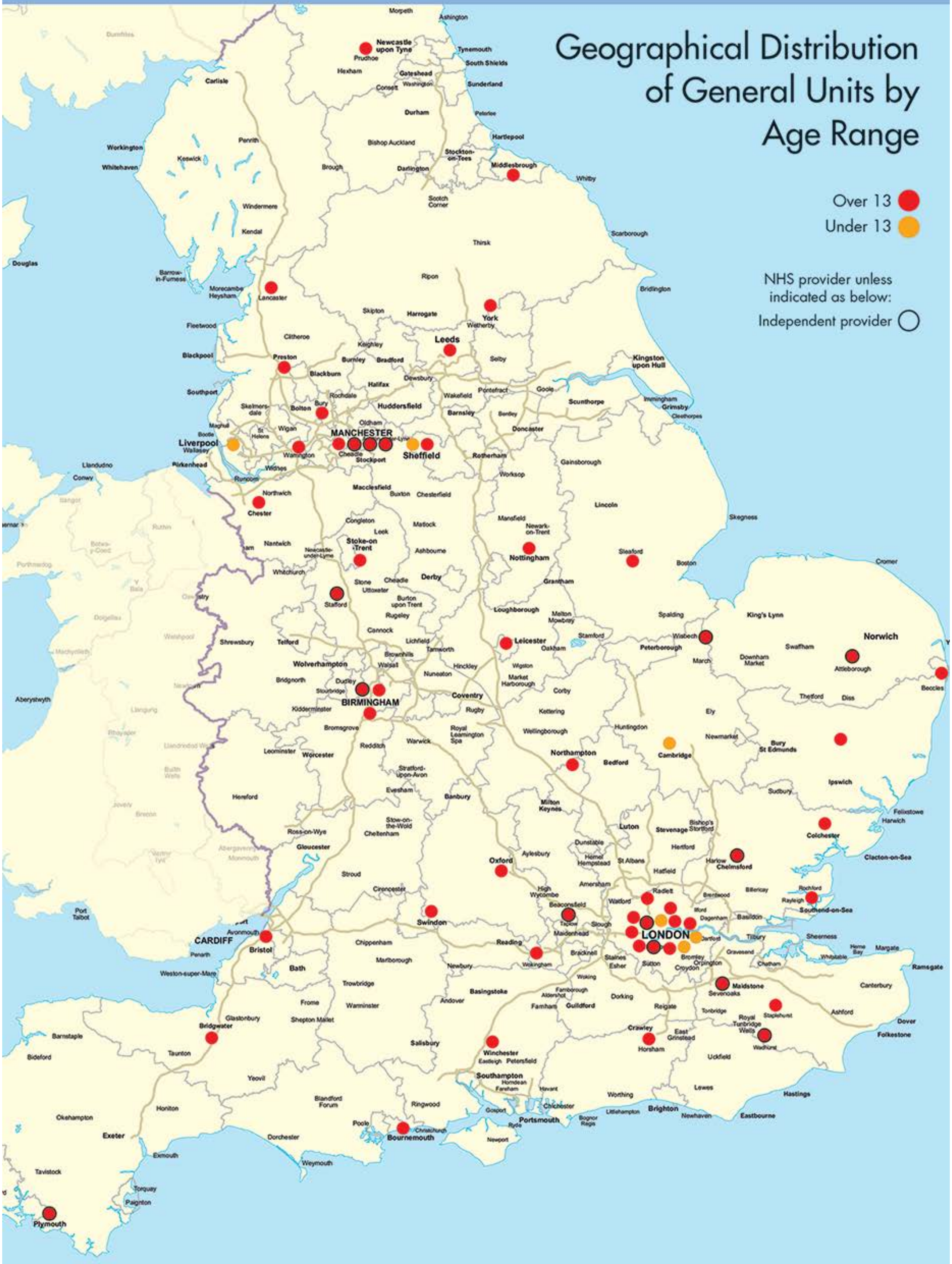
There are however areas of England without any local provision, notably the South West, as well as areas with a relative lack of capacity for example Yorkshire and Humber. This polarisation of provision is more pronounced in relation to designated sub specialty units. It is not uncommon for the nationally designated specialised services to be provided in a few "centres of excellence". Some CAMHS are highly specialised, for instance Medium Secure Adolescent Units, and it is likely for the foreseeable future that these services will continue to be provided from relatively few units across the country.

Provider responses to the survey highlighted that for CAMHS there are potential detrimental effects directly related to admissions out of area. There is a balance to be

struck between concentration of clinical expertise and the desirability for care to be as close to home as possible.

The detrimental effect of admissions out-of-area is highlighted in the provider responses to the review. Similar issues have been raised in work between the Royal College of Psychiatrists and the Youth Justice Board (YJB). The approach adopted by the YJB in considering other factors alongside distance offers a useful framework which could be adapted for use in CAMHS. More discussion is required to define what constitutes “accessible” and this should include involvement and engagement with children, young people, their families and carers.

CAMHS TIER 4 INPATIENT UNITS IN ENGLAND AS AT JANUARY 2014




CAMHS TIER 4 INPATIENT UNITS IN ENGLAND AS AT JANUARY 2014
Geographical Distribution of Designated Specialised Units
Eating Disorder
HDU
Learning Disability
PICU
Low Secure
Medium Secure
Deaf CAMHS
NHS provider unless indicated as below:
Independent provider
MANCHESTER
Liverpool
Sheffield
BIRMINGHAM
LONDON
CARDIFF
Leeds
Bristol
Southampton
Portsmouth
Bournemouth
Plymouth
Exeter
Norwich
Cambridge
Northampton
Middlesbrough
Newcastle upon Tyne

3.16 Beds not available within 50 miles

The review needed to understand whether admissions a long way from patients' homes were focused on particular sub – specialties of CAMHS Tier 4 inpatient provision, and whether the issue was more acute for some area teams than others. Commissioners were asked to describe the position pre-and post-April 2013. Through the case histories, commissioners were also asked to specify distance from home where referrals resulted in an admission.

There is no specified distance beyond which an admission is regarded to be "long-distance". Indeed, the aim for all admissions is to find a clinically appropriate bed as close as possible to the child/young person's home. CAMHS Tier 4 services are, by definition specialised, and will not be available in every local geographical area, as they are low-volume specialties. As can be seen from the maps, the distribution of sub -specialty beds is particularly uneven across the country.

Commissioner responses on beds not available within 50 miles

The area covered by the 10 lead commissioners is frequently geographically very large. This could still mean patients travel a significant distance and are not technically "out of area". Commissioners responded to this question by indicating services not provided within their geographical area (see table below).

Area team	Services not provided within 50 miles
NORTH	
Cheshire, Warrington and Wirral	Learning disability, autistic spectrum disorder is not within the area, though is within 50 miles for Lancashire patients Eating disorder- localised in greater Manchester, no services in Lancashire and limited in Cheshire and Mersey.
Cumbria, Northumberland, Tyne & Wear	Two regional centres provide all services (North and South) within the area, though still greater than 50 miles for some patients
South Yorkshire and Bassetlaw	Adolescent psychiatric intensive care (PICU) low secure adolescent low secure learning disability medium secure adolescent under 12s some areas do not have general adolescent beds within 50 miles
MIDLANDS AND EAST	
Birmingham, Solihull and the Black Country	All services available within 50 miles Low secure and under 12 children's ward not within area

Leicestershire and Lincolnshire	PICU eating disorder learning disability
East Anglia	Low secure in Norwich, but greater than 50 miles depending on patient home; eating disorder within 50 miles of area team HQ
LONDON	
London	Specialised learning disability/ASD (non-secure)
SOUTH	
Bristol, North Somerset, Somerset and South Gloucestershire	Eating disorder learning disability secure
Surrey and Sussex	Learning disability (Kent and Surrey)
Wessex	Learning Disability ASD Low Secure PICU -Wessex – not available within patch, for some bordering North Hampshire, available in adjacent Area Team and within 50 miles. Thames Valley – available in Area Team patch Under 12s Specialist Eating disorder

3.17 How “out-of-area” is defined

This review was commissioned by SCOG following increasing concerns that young people needing admission were being admitted to CAMHS Tier 4 beds further from home than had been the norm prior to April 2013. In compiling the review questions, some commissioners raised potential inconsistencies in defining “out -of -area”. An example was given where placement was geographically closer to the child/ young person’s home, though technically “out -of -area” due to the geography of the area team. In addition to this commissioner question, the case histories provided by commissioners requested information on distance from the patient’s home and reason for placement out of area.

The majority of commissioner responses referred to 'out- of-area' as being out of specialised area team geography. However, some area teams are using beds out -of-area because they are considered closer to patients’ homes. Additionally, one area team notes that its CCGs consider out-of-area to be outside the CCG boundary.

3.18 Number and percentage of out of area patients in local beds

In the run-up to the review, considerable concerns were being expressed about out-of -area placements. Some commissioners had described an inability to contain local demand because of admissions from outside their own area into local beds. Hence, even if local capacity was theoretically sufficient, they were now experiencing the need to place locally resident patients outside their area. However, information was anecdotal rather than systematic.

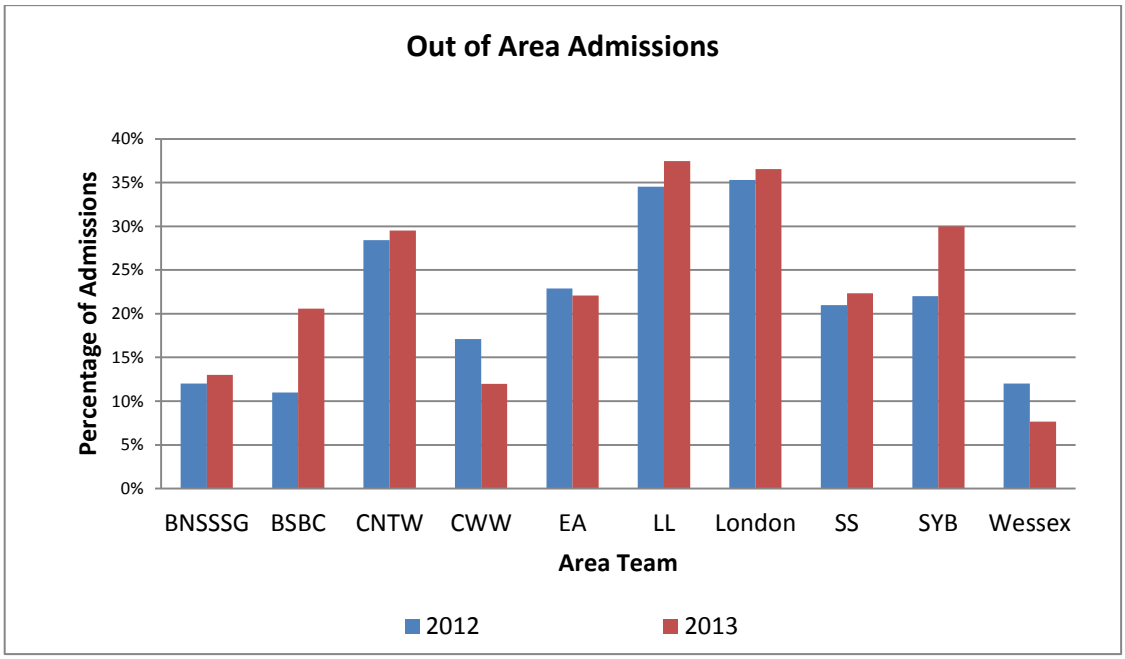
It was unclear whether the situation had worsened since April 2013, or whether it was being observed for the first time because commissioning was now coordinated nationally. There was no data to explain whether this phenomenon was linked to particular sub specialties. Both commissioner and provider surveys requested information on this.

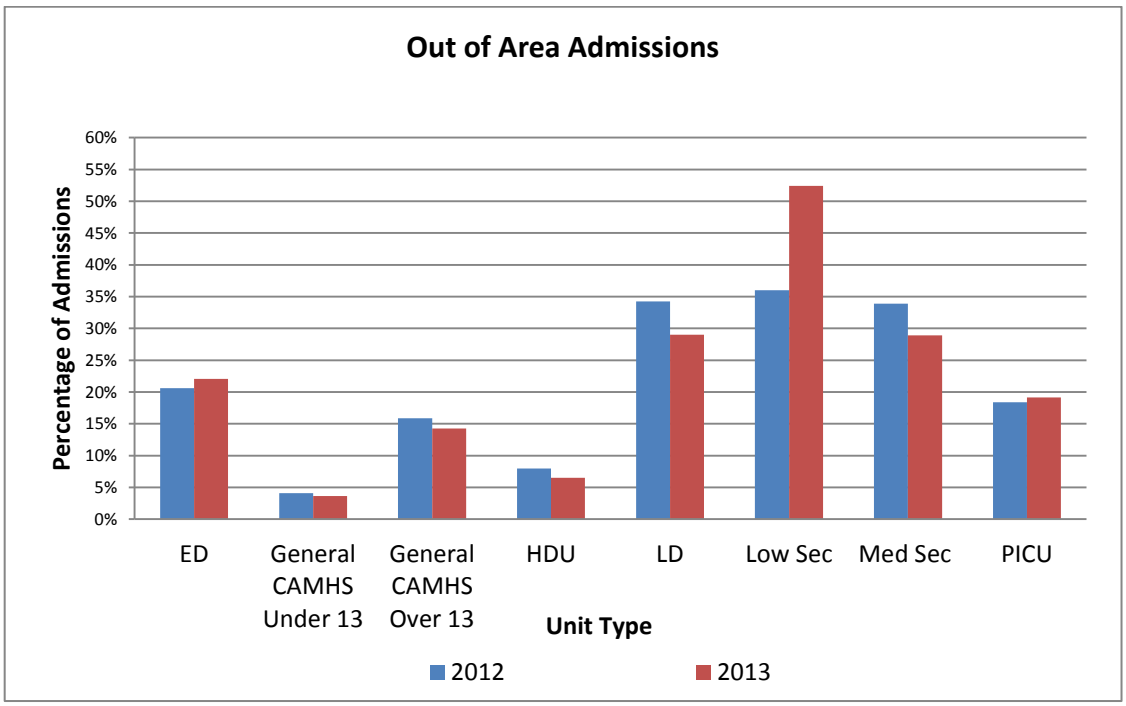
Tier 4 Commissioner responses confirmed that very few area teams could quantify the extent of out- of -area placements before April 2013 and therefore it is not possible to say whether the situation has worsened. Several commissioners were unable to supply information on current volumes. Of those who did, numbers and percentages were highly variable. One commissioner (Cheshire, Warrington and Wirral) described significantly lower out- of- area placements due to robust case management arrangements. A number of commissioners indicated a greater level of out- of- area placements within independent sector beds.

The review did not explore issues around case management (by commissioners) of patients placed out –of- area though interviews with lead commissioners had identified instances where young people were placed out- of -area without the commissioner's knowledge, and hence no monitoring was taking place.

Providers were also asked to identify for 2012 and 2013 the number of admissions out- of -area, defined as "admissions deemed to be placements where young people are harmed by the distance and disconnection from local services, family and friends".

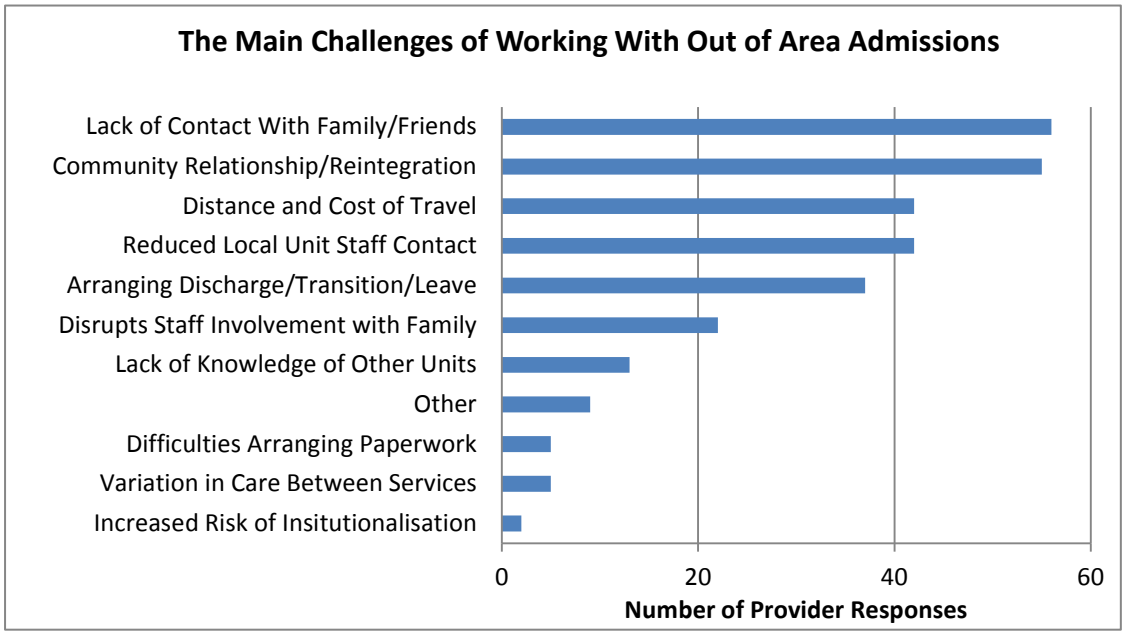
Provider responses:





Provider comments
"Increase in referrals from out of area, which brings challenges with regard to transition, rehabilitation and maintaining relationships with parents/carers". "More out of area unit trying to source beds for young people but with no robust referral, assessment process in place". "...increase in out of area admissions both to us and for young people being moved out of our area". "NHS England can be extremely helpful when planning / agreeing admission to out of area beds..." "Better organisation of regional use of beds..." "Ease of access for out of area access as funding is now part of the national contract".

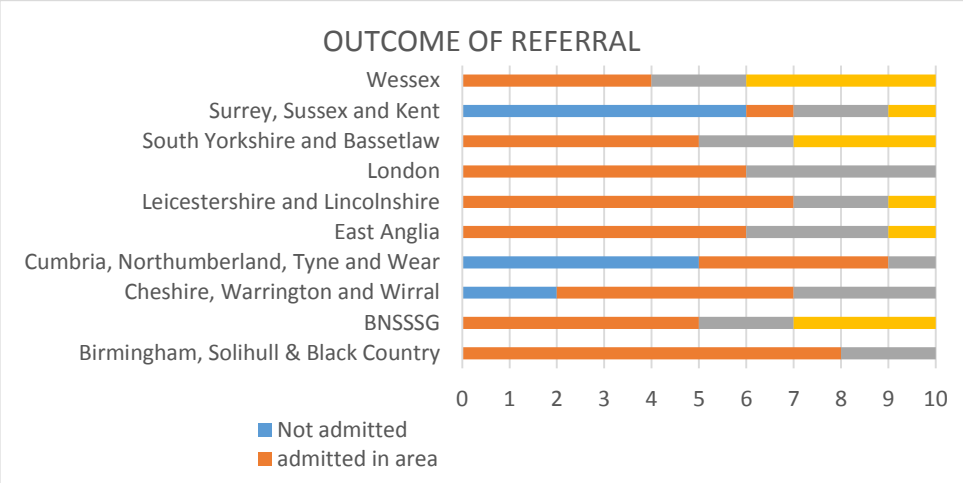
Issues relating to out of area admissions

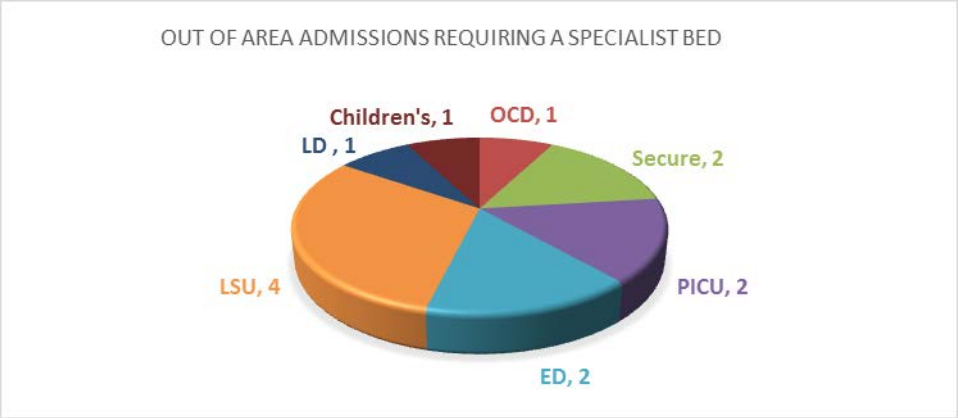


Commissioner responses

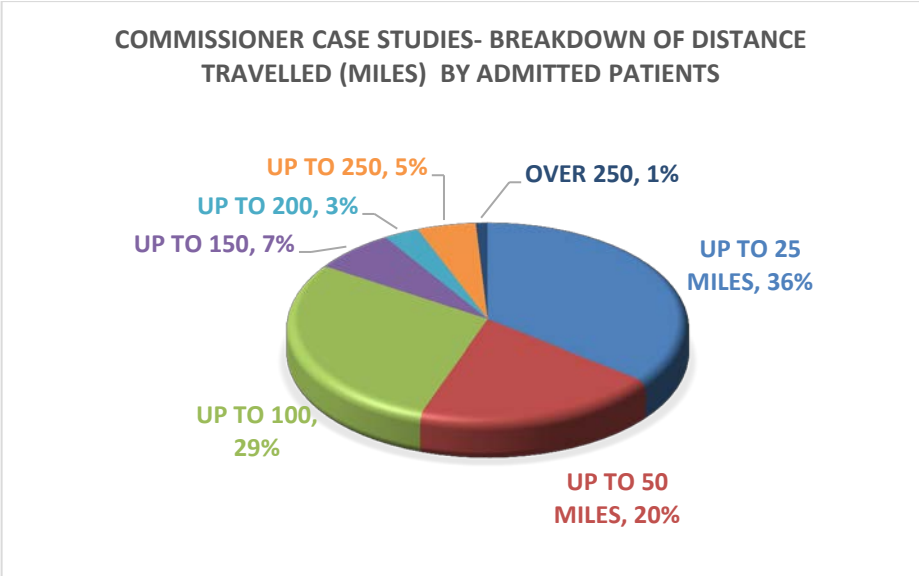
The 100 case histories provided by commissioners provide a snapshot view of referrals and admissions together with some background history. Taken alone the sample is too small to make general assumptions. However they do provide

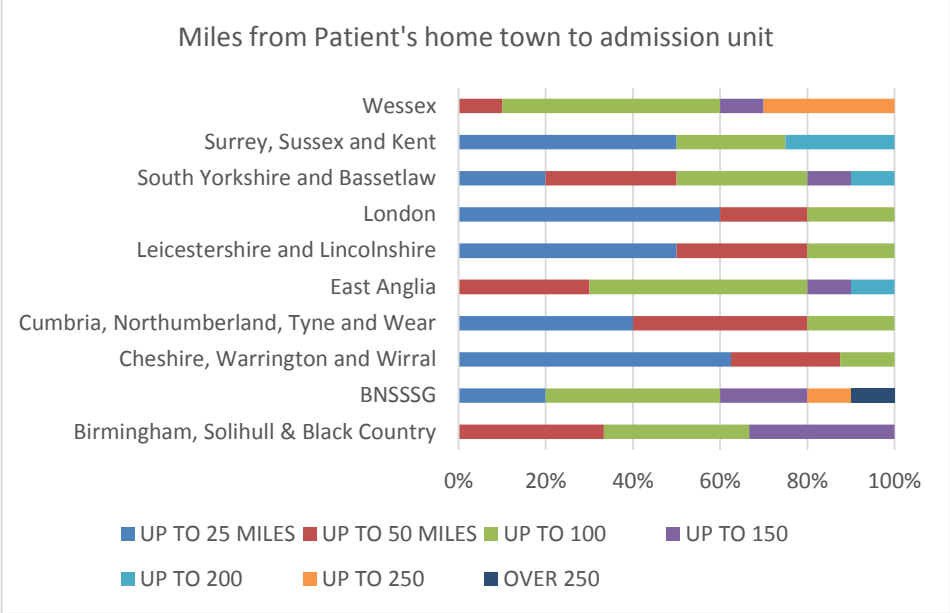
additional insight into some of the background to difficulties being described at the time the review was commissioned. Leading up to the review, there were reported cases of young people travelling very substantial distances for admission. The analysis of the 100 cases, below highlights some of the geographical and sub specialty factors where long distance admissions are more of an issue. Areas of the country which have low bed provision experience longer distances. Whilst most admissions were within area, the reason for out–of-area placements was more often lack of local beds than a specialist bed required.





The analysis of the overall cohort confirms that over a third of admissions were within 25 miles of the patient's home and 16% travelled over 100 miles. As stated earlier the distribution of units coupled with the large geographic area covered by some of the commissioning areas is such that considerable distances are travelled even by patients who are technically within their own area.





Of the 14 patients who travelled over 100 miles for admission, 11 originated from commissioners responsible for large geographic areas and with relatively limited bed provision (Wessex, Surrey& Sussex, East Anglia and BNSSSG). Although this is a small sample, these geographical aspects would have been identical both before and after April 2013. Further work on specialties and reasons for travel out- of -area with a larger sample of data would help to inform future commissioning plans.

Joint work between the Royal College of Psychiatrists and the Youth Justice Board (YJB) has considered issues around placement of young people away from home. The issue of “closeness to home” has been much discussed over many years at the YJB and has been subject to much scrutiny. Closeness to home is now just one of a range of important factors that are considered by placement officers. The following key factors are taken into account:

- basic information (legal status, age, gender, location, court outcome);
- specific risk factors as identified by the relevant YOT;
- risk of harm;
- risk posed to others;
- previous history within the secure estate;
- specific needs, for example the requirement for a specific programme of intervention, health education or welfare needs;
- availability of places, competing demand for places;
- co-defendant/gang-related issues;
- the YOT's placement recommendation; and
- discussions with prospective secure estate establishments that will take into account the current mix of young people in that establishment.

There are parallels in the placement of children and young people in CAMHS Tier 4. This helps to set in context the complexity of the decision faced in CAMHS admissions. Hence, although the above list relates to children in the justice system, the consideration of factors which need to be taken into account alongside distance offer a starting point for commissioners to use in developing practice for CAMHS placement more generally.

3.19 Is local capacity theoretically sufficient to meet local demand?

We know that the distribution of CAMHS Tier 4 inpatient services is not even across the country. Some areas of the country do not have any local bed provision; additionally distribution for some sub -specialties, particularly CAMHS Tier 4 Psychiatric Intensive Care, CAMHS Tier 4 Learning Disability and CAMHS Tier 4 Low Secure Care is patchy. The specialised nature of these services means that patients need to travel to access them.

We know that bed provision has increased significantly from 844 in 1999, to 1128 in 2006, (O'Herlihy A, 2007) to 1264 commissioned beds in January 2014 (and at least a further 119 beds available. although currently uncommissioned according to the provider survey responses). And yet, both commissioners and providers describe pressure on available beds.

Commissioners were requested to offer a view about whether "in theory" there were sufficient beds to meet local demand both before and after April 2013. Responses were mixed; some said theoretically there were sufficient beds locally and others had a clear view that there were not, whilst some described a mixed picture across their geography. Most noted an increase in demand since April 2013 and therefore a current insufficiency of beds.

It appears that the current difficulties being experienced are the consequence of a range of factors which adversely affect capacity. It is therefore impossible to conclude definitively whether the current level of bed provision is sufficient to meet the need. Variations in practice around admission protocols, approvals, availability of intensive community services and management of delayed discharges compound the picture as do bed closures and staffing problems. Some controls that were in place pre-April 2013 have been discontinued. Equally however, difficulties that were previously experienced at a local level are now seen nationally for the first time.

The review has not been able to establish numerically that long-distance admissions have increased. However both commissioners and providers in their free text responses have described increased issues with this over the past year.

Some commissioners hold the view that the weekly national stock take of beds has contributed to more distant placements. They are now aware of a clinically suitable bed being available and hence feel pressure to place the young person even though it may be a great distance, rather than risk keeping them in inappropriate services/environment locally. Some areas previously able to contain local demand now find themselves unable to do so because of out of area patients in local beds.

3.20 Good practice evidence submitted to the review

The terms of reference asked the review to indicate examples of where providers and commissioners were working well across delivery of the whole care pathway.

Commissioners and CRG representatives offered the following for consideration, representing various different types of health economy:

- Oxfordshire and Buckinghamshire-particularly in the range of out –of-hours services and intensive community services
- West Midlands-in respect of good provision for the general adolescent population and development of community services. Introduction of the home treatment team based on research and complex care planning processes.
- Cheshire Warrington and Wirral, as a mixed urban and rural economy
- Sussex-where the provider holds the entire pathway from Tiers 2 to 4 including transition to adult mental health services and there are well developed crisis services.
- CNTW-reconfiguration of services in the North, following a service review pre April 2013 which led to consolidation of Tier 4 beds and improvement of CAMHS Tier 3 services from the money released; Tiers 1-3 redesigned including home treatment services
- Strong commissioner networks which are longstanding and cover Tiers 2-4 exist in SYB and BSBC

Area team documentation and initiatives submitted in response to the review

Commissioners were requested to provide any of the following that they wished the steering group to consider:

- Research evidence, local standards or standardised documentation in use which may be considered for country-wide implementation.
- Local good practice where local services, agencies and commissioning organisations are working together to improve the pathway.
- Local commissioning arrangements which may be considered for sharing as exemplars of good practice
- Potential best practice on trial home leave and/ or discharge planning / thresholds.

The following documents have been received and are available from the Assistant Head of Specialised Services for NHS England.

Cheshire Warrington and Wirral

- report on pathways to Tier 4 care
- report on outcomes for 100 children in crisis
- CAMHS admission gatekeeping guidance
- Review of Tier 4 services 2003

Cumbria Northumberland, Tyne & Wear

- pathway protocol where the provider manages the whole care pathway
- Tier 4 North West commissioning strategy – March 2010
- Tier 4 North West regional CAMHS admission report
- North West CAMHS needs assessment – Jan 09

Birmingham Solihull and Black Country

- CAMHS Tier 4 strategy
- Birmingham home treatment team-the case for CAMHS home treatment in an urban setting
- protocols for out of hours arrangements

East Anglia

- Tier 4 service review tool
- Tier 3 monthly evaluation tool
- Patient placement notification form (PPNF)

South Yorkshire and Bassetlaw

- Yorkshire and Humber Tier 4 pathway protocol
- South Yorkshire and Bassetlaw overarching protocol
- Protocol where Yorkshire and Humber is the originating area

Leicestershire & Lincolnshire

- Delayed discharge pilot documentation
- Case Manager ED monitoring tool
- Commissioner referral form

Wessex

- i2i community and home treatment service

The above offers a range of tools and approaches which have been found to be successful within area teams and relevant to their own local population and geographic conditions. Whilst it would be inappropriate to suggest a one size fits all approach, there are clear examples of good practice which are successful in certain areas of the country and could be considered for national implementation. Issues raised through both the provider and commissioner surveys could be addressed, at least in part, by the more systematic adoption of these protocols.

In particular, those areas which have adopted standardised referral, assessment and approval procedures and standardised documentation should be considered for wider application. The pilot initiative on delayed discharges is focussing on an aspect of the care pathway which has been raised by many in the survey as a problem and should be considered as a model for wider adoption.

3.21 CAMHS CRG draft guidance on standards

> Identify commissioning proposals for CAMHS Tier 4 that include
>
> **i.** quality standards
> **ii.** access standards
> **iii.** environmental standards
> **iv.** contract levers
>
> *Tier 4 review terms of reference*

In its terms of reference, the steering group was tasked with working with the Tier 4 CAMHS Clinical Reference Group (CRG). The SCOG requested that the CRG offer proposed guidelines for further consultation as follows:

- determine access assessment standards (generic and by service)
- identify “best practice” for trial or home leave
- identify “best practice” for discharge thresholds and discharge planning
- produce guidance on managing suicidal ideation
- identify environmental standards for inpatient units
- consider and comment on the potential impact on demand and capacity by introducing these standards

The CRG identified lead individuals from amongst its membership to coordinate the above pieces of work. Draft guidance was produced and CRG comments were received and incorporated. Where possible, CRG members have endeavoured to build upon existing acknowledged good practice (e.g. NICE guidance or voluntary standards such as those developed by the College Centre for quality improvement (CCQI). The Tier 4 CAMHS CRG also liaised with the Secure CAMHS CRG. The remainder of this chapter contains the guidance developed by the CRG in response to the terms of reference and has not been altered by the Steering Group and thus would require wider consideration before being implemented.

3.22 Quality standards

The Tier CAMHS 4 CRG and Secure CAMHS CRG consider that the existing Quality Network for Inpatient CAMHS (QNIC) standards offer the best starting point for the development of quality standards for Tier 4 CAMHS services in-patient services. QNIC is a membership organisation hosted by the College Centre for Quality Improvement within the Royal College of Psychiatrists (CCQI)

The QNIC standards are the basis for the annual standards-based self and peer reviews carried out by QNIC members. As over 95% of CAMHS Tier 4 units are members, the QNIC standards are widely used and understood. The standards themselves have been developed by members with the involvement of users/carers and to date have been reviewed biennially. The QNIC standards map onto Care Quality Commission (CQC), 'You're Welcome' criteria and Monitor quality standards. The standards cover:

- environment and facilities;
- staffing and staff training;
- access, admission and discharge
- care and treatment;
- information, consent and confidentiality;
- young people's rights and safeguarding children;
- clinical governance.

All criteria are rated as Type 1, 2 or 3:

- Type 1: failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law.
- Type 2: standards that an inpatient unit would be expected to meet.
- Type 3: standards that an excellent inpatient unit should meet or standards that are not the direct responsibility of the ward.

There is a sister network the Quality Network for Community CAMHS (QNCC) which also sets standards and follows a similar process, although this network is less well developed in terms of coverage. The close working between the networks allows the potential to align standards across the pathway. CCQI hosts a number of other Quality Networks pertinent to CAMHS Tier 4 including the Quality Network for Eating

Disorders, the Quality Network for In-patient Learning Disability Services, as well as Quality Networks for low and medium secure services for adults, which again provides opportunities to co-ordinate the development of standards. CQC is currently developing standards and processes for the inspection of CAMHS services, including CAMHS Tier 4 inpatient units and in doing so are working closely with QNIC /QNCC. NICE is also starting work on safe staffing profiles within CAMHS and again is working closely with QNIC.

Type 1 QNIC standards are stipulated in the 2013/14 CAMHS Tier 4 service specifications. As discussed in the public consultation on the specifications, services that meet *only* Type 1 standards would not be able to offer an adequate standard of care. The 2012/13 QNIC annual report provides an overview of the extent to which the collective QNIC membership meets the QNIC standards.

There is potential to strengthen the relationship between QNIC and NHS England in order to co-ordinate the timings of the reviews of both the service specifications and QNIC standards, and to use QNIC data to inform CQUIN development. The strength of the CCQI networks lies in their independence. Thus, any relationship would need to be negotiated so as to not compromise this.

There is potential for commissioners to utilise and strengthen existing QNIC standards to help address some of the current issues associated with access, admission and discharge. Below are extracted standards identified by CRG for the review relevant to these issues for consideration:

3.1.1 The inpatient unit has written criteria for admission**.** These consider:
i. Age restrictions
ii. Psychiatric condition and severity

3.1.2 Information and guidance about the unit, including timescales from referral to admission and referral criteria, are readily available to referrers (written and online)

3.1.3 Where young people are not admitted to the service, the reasons are explained to the referrer, and young people and parents/carers where appropriate

3.1.4 The unit formally records all referrals with respect to race, gender and disability and this is reviewed annually

3.2.1 Young people at severe risk can be admitted as emergencies (i.e. within 24 hours) including out of hours. Arrangements are in place to ensure that 24 hour is provided to meet children's urgent needs.

3.2.2 There is a system in place to monitor and address delays in admission and treatment which is reviewed annually

3.2.3 If admission is considered appropriate, the aims of treatment are discussed with the young people, parents/carers and referrers

3.3.1 The service actively supports families to overcome barriers to access

3.4.1 Young peoples' and/or their parents/carers involvement with other agencies is clearly identified during the admission process

3.4.2 Clinicians making an assessment seek to review relevant information from all agencies involved with the young person to inform their assessment

3.5.1 The unit invites a representative from the young person's local community mental health services to attend all reviews (CPA or local equivalent) and discharge planning meetings

3.5.2 When a young person transfers to adult services and other involved agencies, unit staff invite adult services to a joint review to ensure an effective handover takes place

3.5.3 There are joint protocols between the unit and local adult mental health services to ensure collaborative working and discharge planning using CPA. Units working with young people from outside the local area have agreed protocols for discharge

3.5.4 A clear initial discharge plan should be in place and distributed to all relevant parties prior to or on the day of discharge. A written comprehensive MDT summary is produced and distributed within two weeks of discharge.

Analysis of the reports from peer and self-assessment as to how units meet the 2013 standards together with the information held by commissioners will enable an overview of the extent to which the existing CAMHS Tier 4 estate is able to meet the standards and aid estimates of the impact of introduction / changes in the standards.

3.23 Access assessment standards

Summary

The reasons for admission to a CAMHS Tier 4 inpatient unit fall into three broad categories:

- Children/young people who present with high risk due to mental disorder who cannot be managed safely in the community and where the assessment / treatment they require can only be provided in hospital
- Children/young people who require an intensity of intervention or specialist young people who require a time-limited period of intensive assessment involving 24 hour observation by a specialist mental health team. This should not be an alternative to a thorough community based assessment.

In order to ensure these criteria are met whenever possible a pre-admission assessment should be carried out by the CAMHS Tier 4 team.

The CAMHS Tier 4 assessment will establish:

- Whether admission will address the identified problems;
- That there are clear and measurable goals of admission agreed with the child/young person and their parents/carers and where appropriate with the referring team;
- That there are no suitable or preferable alternatives;
- That admission is not likely to cause more harm than good.

The Tier 4 team should liaise closely with the referring team and any other agencies involved in conducting the assessment and formulating an agreed care plan.

Where it has not been possible for the CAMHS Tier 4 team to carry out a pre-admission assessment for example, in the case of the emergency referral out-of-hours of young people at imminent risk there should be a multi-agency review as soon as possible following admission of the need for and aims of inpatient care this should involve the Tier 4 team, referring Tier 3 CAMHS team and any other agencies together with the child/young person and their parents/carers.

This review should address whether there is a continuing need for admission and whether the provision of community services could provide a safe and effective alternative to admission as well as the domains identified in the CAMHS Tier 4 assessment. The CAMHS Tier 4 CQUIN for 2014/15 has stipulated that such a review be carried out within 5 working days of admission.

Indications/criteria for admission

As summarised in the National Inpatient Child and Adolescent Psychiatry Study (Royal College of Psychiatrists' Research Unit, 1999) there are no absolute indications for admission to child and adolescent psychiatric units. A number of mostly American studies have attempted to identify the factors determining the likelihood of referral/admission, these are summarised in the NICAPS report as:

1. Diagnosis (Hillard et al, 1988);
2. Poor psychosocial functioning (Steinhausen, 1985);
3. The burden the young person's condition places on the family (Bickman, Foster & Lambert 1996);
4. Ease of access (Gutterman et al, 1993);
5. The clinical experience of the referrer (Morrisey et al, 1995);
6. The range of alternatives to in-patient care (Bickman, Foster & Lambert, 1996);
7. The availability of funding (Patrick et al 1993); and
8. The general backdrop of service organisation (Blanz & Schmidt, 2000).

For full references see NICAPS report.

Whilst the above review was written more than 10 years ago it is likely that the same range of variables affect whether admission is considered or not, to this we would also add considerations of risk.

Admission criteria in the UK continue to vary between individual inpatient units, but generally now fall into three broad categories (see Cotgrove, 2014; Green, 2002; NICE, 2005; O'Herlihy et al 2009).

1. **High risk due to mental disorder**. Admission may be indicated when there are high levels of risk to the child/ young person, secondary to suicidal thoughts or behaviours, self-neglect, disordered/abnormal thinking, risk-taking behaviour or aggression in the context of mental disorder and which is beyond the capacity of the family and community based services to manage. Admission should be expected to reduce this risk.
2. **Intensive treatment**. This is when the intensity of treatment needed is not available from other services. This is commonly the case when a disorder is associated with other psychosocial difficulties, and/ or co-morbid disorder resulting in difficulties pervading all aspects of the child/ young person's life.
3. **Intensive assessment**. An in-patient unit can offer 24 hours-a-day assessment and supervision by a multi-disciplinary team to gather information to guide further management. This may involve observing the child/young person's behaviour and their interaction with others, observing the effects of a specific intervention, such as the use of medication, or allowing time for a range of investigations to be carried out, such as cognitive assessments, OT assessments, speech & language assessments or physical investigations.

Contra-*indications* or risks of admission

It is important when considering an admission, that the potential benefits of admission are balanced against potential harm. There are a range of reasons why in-patient treatment may not be appropriate:

- There may be concerns about the effects of separating the child/young person from their home environment;
- There may be concerns about admitting a particularly vulnerable child/young person into an environment where there are high levels of disturbance potentially compounding their difficulties; for example where there are high levels of deliberate self-harm or acting out behaviours a vulnerable child or young person may be at risk of acquiring additional dysfunctional behaviours or coping strategies, in the case of anorexia nervosa being with a cohort of young people with similar problem can potentially reinforce the difficulties even where a skilled and experienced

staff team openly address such difficulties. This can result in both escalating and/or reinforcing negative behaviours;

- Admission to hospital may undermine the parents/carers ability to support the child/young person for example, in the case of anorexia nervosa where the parents/carers ability to support their child's eating is crucial to recovery;
- If protracted, an admission runs the risk of "institutionalisation" for the child/young person, including loss of connection with and support from the child's/young person's local environment, plus detrimental effects on family life (Green & Jones, 1998)

In addition, whilst they are not a contraindication, inpatient treatments are expensive.

For all of these reasons in-patient admission is often considered a last resort.

Evidence base for above admission criteria

Garralda (1986) and Wolkind and Gent (1987) in UK studies, found criteria for admission included failure of outpatient treatment, difficulties with assessment or diagnosis, family difficulties and the need for 24 hour observation or care. Wrate *et al* (1994) in a UK multi-centre prospective study looked at reasons for admission in 276 young people admitted to specialised adolescent psychiatric units.

The reasons given were: to provide a detailed psychiatric assessment (51%); to establish better therapeutic control of a case (36%); to provide a therapeutic peer group experience (36%); to obtain improved control over the adolescent's behaviour (26%); to relieve out-patient colleagues from a treatment failure (20%); to assess or facilitate future placement needs (19%); to provide relief to exhausted parents (18%); to achieve psychological separation between parents and the patient (17%); and to provide an out-patient with schooling otherwise unavailable (9%).

Further surveys of criteria for admission to in-patient units have been carried out in the US (Costello *et al*, 1991; Pottick *et al*, 1995). These studies generally replicate the UK findings, but also include factors specific to the US, such as the presence of insurance cover (Pottick *et al*, 1995). Costello *et al* (1991) developed a checklist of criteria which had good predictive value when determining whether or not a child needed admission. However, admission rates in the US are much higher than the UK, one study suggesting by approximately five times (Maskey, 1998). Clearly, caution is needed in applying such findings to settings in England and Wales.]

Assessment procedure

Decisions regarding accessing admission are based on information gathered by a thorough assessment. The aim of an assessment is to establish if an admission is desirable and explore alternatives. The main issues to be taken into account are:

Is admission desirable?

- Are the presenting problems likely to be helped by admission?
- Is there motivation to change? (clear aims and objectives can help clarify this)
- Are there any suitable/better alternatives?
- Could admission cause more harm than good?

Relevant information can be gathered from multiple sources, but must include a full psychiatric and systemic assessment (including relevant social care and educational issues). Whilst information from the referrer and other professionals is essential and can save duplication, it is not an alternative for a direct assessment by staff from the in-patient service. In-patient staff need to start engaging the child/young person, clarifying with the child/young person and their family what ideas they have about who or what needs to change, and how they think an inpatient unit may or may not be helpful, before admission. In-patient staff are in a good position to judge whether or not admission will be helpful based on their day to day knowledge of the service.

Intensive outreach / crisis teams can play a crucial role in the assessment process, especially in managing emergency/crisis cases that would otherwise need admission (see below in section on alternatives to admission). They can work very closely with in-patient services and are therefore as well placed as in-patient staff to judge if an admission is needed. What the in-patient staff then bring to that assessment is the matching of the patients 'needs' to their own milieu.

It is desirable to have motivation and cooperation from the child/young person, their family and the referrer. This motivation needs to be based on informed consent. In some cases, such as in the treatment of anorexia nervosa, an admission is far more likely to be successful when there is a clear motivation to change on the part of the child/young person and their family. In-patient treatment may still be indicated in cases where informed consent may not be possible at the outset, for example in the case of psychotic illness.

Where possible, clear aims and objectives for the admission need to be identified with the child/young person, family and sometimes the referrer before admission. These can be helpful in clarifying motivation for change, but also to gauge progress during an admission. The Goal Based Outcome measure developed by the CAMHS Outcome Research Consortium (CORC) and implemented as part of the CYP IAPT programme is a good example of how using aims can be standardised and provide a measure of outcome (CORC, 2007). Whatever the aims, even if they are difficult to measure, they need to be realistic, and preferably SMART (specific, measurable, achievable, relevant and timely).

The issue of whether an admission could cause more harm than good is one which clinicians, in their enthusiasm to be helpful can sometimes overlook, but which should always be considered. An admission is less likely to be harmful when it is agreed by the child/young person, their family, the referrer and the assessing professionals from the in-patient unit, and there are clear SMART aims for that admission. Even in these cases there are possible risks, including increased

dependence and institutionalisation. It can be a major step, particularly for the younger and less mature child/young person, to be removed from their families and other support networks. This experience could be traumatic and may compound existing problems.

The age of the child/young person, both chronological and developmental, needs to be taken into account as part of the assessment. For example, when deciding between a children's unit or an adolescent unit, developmental rather than chronological age may be the significant factor in deciding best fit for the child/young person. E.g. a pre-pubertal child with some learning difficulties, even if their chronological age fits the admission criteria for an adolescent unit, may more appropriately receive treatment in a CAMHS Tier 4 Children's unit. It is important that services are flexible with chronological age boundaries sourcing a service that meets the child/young person's developmental needs.

With increasing pressure for in-patient units to admit children/young people in a crisis immediately it may not always be possible to conduct a comprehensive pre-admission assessment. This is especially true with out-of-hours admissions. In-patient services must be responsive to children/young people in mental health crisis; however, accepting admissions without a thorough assessment can result in admissions that could have been better managed with non-bed based services. Crisis admissions can in some cases lead to an escalation and/or reinforcement of risky and other dysfunctional behaviours resulting in negative outcomes for children/young people.

Alternatives to admission

Integrated CAMHS Tier 4 /Tier 3 can reduce the need for admission and improve patient outcomes.

A range of services are needed alongside in-patient services, including:

a. crisis assessment and crisis management services for children/young people in acute crisis, usually presenting with high levels of risk, which can provide both intensive community support in a crisis and gate-keep admissions;
b. intensive outreach services designed to facilitate pre-admission planning, early discharge, reduce lengths of stay, support transitions to other services and as a step down to enable embedding of interventions used in an inpatient setting in the home;
c. planned intensive home treatment services for children/young people who need intensive long-term treatment, equivalent to that provided in an inpatient setting;
d. specialist treatment services for example for children/young people with eating disorders or severe self-harm (e.g. dialectical behaviour therapy); and

e. specialist services for children/young people with complex neurodevelopmental or neuropsychiatric difficulties and other rare disorders requiring specialist expertise beyond the level of Tier 3 CAMHS and for whom inpatient services are environmentally unsuitable.

The functions/services listed above should be provided as part of a provider network linked to an inpatient service. Each of the services listed provides a different function, but some functions may be combined into a single team to create continuity and efficiency.

Particular issues for CAMHS Tier 4 Children's Services

As there are only six children's units in England they cover much larger geographical catchment areas than do CAMHS Tier 4 General Adolescent Services. This poses particular challenges in terms of transitional support for children and families prior to and after discharge. CAMHS Tier 4 Children's Units need to be funded and commissioned to offer effective transitional services to ensure that therapeutic gains are maintained on discharge and that children's care can be returned to community services in a timely way. Children should also have access to the intensive support services in their localities as described above.

Particular issues for Specialist CAMHS Tier 4 Learning Disability Services

As is the case for CAMHS Tier 4 Children's Units, there are very few specialist learning disability in-patient units covering very large geographical areas and thus the issues regarding transitional support are similar. In addition community CAMHS Learning Disability Services are not well developed in many areas of the country at present. There is a need for further work on the role and remit of inpatient care for children and young people with learning disabilities and how this fits into the care pathway.

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3.24 Best practice for trial or home leave

Introduction

Admission to CAMHS Tier 4 inpatient units as noted above is for children and young people who require intensive assessment and treatment which cannot be safely or effectively provided within a community setting.

Although there is a good evidence base for the effectiveness of such services, there can be challenges associated with admission including the risk of disrupting family relationships and the risk of failure to maintain meaningful connections with school, peers and social activities. The use of home leave forms part of a recovery orientated care plan, allowing children, young people and their parent's/carer's to practice the skills acquired in the unit in their home/community environment and enabling generalisation of treatment effects to the home environment as well as facilitating a graded step-down from the in-patient setting.

Home leave allows children and young people to maintain a connection with their home environment and reinforces to all (the child/young person, parents/carers as well as the professional network) the goal of discharge. Such leave requires careful planning with reference to the individual care plan for the child/young person, the risks posed and the available community support for such leave.

Use of home leave

Maintaining positive relationships and connections

Maintaining relationships, particularly with family/carer but also with friends is essential for children and young people when their treatment involves in-patient admission. Admissions should be as close to home as possible and for as short a time as possible.

Whilst contact during admission can occur via telephone calls and visits, early home leave where safety allows, provides a much richer contact experience.

Many CAMHS Tier 4 Children's Units are currently only commissioned to provide 5 day care thus return home at weekends is the expectation for children admitted to these units.

Facilitating step-down towards discharge

Successful home leave is important in building confidence for children / young people and their parents/carers. Preparing and planning such leave is part of the therapeutic programme with goals set to achieve during leave periods. Specific planning and preparation for leave will be a necessary part of the therapeutic programme.

Co-work with Tier 3 community services

Support during periods of leave should be provided on a shared care basis involving both the CAMHS Tier 4 unit and the CAMHS Tier 3 services. A clear agreement and care plan should be in place ahead of these periods of home leave. Where there are outreach services provided from the CAMHS Tier 4 inpatient setting or intensive home treatment services are commissioned services. Such services can be used to provide support during the leave period.

Home leave can also enable connections to be maintained with CAMHS Tier 3 services. This is particularly important as children/young people and parents/carers at discharge will often transfer from high intensity Tier 4 support to less intensive Tier 3 services. Ensuring seamless transition and confidence in the process is a key factor in successful discharge.

School reintegration

Successful school / education reintegration is a key element in maintaining the gains made during a CAMHS Tier 4 inpatient admission. School/education integration should be individually planned and supported by the professional network. Such integration plans will include travel to and from school/educational setting from home to ensure successful school attendance at discharge. This work is vital for successful discharge planning.

Community treatment orders

These Mental Health Act powers are rarely used in treating young people. The patient will be discharged from the Inpatient Service and is thus not actually "on leave from a bed". The order allows for their statutory recall to hospital for assessment and subsequent readmission on a detained patient if needed.

Use of leave beds for emergency admissions

This practice is widespread in Adult Mental Health Services, but is less common in CAMHS Tier 4 inpatient services. As units are generally small (14-16 beds on average), and lengths of admission are in general longer than those of adult , patient turnover is lower and there is logistically less opportunity to use leave beds for an incoming admissions. Planned leave is used as part of the therapeutic treatment plan but early return from leave must be available for these vulnerable and complex young people/ children.

An informal survey in 2013 of 13 Units and one commissioner (Eyre 2013 unpublished data) revealed 50% of respondents unwilling to commence such practice (including the commissioner) at all. Two of the respondents did have guidelines to both formalise and limit the practice. The rest were against it in principle but on very rare occasions were prepared to make an arrangement – particularly to avoid a local patient having to be admitted to a very distant bed.

The CRG recommends that there should be clear local protocols agreed with specialised commissioners on the use of leave beds. Important accompanying principles should be:

- The use of the leave bed must not be detrimental to the care of the young person concerned.

- Willingness to use a bed in this way, with appropriate policy safeguards does not constitute "additional bed capacity" and stakeholders need to be clear on this issue.

- Consideration of the impact on the existing patient group as such arrangements will give rise to uncertainty and anxiety across the whole in-patient peer group with regard to the security of their own treatment and may lead to unanticipated consequences for other patients.

- It may be appropriate to stipulate that exceptional use of leave beds should only occur where the patient's Community CAMHS Service provides Intensive Outreach and Crisis Services out of hours, able to create therapy and support package of care in the community with 24 hours' notice.

The CRG further took the view that the use of leave beds for emergency admission may not be appropriate in all CAMHS Tier 4 inpatient settings. Thus for example the CAMHS Tier 4 Children's Units tend to have a high proportion of planned admissions,

there is less of a need for emergency admission and the services run at close to 100% capacity. Similar considerations apply for the CAMHS Tier 4 Learning Disability Units.

3.25 Discharge planning from CAMHS Tier 4 inpatient settings

Discharge planning should be an integral aspect of care planning throughout the in-patient episode. Where possible, clear aims and objectives for the admission (including the criteria for discharge and a return to community care for the particular child/young person or in the case of secure CAMHS transfer to a lower level of security) need to be identified with the young person and where possible the child, the parents/carers and the referrer prior to admission and in the case of unplanned, emergency admissions as soon as possible following admission.

Agreeing the goals of admission can be helpful in engaging the child/young person and their family, clarifying motivation for change, and aid the assessment of progress during an admission. The Goal Based Outcome measure developed by the CAMHS Outcome Research Consortium (CORC, 2007) and incorporated into the CYP IAPT programme is a good example of how goals can be used to gauge progress and provide a measure of outcome (CORC, 2007). Whatever the goals of admission, even if they are difficult to measure, they need to be realistic, and preferably SMART (specific, measurable, achievable, relevant and timely).

Care Programme Reviews (CPAs) should be held regularly throughout the in-patient episode at a frequency determined by the child/young person's needs. These reviews should include a review of the goals of admission, whether these are still appropriate or need revising, progress again goals as well as what is required to enable discharge (or in the case of Secure CAMHS transfer to a lower level of security) both in terms of the criteria for discharge in the case of the individual child/young person and services required.

Agreeing the criteria for discharge should, wherever possible, be a collaborative process (subject to considerations of risk) involving the child/young person and their parents/carers and include the referrers and other agencies as appropriate.

The NHS Institute for Innovation and Improvement developed generic discharge planning guidance (http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/discharge_planning.html). The Care Services Improvement Partnership developed a good practice toolkit for discharge planning from in-patient mental health services which focused largely, but not exclusively, on the adults (Care Services Improvement Partnership, 2007). The CRG recommends that further work is undertaken to establish the potential for such guidance / tool-kits in Tier 4 CAMHS. The latter could be undertaken by the CRG under the auspices of the Quality Network for In-patient CAMHS and in collaboration with the Quality Network for Community CAMHS.

Where the in-patient episode is prolonged with reference to the particular patient group, particularly where the individual child/young person does not appear to be making progress against the goals of admission, consideration should be given to a clinical review/second opinion of the child/young person's care. The facility for such clinical review could be developed by setting up clinical networks amongst providers – these already exist in the case of Medium Secure CAMHS services and the CAMHS Tier 4 Children's Units.

3.26 Self-harm and suicidality

Suicide and self-harm in children and young people

Many admissions to CAMHS Tier 4 services are prompted by suicidal and serious self-harm behaviours.

Self -harm ranges from behaviours with no suicidal intent (but with the intent to communicate distress or relieve tension) through to suicide. As outlined in a review by Hawton and James (Hawton and James A, 2005) some 7%-14% of adolescents will self- harm at some time in their life, and 20%-45% of older adolescents report having had suicidal thoughts at some time.

A recent study of suicide in children and young people (Windfuhr K, While D, Hunt I, Shaw J, Appleby L, Kapur N: Suicides and accidental deaths in children and adolescents. Arch Dis Child 2013. doi: 10.1136/ archdischild-2012-302539 [epub ahead of print]) found the suicide rate in England and Wales among 10–19 year olds is 2.20 per 100,000; it is higher in males (3.14 compared with 1.30 for females) and in older adolescents (4.04 among 15–19 year olds compared with 0.34 among 10–14 year olds). Recent research has shown a significant fall in the rates among young men in the period 2001–2010.

Psychological post-mortem studies of completed suicides show that a psychiatric disorder (usually depression, rarely psychosis) is present at the time of death in most adolescents who die by suicide (Hawton K and James A, 2005). A history of behavioural disturbance, substance misuse, and family, social, and psychological problems is common.

Hawton and James (2005) in their review report that most self- harm in adolescents inflicts little actual harm and does not come to the attention of medical services. Self -cutting is involved in many such cases and appears to serve the purpose of reducing tension or of self- punishment.

By contrast, self -poisoning makes up about 90% of cases which lead to hospital attention (usually A and E and general medical/paediatric services). Self-harm by more dangerous methods, such as attempted hanging, may be associated with considerable suicidal intent. There are strong links between suicide and previous self- harm: between a quarter and a half of those committing suicide have previously carried out a non-fatal act (Hawton K and James A, 2005).

Suicidality and self-harm can occur in the context of a wide range of mental disorders - depression, anxiety disorders, conduct disorder, psychosis, eating disorders, PTSD and emerging personality disorder.

Intervention

Most adolescents who self-harm do so in response to interpersonal crises and can treated as outpatients. In-patient psychiatric treatment is usually reserved for those who have severe depressive or psychotic disorder, who present an ongoing risk of suicide, or are in the middle of major psychosocial difficulties, such as disclosure of sexual abuse.

For young people who may require in-patient treatment the need is to begin treatment of the underlying disorder whilst keeping the young person safe.

For many young people admission can be life-saving, providing an opportunity for intensive care away from home where their often complex and multiple difficulties can be assessed, new treatment options tried and challenges within the home environment explored and better understood.

However, admission to hospital can also have an iatrogenic effect, particularly for people with chronic suicidality and self-harm, and this is recognised in the NICE guidelines on the Treatment and Management of Borderline Personality Disorder (NCCMH, 2009). This phenomenon is also described by CAMHS Tier 4 clinicians in that admission can lead to a spiral of worsening symptoms and increased suicidality in some young people.

In such cases discharge becomes increasingly problematic as inpatient and outpatient teams and families become increasingly concerned about risk and reluctant to pursue discharge even in the face of a worsening presentation. This can lead to prolonged stays in hospital and in some cases an escalation to increasing levels of security.

The NICE guidelines on the Treatment and Management of Borderline Personality Disorder –BPD - (NCCMH, 2009) recommend that adults with this diagnosis should not be admitted for treatment of chronic suicidal thinking or actions but only in circumstances where there was an acute exacerbation of risk. It was recommended that admission under these circumstances be generally time-limited, short and focused around reducing acute risk.

Treatment of chronic suicidal risk in clients with BPD was considered most effectively addressed using comprehensive treatment packages that were multi-modal and comprised therapist supervision as part of the model. For female clients where reduction in self-harm is a clinical priority the guideline recommended considering Dialectical Behaviour Therapy.

In the absence of any specific evidence for treatment of adolescents, the guideline recommended similar treatment approaches for young people. Implementing the BPD guideline advice for admission is more challenging with young people as there are perhaps fewer intensive community treatment options for young people and also

community and societal tolerance of suicide risk in the young is often lower than that in adults. Additionally, clinicians are reluctant to diagnose BPD in adolescence for understandable reasons; adolescence is a time major developmental transition and BPD is a highly stigmatising label. Moreover, this diagnosis may become only apparent with time and the young person's problems may be maintained by psychosocial adversity including unrecognised abuse.

A more recent review by Bevington et al (2014) of self-injurious behaviour in young people found some evidence (a small number of studies with weak methods) to support the use of in-patient treatment for self-harm in adolescents. Predominantly these are cases where the risk to safety is judged to be high. There was limited evidence (one study) suggesting that brief admission promotes engagement with out-patient treatment post-discharge.

There was also limited and conflicting evidence (a small number of studies, nonstandard adaptations of treatments, limited evidence of effectiveness in self harm) to support the use of intensive, home- or hospital-based manualised treatment packages such as Dialectical Behaviour Therapy (DBT) or Multi-Systemic Therapy (MST). The CAMHS Tier 4 CRG is aware of 2 large international studies on the use of DBT with adolescents but these are as yet not published.

Recommendations on self-harm and suicidal ideation

1. The CRG recognises that there is a continuing role for inpatient admission of young people at high risk of suicide or serious self-harm.

2. The CRG also endorses the recommendations by NICE (NCCMH 2009) and Bevington et al (2014) that there should be further research on the most effective interventions for repeated self-harm and suicidality in young people as well as the role of in-patient care.

3. The CRG also recommends, as indicated in the NICE guidelines (NCCMH 2009) and Bevington et al (2014) structured multi-domain approaches (and, if necessary, brief hospitalisation) are recommended for young people where there is a pattern of repeated self-harm or more chronic suicidality who are either nonresponsive to treatment at lower levels of intensity, or who present with the highest acute clinical risk. Services working with such young people in the community need to work closely with CAMHS Tier 4 inpatient services.

Management within inpatient settings

The task within the in-patient setting when young people are admitted because of risk to themselves is to keep the young person safe whilst carrying out a comprehensive, holistic assessment and providing treatment for any underlying disorder.

Ensuring safety will require adequate staffing and an appropriate environment. Care should be provided according to the principles of the least restrictive environment possible.

Many CAMHS Tier 4 services have developed local risk assessment and risk management protocols.

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3.27 Environmental standards

All CAMHS Tier 4 inpatient services are expected to comply with recognised National environmental safety standards as appropriate to their designated level of security. In addition all CAMHS Tier 4 inpatient services should be child/young person friendly and in order to ensure this the CRG recommends that QNIC standards be adopted as the starting point for environmental standards for CAMHS Tier 4 services for the reasons outlined in the report section dealing with quality standards (Section 2.22).

All units must comply with CQC standards. The QNIC environmental standards are shown below. They encompass a range of standards from essential to excellent. The CRG recommends that SCOG engages more widely on these to identify which ones, over and above those required by CQC, should be included within the contract with providers as mandatory for units to meet and which ones they should be working towards as part of quality improvement.

All criteria are rated as Type 1, 2 or 3:

- Type 1: failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law.
- Type 2: standards that an inpatient unit would be expected to meet.
- Type 3: standards that an excellent inpatient unit should meet or standards that are not the direct responsibility of the ward

	Rating	Standards and Criteria
1		**Environment and Facilities**
1.1		**The inpatient unit is well designed and has the necessary facilities and resources**
1.1.1	2	The service entrance and key clinical areas are clearly signposted
1.1.2	3	There is sufficient car parking space for staff and visitors near the unit
1.1.3	3	Staff, young people and parents/carers may access the unit using public transport
1.1.4	2	The unit is maintained at a high level of cleanliness
1.1.5	2	The unit is in a good state of repair and maintenance is carried out in a timely manner
1.1.6	2	Staff members can regulate heating and ventilation through local controls
1.1.7	3	Young people can control the ventilation in their bedrooms
1.1.8	2	Waiting rooms/areas are provided
1.1.9	2	There is indoor space for recreation which can accommodate all young people
1.1.10	2	There is a designated outdoor space
1.1.11	2	Young people have access to designated outdoor space for 30 minutes a day (where weather and clinically appropriate)
1.1.12	2	The unit contains rooms for individual and group meetings
1.1.13	2	There is a designated dining area
1.1.14	2	There is designated teaching space for education which can accommodate all young people in the unit
1.1.15	1	Where seclusion is used there is an adolescent specific facility which meets the following requirements:
1.1.15.1	1	i) Allows clear observation
1.1.15.2	1	ii) Is well insulated and ventilated
1.1.15.3	1	iii) Has direct access to toilet/washing facilities

	Rating	Standards and Criteria
1		**Environment and Facilities**
1.1.15.4	1	iv) Is safe and secure - does not contain anything which could be potentially harmful
1.1.15.5	1	v) Includes a means of communicating with staff
1.1.16	3	There is a designated low-stimulus area separate from any seclusion room, for the purpose of reducing arousal and/or agitation
1.1.17	2	The unit has age appropriate games and entertainment for young people. *Guidance: This includes TV, DVDs, Books, Magazines, Game consoles etc.*
1.1.18	2	One computer is provided for every two young people in school
1.1.19	2	Young people have access to the internet for recreational purpose
1.1.20	1	Each young person has the educational materials required for continuing with their education
1.1.21	2	All staff have access to IT facilities to support high quality care and the monitoring and evaluation of the service.
1.1.22	3	There are facilities for young people to make their own hot and cold drinks and snacks where risk permits
1.1.23	2	Parents/carers have access to refreshments at the unit
1.1.24	3	Children's units can provide accommodation for families, where necessary
1.2		**Children's units and adolescent units are separate from adult units**
1.2.1	1	There are policies and procedures to prevent unwanted visitors to the unit *Guidance: This includes what to do if access is breached*
1.2.2	1	When a unit is on the same site as an adult unit, there are policies and procedures to ensure young people are not using shared facilities at the same time as other adults
1.3		**Premises are designed and managed so that young people's rights, privacy and dignity are respected**

	Rating	Standards and Criteria
1		**Environment and Facilities**
1.3.1	1	All confidential case materials are kept in accordance with the Caldicott Report (1997) *Guidance: This includes locking cabinets, offices, password protected computer access and ensuring no confidential data is visible*
1.3.2	1	The environment of units that admit young people with a disability meets their needs and complies with current legislation *Guidance: The Equality Act 2010*
1.3.3	2	All young people have the choice of having a single bedroom
1.3.4	2	Sleeping areas are arranged into separate male and female zones
1.3.5	2	The unit has at least one bathroom/shower room per 3 young people
1.3.6	1	Separate male and female toilets and washing facilities are available in the unit and are clearly labelled male or female
1.3.7	2	At night, young people do not pass through areas occupied by members of the opposite sex to reach toilet and washing facilities
1.3.8	3	There is a single sex lounge available on the unit
1.3.9	1	The unit has a designated room for physical examination and minor medical procedures
1.3.10	2	The unit has at least one quiet room other than young people's bedrooms
1.3.11	2	The unit has private rooms, other than young people's bedrooms, where young people may meet relatives and friends *Guidance: This room should be comfortable and contain toys for younger siblings*
1.3.12	2	Young people have access to a telephone which can be used in a private area
1.3.13	2	There is a safe place for young people to keep their property
1.3.14	2	There is a safe place for staff to keep their property

	Rating	Standards and Criteria
1		**Environment and Facilities**
1.3.15	3	The unit has a multifaith room available for young people
1.4		**The unit provides a safe environment for staff and young people**
1.4.1	1	Drugs are kept in a secure place with the dispensary book in line with the hospital's medicine management policy
1.4.2	1	Entrances and exits are designed to enable staff to see who is entering or leaving and if required CCTV is used to achieve this
1.5		**Young people are consulted about the unit environment and have choice when this is appropriate**
1.5.1	3	Staff consult with young people when decisions are made about changes to the unit's environment that may affect them
1.5.2	2	Young people are able to personalise their bedrooms
1.6		**There is equipment and procedures for dealing with emergencies in the unit**
1.6.1	1	There is a procedure for evacuation in case of fire which is rehearsed at prescribed intervals *Guidance: The organisation's policy will determine how often the procedure needs to be rehearsed*
1.6.2	1	The unit has resuscitation equipment and its location is clearly identified
1.6.3	1	Staff have a communication system which includes personal alarms
1.6.4	2	There is a way for young people to raise an alarm in an emergency *Guidance: This is not to be achieved through staff observation or through the young person shouting*
1.6.5	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed

4 Findings and recommendations

The introduction of national specialised commissioning presents an opportunity for a more managed and equitable system for access to inpatient CAMHS care. In this chapter, the results of the review are considered, and recommendations to SCOG are proposed in response to the terms of reference it was set.

The Steering Group thanks contributors for their candidness in sharing the day-to-day reality of CAMHS Tier 4 inpatient services. It is clear from all those who contributed to this review, both providers and commissioners, that their desire is for the system to improve for children and their families/carers.

The survey has generated extremely valuable insights, now quantifiable and more clearly described about the picture of CAMHS Tier 4 commissioning and provision across the country, at a snapshot in time. The review has revealed variations and inconsistencies, many of which there is now the potential to address by the virtue of having one national commissioner.

Some of the recommendations which follow offer quick wins and are described with a level of detail and specificity to assist speedy implementation, if they are approved by SCOG. A number of these are practical approaches to standardising practice, in line with what has been found to work in some areas. Some of the inconsistencies found in the review pre-date the recent commissioning change. As the new system beds-in, there is a golden opportunity to align approaches and address past inadequacies in systems.

Since the membership of the review steering group includes both provider and commissioner representation, it is perhaps understandable that the recommendations include observations about how the whole system might work better together.

As was observed at the outset, there are numerous issues relating to the delivery of CAMHS generally, and CAMHS Tier 4 inpatient services are only a component part of the overall pathway. Throughout the review, the steering group has been mindful of this, and of the essential interfaces in the delivery of care which directly impact upon the quality of services received by children and young people.

NHS England commissioned this review in order to examine those aspects of the care pathway that it is responsible for commissioning, and to seek recommendations and guidance about this. Inevitably, further work will be required to address issues beyond the remit of this review.

The steering group would wish to offer suggestions based on its findings of areas that it feels merit further consideration. These would need involvement and collaboration with other statutory bodies, the engagement of clinicians and providers across the care pathway and the involvement of children/ young people and their families and therefore, these proposals are offered in a separate section at the end of this chapter.

The recommendations are subdivided into five sections for consideration by SCOG:

- The interaction of geography subspecialty and age in influencing admissions
- Contracting issues
- Standards
- Procurement
- Further recommendations for consideration by commissioners working with the wider system

4.1 The interaction of geography, sub-specialty and age as determining factors for admissions

There is variation in current sub-specialty provision and how the care pathway operates in different areas. There are geographical inequities in provision of services with some areas very poorly served. These variations have existed for some years and reflect both historical local priorities and sometimes uncoordinated growth. An additional complexity is that the child/young person's age (whether over or under 13), and whether they require a sub-speciality placement must also be taken into account and these interact with the geographical variations in provision.

In addition to general CAMHS beds, units currently define their beds as the following:

- Eating Disorder
- High Dependency
- PICU (Psychiatric Intensive Care Unit)
- Learning Disability assessment & treatment
- Low Secure including Learning Disability
- Medium secure including Learning Disability

These sub-speciality services are generally for over 13s, except for Learning Disability services which span the full age range up to 18. High dependency and PICU are descriptors of models of care and can be co-located /integrated with other CAMHS Tier 4 inpatient services.

The interaction of these three factors (geographical location, sub-specialisation, and age) may have unintentionally increased fragmentation of CAMHS inpatient services and may be a contributory factor in admissions further from home. The impact of these on admissions is discussed below.

Geographical location

The maps show a concentration of units around major centres of population, with a reasonable distribution of adolescent units. Units for under 13's and sub-specialty units are less evenly distributed.

There are areas of England without any local provision, notably the South West; as well as areas with relative under-provision for example Yorkshire and Humber. This polarisation of provision is more pronounced in relation to children's units and designated sub specialty units. The total number of beds required for children under 13 is lower, as there is a smaller cohort of patients (as seen in the data on volume of admissions).

All area teams should have adequate access to both general purpose adolescent and general purpose children's beds, relative to their population and need (whether this is within their own geographic footprint or, more likely for children's units, a neighbouring one). The steering group is persuaded that each of the 10 geographical footprints (covered by the specialised commissioners) should have access to adequate capacity within their area to CAMHS Tier 4 General Adolescent beds. Further work is required to define adequate capacity for each area.

When each area has sufficient general adolescent beds, consideration could be given to whether general adolescent services continue to meet the criteria of specialised services. Some CRG members have indicated that such a redefinition would need to be fully debated and safeguards would be required to avoid slippage to the previous pattern of inequity. Also, if change occurs in designation as specialised services, the pathway between the CAMHS Tier 4 general Adolescent services and Tier 4 sub-speciality beds must not become fragmented.

In addition to adequate general bed provision, there then needs to be an accessible network of CAMHS Tier 4 children's beds and sub-speciality beds.

There is a balance to be struck between need for a concentration of clinical expertise and a specific therapeutic environment, and the detrimental effect of long-distance admissions. Similar issues have been raised in work between the Royal College of Psychiatrists and the Youth Justice Board. The approach adopted by the YJB in considering other factors alongside distance offers a useful framework which could be adapted for use in CAMHS. More discussion is required to define what constitutes "accessible" and this should include involvement and engagement with young people, their families and carers.

Sub-specialisation

Sub specialty beds have increased variably across the country and are largely provided for over 13s, although they are available for younger children by arrangement. Thresholds for access to these sub specialties appear to vary across the country. There are very few specialised learning disability and children's beds across England, with fewer beds now than in earlier studies undertaken in 1999 and

2006 (O'Herlihy A, 2007). Sub-speciality growth has been largely provider driven (with the exception of medium secure care) and particularly in the areas of PICU/Low Secure and CAMHS Tier 4 Eating Disorders.

The interface between general and sub specialty services needs more consideration, including advice on when a young person needs to be admitted to a subspecialty unit or transferred from a general adolescent bed to a sub specialty one. Clearer thresholds for escalation into more specialised services, whether this is higher levels of security or greater sub-specialisation would help to ensure that patients are placed in the right beds at the right time to suit their treatment needs.

CAMHS Tier 4 are serving a very wide range of needs/risks/maturational and developmental issues, which may influence admission decisions even when a young person meets the criteria (due to needs/risks of current population on unit etc.). It is important to ensure that children and young people are able to gain access to services, whilst also ensuring that individual units are able to safely manage their case mix at any given point.

Consideration needs to be given to the extent to which CAMHS Tier 4 General Adolescent services can and should provide a broad range of care (and therefore services potentially closer to home) within the unit without being detrimental to the young people and the quality of care provided.

A key area to consider is to what extent the CAMHS Tier 4 General Adolescent Units can and should provide a level of high-dependency/intensive care and the impact of doing so on the therapeutic environment of the unit, whilst meeting the needs of the range of patients requiring in-patient care. Clarity from clinicians about which care pathways or sub-specialities can coexist would support commissioners in specifying the optimum distribution of services longer term and procuring them.

It is important to distinguish the different care pathways and sub-specialities which might co-exist within any one Tier 4 Unit, e.g. eating disorders; high-dependency care; learning disability care - and that these might not all be expected to have the same geographical coverage.

Consideration may be given to whether there are specific factors or thresholds that require admission to a separate sub-specialty service following admission into, or assessment by, a more general service. Hence, any rule about distance to travel to Tier 4 Units would need to be varied depending on the care pathway and clinical needs of the child or young person. The sub-specialty units might serve a wider catchment population than the footprint of a single area team and access should be within reasonable travel time depending on the specialism of the care pathways.

The distinction between PICU and Low Secure is currently being considered by the Secure CAMHS CRG and as part of this work the relationship to CAMHS Tier 4 General Adolescent Units should be considered. CAMHS Tier 4 General Adolescent units are generally able to manage young people who require high levels of containment because of absconding / risk self-harm but only where this is not prolonged. In this context, the thresholds between general and secure units need to be explicit. The provider surveys revealed that bed closures were often due to patient

mix/acuity and some providers reported that problems related to delays in transfer to PICU/Low Secure settings. The review supports work currently underway by the secure CAMHS CRG into defining access to low and medium secure CAMHS and establishment of a formalised gatekeeping/access assessment process.

Another key area is the models of care for eating disorder provision. Previous studies (e.g. NICAPS) have found that the majority of children and young people with eating disorders who require admission are cared for in the general adolescent or children's units.

There are a small number of sub-specialty eating disorder units. These may be co-located with a CAMHS Tier 4 General Adolescent unit or be stand-alone units. The latter arrangement is more common in the independent sector. Involvement of the CAMHS CRG with the Children and Young People Improving Access to Psychological Therapies Team (CYP IAPT) programme led by NHS IQ, (due to the work they are doing in developing training and services for community eating disorder treatment) and the Eating Disorder CRG could help to identify any factors relevant to provision in a CAMHS general service and those in a specific eating disorder service. They could then advise on the most appropriate model of care relevant to particular circumstances.

Age

There is a clear delineation in the age ranges served by individual CAMHS Tier 4 Units (whether children or adolescent) though the age bandings in place vary slightly from unit to unit. The upper threshold for children's services is described as age 12 or 13 and under. Clinical members of the review steering group and CRG confirm that these age bands are widely supported as the clinical presentation of patients is distinct between these two groups and the model of care differs. Also, as the population within the adolescent services is increasingly becoming older adolescents (16-18 years), these become less suitable placements for under 14's.

There would be major concerns about young children being admitted to adolescent units and therefore the age distinction is supported within the profession. Issues were raised before the review commenced about children and young people being admitted to units inappropriate to their age through non-availability of a suitable bed. Within the CAMHS bed estate, this does not emerge as a particular issue from the provider returns to the survey. The sub-specialisation by age appears appropriate although as noted there is inequitable access across the country.

Considering the three factors together

Commissioners and providers would agree that the overarching aim should be that all children and young people in England are able to access age-appropriate services as close as possible to where they live. Some of these services may be at a greater distance from home because of their specialised nature (sub-specialty), but they

should nonetheless still be accessible through having a defined catchment area. To support the achievement of this aim, the following recommendations are made:

Recommendation 1
Specialised commissioners should develop a framework, in conjunction with clinicians, to identify factors for consideration when placing a child or young person in an in-patient service. The factors described on page 74 through joint work between the Royal College of Psychiatrists and the Youth Justice Board provide a starting point for such a framework.

Recommendation 2
Every Area should have adequate capacity of CAMHS Tier 4 general adolescent beds.

- ***Specialised commissioners should review un-commissioned beds identified by existing providers to check whether the environment is suitable, there are any quality or safety concerns and the beds can be staffed.***
- ***Subject to the outcome of that review, consideration should be given to procurement of additional general adolescent beds to deliver more uniform coverage across the country. This would be on a short term basis allowing short term capacity from 'new market entrants', pending a more comprehensive procurement.***
- ***When each Area has sufficient general adolescent beds, consideration could be given to whether general adolescent services continue to meet the criteria of specialised services. Such discussion must include securing continued equitable access to general beds and clear pathways to sub specialty Tier 4 services.***

Recommendation 3
Further work needs to be undertaken to determine which sub specialties can co-exist in CAMHS Tier 4 General Adolescent units, through the adoption of different models of care, and which are required to be in designated sub specialty units. Consideration needs to be given to whether from those 'co-existing' care groups there are any particular factors that would lead to onward referral to a designated sub specialty unit.
This will need to be completed in the short term, in order to inform a comprehensive procurement for all CAMHS Tier 4 to align contract currencies and prices.

4.2 Contracting issues

Sharing emerging best practice

The review asked commissioners to share local initiatives which might be considered for wider adoption. The adoption of some of these is discussed further below in relation to standardising approaches, reflecting the fact that there is now one national commissioner at Tier 4 administered through 10 area teams. Mental Health specialised commissioners meet nationally on a monthly basis to coordinate their activities but there is no formal mechanism to require the adoption of commissioning good practice across all services. The examples of good practice shared by area teams should be reviewed to determine what should be nationally adopted to support consistent practice. Once approved by SCOG these could then be added to the Mental Health Standard Operating Manual being developed and subsequently recommend to SCOG for approval and adoption.

Recommendation 4
Review examples provided by area teams to consider which should be adopted nationally and included in the Mental Health Standard Operating Manual.

Referral, assessment and approval arrangements

Given that CAMHS Tier 4 services have only recently become a nationally commissioned service, with a single national specification, the variation seen in arrangements inherited across the country is understandable, but progress now needs to be made to standardise these.

Chapter 2 indicated those factors which Tier 4 units considered as having a positive influence on accessing admissions to Tier 4 inpatients appropriately. The following ones appear to be key and merit adoption as standard practice:

- agreed protocols for assessment and referral
- working to standard assessment policies and procedures that involves case managers and have clear information requirements
- adequate assessment in Tier 3 CAMHS prior to referral (including full consideration of alternatives to admission)
- referrals which are consistent with the services provided by the specific Tier 4 unit receiving the referral (e.g. age range, sub specialty service criteria) and which contain all the necessary information
- ensuring that children and young people have clear aims on an admission

- ensuring that children and their families or carers are fully involved (and are not subject to clinically unnecessary assessments)

A number of specialised commissioners supplied standard protocols for handling referrals for admission. These set out a consistent approach which is applied both in and out of their area. There now appears to be more variability in prior approval arrangements by commissioners post- 2013 than existed previously. Given the pressures on beds currently being experienced, consideration should be given to whether commissioners are advised of in-area referrals, as well as those out of area.

The impact of the variation in assessment arrangements is also seen through the provider responses and their descriptions of inappropriate and multiple referrals. There seems to be a clear opportunity to standardise practice in line with those who have consistently applied rigorous processes. Some commissioning areas have had consistent approaches over a period of years based on multi-disciplinary assessments with a track record of redirecting inappropriate referrals and a greater ability to accommodate demand for beds locally. SCOG may wish to build in a standard access assessment process within the comprehensive procurement exercise.

Those areas which do have clear referral and assessment procedures, which are adhered to, appear to be better able to manage demand. The review was told however of instances where, even though protocols do exist, they are not universally adhered to, with commissioners unaware of placements of their residents out of area.

Commissioners need to be aware of referrals into units they are responsible for, in order to understand demand within the system, and hence the implications for commissioning, in order to avoid the situation of multiple referrals raised above and consequential wasted clinical time.

Recommendation 5
Specialised commissioners should:
Identify access assessors
agree standardised referral and assessment procedures that involve case managers, with clear approval mechanisms for 'any out of hours' emergency admissions which are monitored for compliance
Comply with agreed specialised commissioning placement notification processes
Outline clear expectations for the involvement of young people and their families/carers

Delayed discharges

Commissioners described delayed discharges as an increasing problem and cited issues around access to social care provision as a key area. This is confirmed

through the provider responses. Leicestershire and Lincolnshire area team is piloting an initiative to address delayed discharges and will share its results. Proactive monitoring and case management should be considered for patients clinically fit for discharge. This could be overseen by case managers. This approach has been adopted successfully in other services resulting in speedier discharge, thereby releasing beds for admissions and identified the reason for delays and thus what other services may need to be created locally to meet gaps.

Recommendation 6

- ***Standardised and proactive monitoring of delays in transfers of care should be put in place nationally to ensure that delays are identified and addressed promptly thus creating capacity for those requiring admission.***
- ***Develop mechanisms to monitor waiting times for admission which should be reported nationally***
- ***Regular national reporting of delays in transfers of care should be considered.***

Within general and acute services there are clear expectations for admission and discharge. Implementation of these CAMHS Tier 4 admission and discharge recommendations would support parity of esteem for mental health services.

Case management

This group of staff appear to be key to keeping the system moving and in terms of numbers of staff and caseloads the resource is currently fragile (non- recurrently funded) and highly variable across the country. These staff have an important role in helping patients to navigate the care pathway, and in keeping care as local as possible. They could help to address some of the current difficulties in relationships between Tiers 3 and 4 which are now the responsibility of different commissioners as well as being involved in referrals, ongoing patient reviews and delayed transfers of care. Recruitment of temporary case managers in autumn 2013 has been beneficial but now needs to be embedded in the system. Some of the fragmentation of commissioning arrangements between Tiers three and four can be addressed by case managers working collaboratively with CCG commissioners and any case managers they may have.

Sustainable and effective case management is a cornerstone of seamless care across the CAMHS pathway. The opportunity should now be taken to strengthen this function which can streamline the interface between providers and commissioners.

Recommendation 7
Sustainable case management arrangements should be established

Bed management

Both commissioners and providers have described substantial amounts of time spent sourcing available beds. Providers also highlighted the issue of multiple referrals for individual patients which cause additional avoidable pressure in the system. In August 2013 area teams were asked to report on bed availability on a weekly basis. By November 2013 providers were inputting to a centralised computer system that provided a 'snap shot' of bed availability each Friday. Initially, some providers indicated beds were available but then declined referrals. This weekly system of 'sitreps' has continued but was supplemented in December by weekly telephone conference meetings involving all area teams to consider the 'snap shot' and share intelligence. This now gives a more accurate picture of the availability across the country, as well as which areas and specialties are under pressure. Views differ about whether this has perversely driven longer distance referrals (because available beds are visible) or whether it has been beneficial.

The weekly meetings have however been useful in identifying emerging issues e.g. in one area a recent examples of Tier 3 clinicians assessing and completing Mental Health Act documentation to detain young people who CAMHS Tier 4 clinicians then did not agree met the criteria for detention, nor required inpatient care . The meetings are also receiving updates for delayed transfers of care, the majority being for social care reasons.

"No coherent national bed management system or ability to identify available beds at a given time, and the current snapshot provided on a Friday does not reflect the true national state of the bed situation as there have often been local agreements to close beds for short periods that are not reflected in the report."

"We would recommend some strategic work being undertaken at NHS England level (perhaps in Clinical Reference Groups) to develop coordinated and well-informed regional CAMHS bed management systems." (Provider Comment on commissioning changes)

The review has considered whether the introduction of a "live bed state" would support better bed utilisation. A similar approach was adopted some years ago in general and acute services for intensive care, at a time when there was extreme pressure on a limited number of beds. Access to these beds has since been contained through clear clinical protocols and agreed collaborative arrangements within a defined geography.

In CAMHS, collaboration between units, underpinned by clear access protocols could streamline identifying available capacity. Such a "bed network" might be better implemented on the geographic footprint covered by the area teams rather than on an England-wide basis (as the current sitrep is). There would then be an incentive to contain admissions within the bed network, with escalation procedures involving contacting surrounding networks when beds cannot be found in area, once sufficient additional capacity has been procured.

Recommendation 8
Consideration should be given to a standardised system for live reporting of bed availability based upon the geographic footprint of the 10 specialised commissioning areas, and which allows inter-area communication if demand for beds cannot be contained within area. It is understood that previous procurement exercises built in 'live' bed reporting so this could be explored further

Access to patient information

Throughout the review, repeated mention has been made of the obstacles to commissioners in accessing appropriate data to enable them to fulfil their responsibilities of ensuring children and young people are receiving the most appropriate care and treatment. NHS England is currently not entitled to access patient identifiable information. These issues have contributed to some of the inconsistencies in practice around the country and commissioners' inability to effectively manage the flow of patients through the system. A case is being made to seek a temporary exemption to allow access to patient information and it is understood legislative regulations are to be drafted to come into effect from the autumn. These regulations are long awaited.

Recommendation 9
SCOG is requested to press the case for speedy change in legislation to allow commissioners necessary access to information so that they can fulfil their responsibilities.

Four area teams have recently piloted the use of a national CAMHS case management database. All four area teams reported favourably on its use but were concerned about recommending full roll out given the temporary nature of the current CAMHS case manager roles. Case managers need sufficient timely and appropriate information to carry out their role. Case managers will require particular information including patient identifiable data in order to carry out their functions.

Recommendation 10
Case managers should have access to robust information systems to support effective care pathway management

Contract levers

The terms of reference for this review referred to commissioning proposals on contract levers. Implementation of the recommendations from this review would provide commissioners with a range of information and methods which can be either applied or developed into contract levers. These are described in greater detail elsewhere in this report. In particular the following are relevant:

- The further work recommended on the distribution and sub specialisation of beds
- clearer care pathway protocols
- description of the levels of compliance required against the proposed quality standards
- implementation of the additional standards prepared by the Tier 4 CAMHS CRG
- alignment of commissioner practice across the area teams, and associated alignment of contract currencies (what is included in the price) and prices
- standardised assessment and gatekeeping/access assessment protocols, geared towards containing admissions within the specialised area footprints as far as possible.
- Commissioner (case manager) involvement in placement and retrospective acceptance (for those emergencies) of 'out of hour's' admissions. If no adherence to protocols then funding withheld.
- Expected compliance through contracts to information exchange with commissioners on referrals, waiting times and delayed transfers of care

4.3 Standards

The terms of reference for the review asked that the steering group should work with the CAMHS CRG to develop recommendations for adoption nationwide in the following areas:

- Quality standards
- Access standards
- Environmental standards

- best practice for trial or home leave
- best practice for discharge thresholds and discharge planning
- guidance on managing suicidal ideation

The resulting proposed standards are included earlier in this report and require further involvement and engagement prior to adoption by SCOG. Once considered more widely, SCOG should support inclusion in the contract standards in these areas.

The CRG works closely with the College Centre for Quality Improvement within the Royal College of Psychiatrists. CCQI has developed the QNIC standards which has formed the basis of a number of areas within this guidance. These standards evolved in response to the National Inpatient Child and Adolescent Psychiatry study (Royal College of Psychiatrists' Research Unit, 1999).

These standards are widely understood and accepted and have evolved from within the CAMHS clinical community. They have been produced through consultation with members and advice from children, young people and their carers.

The associated accreditation process has inbuilt peer review and the network has over 90% of CAMHS providers (both NHS and Independent Sector) as members. QNIC is also working with the CQC and other stakeholders in developing the CQC standards and processes for inspection of CAMHS. QNIC is also working with NICE and other stakeholders on the development of guidance on safe staffing levels in CAMHS. There is thus an opportunity to ensure alignment across the various inspection frameworks.

The CRG would recommend broader engagement on the proposed standards developed as part of this review i.e.:

- access assessment standards
- best practice for trial or home leave
- best practice for discharge thresholds and discharge planning
- managing suicidal ideation

The CRG recommends that the QNIC network should be used for engagement with providers, with additional involvement of CAMHS Tier 3 providers and NHS commissioners. Consideration should be given to how children/young people and their families/carers and other providers and commissioners of children’s services can comment and provide feedback.

Quality and Environmental standards already exist within the QNIC accreditation process. Provider contracts already require that units comply with essential standards. Furthermore, all CAMHS tier 4 units must already comply with CQC standards.

The CRG recommends that SCOG engages more widely on expanding the QNIC standards which are a contractual requirement. The CRG has highlighted specific standards for consideration relating to standard 3- “Access, assessment and

discharge". Further engagement is recommended to identify which of the environmental standards; over and above those required by CQC, should be included within the contract with providers as mandatory and which ones they should be working towards.

The adoption of unified standards is likely to highlight existing variation in provision. The QNIC standards make the distinction between core requirements and aspirational standards. Assessment against these and the other standards proposed will reveal where there are gaps between current standards of provision and the ideal.

The availability of the necessary resources to address this (both manpower and financial) may dictate the pace at which the standards can be achieved. The adoption of unified standards for access / discharge may also highlight variation in CAMHS Tier 3 and other agencies and this will again require further work to address any issues which arise.

Recommendation 11
The following proposed standards should be consulted upon more widely:

- ***access assessment***
- ***best practice for trial or home leave***
- ***best practice for discharge thresholds and discharge planning***
- ***managing suicidal ideation***

The QNIC network should be used for engagement with providers, with additional involvement of CAMHS Tier 3 providers and NHS commissioners. Consideration should be given to how children/young people and their families/carers and other providers and commissioners of children's services can comment and provide feedback.

Following this, early implementation to support standard practice across the country is recommended.

Recommendation 12
Specialised commissioners should further consider including additional standards beyond current CQC requirements in contracts. These should include the specific QNIC access, assessment and discharge standards proposed by the CRG in section 2.22 and further engagement on which of the QNIC environment and facilities standards should become a contractual requirement, alongside consideration of the appropriate pace of change.

4.4 Procurement

Commissioners have an opportunity to consider use of the available "uncommissioned" capacity that providers have indicated exists. They may then procure additional capacity as a stopgap; to mitigate the current pressures being felt in the system. This has been referred to earlier in recommendation 2 above. Commissioners need to quickly reconcile the differences between bed type and numbers reported weekly to commissioners and the numbers indicated in the survey responses.

It is impossible presently to specify the ideal longer term overall configuration and distribution of services. Public Health England may be able to assist or undertake work to provide up to date estimates of bed numbers for catchment populations.

As stated earlier, each area should have a CAMHS Tier 4 General Adolescent Unit. The range of sub-specialty provision supporting this- possibly at a 'supra regional' level (more than one area) requires further discussion as set out in section 3.1.4 above. If emerging best practice and standardised approaches across the country are adopted, together with greater collaboration with Tier 3 commissioners, additional bed requirements may be considerably mitigated. Consideration however needs to be given to whether the role of access assessment/gatekeeping to specific standards should be procured quickly.

Any short-term measures taken to ease pressures should not in themselves become a long-term commitment to a given pattern of service. The need for more integrated commissioning may in fact signify less demand upon beds and greater emphasis upon intensive community support. Indeed, with better provision commissioned across the care pathway, it may be possible to contain some of the demand by more extended use of intensive community services, as has already been put in place in some parts of the country under previous arrangements.

Some of the volatility experienced over the past year in inpatient services may ease as commissioning becomes more standardised and involved in setting clear expectations and better controls are implemented which smooth the patient's journey through the pathway (e.g. consistent referral, assessment, case management and management of delayed discharges). These factors will also have a bearing on the longer term bed capacity required.

Recommendation 2 above highlighted the urgent need for increased capacity in general adolescent services in those areas of the country which currently have no provision. It would seem likely that this provision will continue to be needed longer term to support better integrated pathways of care for children and young people.

The provider survey confirmed beds which are not subject presently to contractual arrangements. There may be varying reasons for this, including environmental or staffing issues.

Before proceeding to procure new capacity, commissioners should establish whether this capacity can be accessed short term to give temporary relief to the pressures being experienced.

Recommendation 13
Commissioners should first verify bed numbers and types, then explore the extent of available capacity within the existing CAMHS estate and whether this is available and fit for purpose to be commissioned in the short term to address capacity issues.

Any additional capacity procured short-term needs to be flexible and responsive to changes in demand which emerge following implementation of this review. Therefore, an approach similar to the any qualified provider method may be the most desirable way of procuring capacity in the short-term, without blocking in resources longer term.

A procurement exercise along these lines should be commenced. The short-term procurement might usefully include a standardised process for access assessment in each specialised commissioning area. This would help to overcome some of the disparities seen in response to this review.

Recommendation 14
A short-term procurement of additional capacity for those areas of the system most acutely affected by current inaccessibility of beds should be undertaken following consideration to recommendation 13. This should not be taken as a permanent change in provider capacity and should be subject to a longer term commissioning plan, following implementation of the other recommendations from this report.

Following this, a comprehensive procurement exercise to reflect work carried out as a result of other recommendations in this report will be required that will:

- take account of the agreed distribution and specialisation of units across the country
- take a more systematic look at Children's and Learning Disability units
- reflect further work on the co-existence of care pathways/models of care/sub-specialities within general adolescent units including the extent to which general units can manage more intensive care needs
- reflect standards developed for this review, once approved
- allow for new entrants to the market
- ensure internal NHS England processes exist for financial flows to support placement of children and young people as close to home as possible
- align contract prices and currencies (what is included in the price)

Any future procurement should be flexible enough to allow appropriate development across the geographical and sub specialty requirements indicated by the further work recommended in this review.

Children and young people admitted into adult services

As adult units were not surveyed, we are unable to confirm the incidence of admissions to adult wards. From the 100 commissioner case studies, there were two placements in adult units out of a total of 87 admitted, though provider responses also included comments regarding increased incidence of young people admitted to adult wards. A clear mechanism needs to be established whereby specialised commissioners are notified of children and young people being admitted to CCG commissioned adult wards as a result of being unable to access a CAMHS bed. Standardised referral processes and involvement of case managers may resolve this however until such time as it does, this needs to be resolved.

Recommendation 15
A consistent process should be established by NHS England to notify CAMHS case managers when a young person from their area is admitted to an adult ward. All children and young people should have access to age-appropriate services

4.5 Further recommendations for consideration by commissioners working with the wider system

Collaborative commissioning, commissioning thorough alliances and provision

The absence of sufficient collaboration across geographical areas and pathways of care (including vertically through the different Tiers of service) appears to be contributing to difficulties in navigating timely access to the right care for children and young people. Mechanisms for coordination of the system of care through the different tiers is needed to ensure proper discussion between commissioners and providers. Whilst some areas have benefited from good collaboration historically, this is not universally the case. Some areas have sustained local infrastructure which bridges the care pathway, whereas others have seen the demise of such collaborative arrangements.

Provider networks

The functioning of the system could be supported by consistent development of clinical networks. Lessons can be learned from those areas which have sustained or developed these arrangements across the care pathway. All providers of CAMHS including both NHS and independent sector providers should have access to an appropriate clinical network, which in turn can inform and support collaborative commissioning. An additional benefit of these networks could be to deliver continuing professional development opportunities for the CAMHS workforce.

Sub specialty units should be networked with general CAMHS units. The matrix of connections between different types of units will need careful consideration. The mix of bed types within networks needs consideration; all beds should be linked to agreed pathways, avoiding an uncoordinated expansion in capacity which can lead to disjointed and fragmented care.

Commissioners may wish to specify that involvement in such a network is a contractual requirement. For the purposes of aligning planning, commissioning and coordination of services it may be appropriate to establish these based on the geographic footprint of the 10 specialised commissioners. The implementation of these could be incorporated within the strategic clinical networks (SCNs) arrangements across the country. Also, the opportunity to link with the relevant academic health science networks (AHSNs) would provide a logical and consistent infrastructure.

Recommendation 16
CAMHS Clinical (provider) networks should be established based on the 10 specialised commissioning footprints; consideration needs to be given to how 'supra regional' providers are involved with their relevant 'catchment' networks as well as providers across all Tiers of provision.

Such networks should involve clinicians from all providers of CAMHS care (both NHS and independent). Strategic Clinical Networks and Academic Health Science Networks may have a role to support the development of such networks and their input should be sought.

Commissioning across the whole pathway

The new commissioning arrangements pose a particular challenge where a young person's journey (care pathway) moves across and between organisations and commissioning responsibility. Clarity about how these organisations plan and commission a pathway and how young people move from one part of the pathway to the next is critical in building and maintaining seamless care.

It is essential that the commissioning arrangements collectively result in the best outcomes for children and young people and that commissioning responsibilities do not have unintended consequences for them. Almost all specialised mental health services commissioned by NHS England have care pathways which extend across CCG commissioned services. A number of these have further complexities of multi-agency involvement (i.e. Local Authority, Education and voluntary sector).

Pilot projects known as 'Pathfinder Projects' including one in mental health have begun to explore how commissioning arrangements could be delivered across the pathway. This involves representatives from providers, CCGs and different directorates in NHS England. The underpinning principles are:

- a focus on innovation in service delivery
- care closer to the young person's home,
- driving improvements in clinical outcomes and patient experience

The aim is to ensure the best use of resources through effective commissioning across the whole system. The overall objectives are to identify potential/real barriers to effective commissioning across commissioning entities and other organisations/agencies, identify examples of best practice (where is it working well) and make recommendations for system/process improvements. The pathfinder is anticipated to report in the summer.

The Pathfinder Project is not specifically addressing CAMHS but it is anticipated that some of the lessons learned and recommendations may equally apply to CAMHS commissioning since the pathway extends across multiple commissioners.

Within CAMHS the extent of collaboration to commission has varied historically. The disruption described by the separation of commissioning responsibilities is not simply a consequence of the recent commissioning changes. It is evident from the commissioner responses to the survey that collaborative working arrangements prior to April 2013 were variable.

The opportunity now exists to promote a more systematic model of commissioning which is collaborative and integrated across the pathway of care, rather than focusing upon the Tiers of service delivery. At the same time there is a need for more medium term work to address the broader care pathway issues and in particular the development of services which provide a safe and effective alternative to admission.

The review steering group is of the view that further work should be done on collaborative integrated commissioning across the pathway. As outlined there is the Pathfinder Project and different models developing for commissioning such as commissioning through Alliance contracts (McGough R, 2013).

Were adequate provision of CAMHS Tier 4 General Adolescent services available in every area team, it would be possible to adhere to National commissioning standards (if the service area still meet criteria as a specialised service) whilst simultaneously developing a framework with all commissioners along the pathway in a given area for joint commissioning. The interface with Tier 3 services would need to be included in this. Provider responses to the survey showed significantly reduced lengths of stay

where intensive community outreach teams are available, but 64% of respondents said they did not have these teams. Further consideration would need to be given to where sub specialty CAMHS Tier 4 services would sit within such a CAMHS commissioning model (including CAMHS Tier 4 Children's Units).

Provider responses highlighted the significance of social care issues and their impact on delayed discharges. The significant role played by local authorities in the CAMHS pathway needs to be recognised and included in collaborative arrangements. Networks need to extend to Local Authority children's services so that they are integral to these collaborative arrangements and joint working needs to be better incentivised.

Some area teams have benefited from continuity of local network arrangements which span the various levels of care. These areas appeared better able to mitigate some of the barriers to commissioning across the whole care pathway. The opportunity should be taken to derive good practice for wider application.

There is a need to do further work nationally within some sub specialties e.g. secure services and learning disability.

Recommendation 17
Collaborative commissioning models should be explored which acknowledge that accountability rests with different statutory bodies whilst minimising perverse incentives. This should include care delivered at Tiers 3 and 4. Consideration needs to be given to how best local authority services can be involved in the model.

Consideration could be given to a more permissive commissioning approach reflecting the need for seamless management across the whole pathway. This potentially more far-reaching response to some of the perverse incentives described earlier might be explored by testing the system's appetite for whole pathway integrated commissioning. This approach could be piloted through inviting early adopters to express an interest in joint commissioning.

Recommendation 18
As an extension to recommendation 7, specialised commissioners may consider the outcome of the Pathfinder Project and different commissioning models e.g. commissioning through Alliance contracts.

Specialised commissioners would need to have discussions with other CAMHS commissioners to develop whole system commissioning, using existing legislative freedoms (e.g.to pool funding, or other mechanisms designed with the same objective).

Pilot schemes could be invited where there is a shared appetite by specialised and CCG commissioners, and other partner agencies.

Developing models of care for eating disorders and learning disability services, and developing models of services providing alternative to admission

The steering group is aware of the work initiated by NHS England as part of the CYP IAPT programme aimed at developing skills in managing eating disorders within CAMHS Tier 3. The later work provides the potential for a more medium term review of the model of care for children and young people with eating disorders, including the role and remit of in-patient care. Such work will require the involvement of a wider range of stakeholders

Further consideration needs to be given to what inpatient services are required for children and young people with a learning disability since current provision is concentrated in some parts of the country. This needs to specify the model of care and location of any inpatient services.

It should take into account recent joint work between the Local Government Association and Department of Health on the commissioning of services for people of all ages with behaviour that challenges (Ensuring Quality Services) including how learning disability services relate to challenging behaviour services provided by other agencies. e.g. education and social care. This work should consider the role and remit of in-patient care as part of a comprehensive care pathway.

As outlined in several sections of the report there are well developed services providing safe and effective alternatives to admission. Further work is needed to explore how the development of such models can be more widespread and applied.

Recommendation 19
Further work should be done to develop models of care across the whole care pathway for children and young people

- ***with an eating disorder***
- ***with a learning disability***
- ***services providing alternatives to admission***

Following models of care development specialised commissioners in conjunction with other agencies should consider the appropriate pattern of distribution for learning disability beds

CAMHS staffing

It is clear from the provider survey responses and from the NHS benchmarking report that there are staffing issues in CAMHS which have sometimes led to closure to admissions or issues around quality of services. From provider responses, these are particularly evident in nursing recruitment and stability. The lack of availability of adequately skilled staff trained specifically in CAMHS is understood to be a problem across the country. Qualified staff in CAMHS tend to come from either a children's or general mental health nursing background. There is no well-established postgraduate training route for nurses in CAMHS.

Recent increases in admissions have created short-term pressures in some units resulting in greater dependency on bank and agency staff. Any procurement by NHS England additional beds in the system will generate a need for more staff. There is an opportunity to respond to this across the system as a whole.

Provider survey responses on staffing issues
Of the unit answers supplied, 25% highlighted that there are current staffing issues currently affecting inpatient care.

"...increasing need to use bank staff to fulfil shortfalls in staffing levels with very rare occasion of the need to use agency staff."

"...stretching of roles to manage other aspects of the Trust."

"...discharge delay & frustrated patients impacting upon service moral"

Inexperienced Staff

10 units identified that inexperienced staff are a common issue.

"…there seems to be a lack of availability of experienced applicants".

"…junior clinicians left to manage risky and complex cases".

Specialist Staff Recruitment

As a national commissioner, NHS England has the opportunity to work with Health Education England on the development of the CAMHS Tier 4 workforce including recruitment, training and retention.

> ***Recommendation 20***
> ***NHS England should pursue with Health Education England a wider system discussion regarding the need to develop an adequate CAMHS workforce.***

4.6 Conclusion

This work has provided a comprehensive factual understanding of current CAMHS Tier 4 services from the perspective of commissioners and providers of service. The mapping of services has enabled identification of a number of issues that require addressing now.

The involvement of the CRG has initiated some work on standards for quality and access to services which will be an important building block for the next stage.

There are twenty recommendations made in the report. Of these, three require immediate implementation:

- To procure additional Tier 4 beds in parts of the country where there is insufficient capacity
- To ensure that all admissions to inpatient services are appropriate for the individual child
- To increase the number of case managers to enable timely and effective discharge planning and support back to local services

While these urgent improvements need to be made the work needs to include broader engagement and involvement of children and young people and their families and carers to help in the design and improvement of the services going forward.

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Steering Group membership

Mr Anthony Farnsworth	Area Team Director, Bristol, North Somerset, Somerset and South Gloucestershire, NHS England, **(**Commissioner Representative and co-chair)
Mr Stuart Bell,	NHS Chief Executive, Oxford Health NHS FT (Tier 4 NHS Provider Representative and co-chair)
Professor Dame Sue Bailey	President, Royal College of Psychiatrists
Ms Pia Clinton-Tarested	Head of Specialised Services, NHS England
MS Margaret Cudmore	Managing Director, Huntercombe Group, Independent Sector Provider Representative
Ms Kath Murphy	Assistant Head of Specialised Services, NHS England
Dr Margaret Murphy	Chair Clinical Reference Group Tier 4 Child & Adolescent Mental Health Services

Support to the review:

Ms Brenda Howard	Project Manager
Mr Peter Thompson	Senior Programme Manager, CCQI
Ms Jessica Redman	Administrative Assistant, CCQI

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Briefing from Specialist Mental Health Team- SYB AT, NHS England regards CAMHs Tier 4 – September 2014

The purpose of this brief is to provide an update in respect of CAMHs Tier 4 provision and directly associated pathway issues across Yorkshire and Humber (YH). Previous briefs to stakeholders have described the difficulties in relation to capacity issues experienced across YH. Since the last brief, progress has been made in addressing some of the issues, other work is ongoing.

1. **National CAMHs Tier 4 Review**

This National CAMHs Tier 4 review, commissioned by the NHS England Specialist Commissioning Oversight Group (SCOG), was published on 10th July:

http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf

The report concludes with 20 recommendations; however it was agreed as part of the implementation that 3 key areas needed immediate attention. These are as follows:

Recommendation 2:- Every area should have adequate capacity of Tier 4 CAMHs general adolescent beds.

In response to this recommendation, the National Tier 4 procurement exercise commenced, to enable a short term interim solution to be achieved in respect of those areas with specific capacity issues. YH is identified as one of those areas. Phase 2, a more comprehensive exercise will follow to provide longer term solutions for all types of Tier 4 provisions.

In relation to the short term interim issue, in YH we identified that 13 general adolescent beds and 5 psychiatric intensive care (PICU) beds were required. A number of responses were received from existing CAMHs T4 providers nationally. The outcome is that additional capacity became available from 15th September at Alpha Hospital Sheffield for general adolescent and PICU beds. Further general adolescent beds will become available in York, hopefully early December 2014, provided by Leeds and York NHS FT. These 2 developments will mean that YH's short term requirement is addressed in relation to general adolescent and PICU beds, this will be the first time that PICU beds have been available in area, this is very good news for young people and their families, also for clinicians and commissioners working along the pathway.

Recommendation 7:- Sustainable case management arrangements should be established.

The valuable and essential role of case managers within the Specialist Mental Health Commissioning Teams (SMHT) was identified as a theme throughout the review. In SYB AT, Directors had already supported the MH team appointment of these posts, and two members of staff were seconded in October 2013, the existing compliment of CAMHs case managers addresses the requirement for YH. It is important to note that CAMHs Tier 4 case management takes place on an 'originating basis', so the case managers in SYB AT are responsible for the case management of all children and young people who originate from CCGs in YH, placed in any CAMHs T4 service. This is by far the best approach for this patient group as it ensures that knowledge of local pathways is maintained, and length of stay is kept to a minimum. This does not however negate from the requirement that every

patient in a specialist service has an identified local care coordinator (from the Tier 3 service) identified within their home area.

A national case management database for CAMHs T4 has been piloted and the roll out of this has now been agreed. SYB AT case managers are working towards full engagement in this national process.

Recommendation 5:- Specialised commissioners should identify access assessors, agree standardised referral and assessment procedures that involve case managers……. Outline clear expectations for the involvement of young people and their families/carers.

In order to ensure that access assessments are equitable and timely, additional resource is being made available to enhance existing arrangements, it is hoped that across YH all access assessments will be completed by Tier 4 clinicians. Work is ongoing to develop this at this time.

National work has taken place to agree standardised referral and assessment procedures, staff from SYB AT have been leading this work which is hoping to conclude shortly. It is anticipated that this standardisation will be rolled out nationally in approximately two months' time.

In respect of the involvement of young people and their families/carers the CAMHs Tier 4 Clinical Reference Group (CRG) produced some good practice guidance about admission and discharge arrangements. NHS England Patient Public Engagement (PPE) Directorate have been working with SMHTs and Young Minds to engage young people, families and carers on this subject. A recent national event was very well attended and as a consequence of the event a document is being produced to identify priority areas within the guidance.

2. **National Weekly Reporting**

This continues via Tier 4 providers through UNIFY in terms of bed availability and also via SMHTs regarding young people waiting for Tier 4 beds, on adult or paediatric wards, over 18 year olds in Tier 4 services, and delayed discharges.

This system has been in place since July 2013 and it has helped considerably to ensure appropriate use of capacity and ensuring young people are placed as close to home as possible.

3. **CAMHs Pathway**

As in previous briefs it must be highlighted that there continues to be differences across YH in the provision of Tier 3 CAMHs services, seven areas now have Tier 3 plus services which is very good news. The Strategic Clinical Network (SCN-Children and Maternity) is working closely with specialised commissioners and local CAMHs commissioners to enable an understanding of these differences. Understanding the whole pathway is crucial to ensuring that the system works effectively. Work nationally has commenced, being led by the DoH to consider the future of commissioning across the whole CAMHs pathway so that there are not artificial separations and the pathway is as seamless as possible.

4. **In Summary**

Hopefully the additional capacity, plus the provision of a PICU in area will improve things for young people and their families/carers, also for clinicians making referrals and working with Tier 4 services. There are other pieces of work as described still in development, however if there are any queries or clarifications required please do not hesitate to contact myself, Louise Davies – MH and PoC Lead, Rita Thomas – MH Supplier Manager or Matt Miles/Helen Rutherford- CAMHs case managers.

Louise Davies- MH and PoC Lead (YH- SYB AT NHS England)

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TaMHS Expansion Evaluation 2011 - 2013

TaMHS Performance Measures and Indicator Impact September 2013

Glossary

CAF: Common Assessment Framework
CBT: Cognitive Behavioural Therapy
CCG: Clinical Commissioning Group
CPPs: Child Protection Plans
CYPP: Children's and Young Persons' Plan (for Leeds)
G&S: Guidance and Support multi professional meetings
High/ Borderline/ Normal: Assessment categories for SDQ assessments. High = high level of need, one indicator of a specialist CAMHS referral
GBO: Goals Based Outcomes. Client centred target setting assessment using 0 -10 self-rating scale. 0 = need completely un met 10 = need completely met.
LAC: Looked After Children
Leeds Average: A data set is available for certain CYPP indicators. For each there is an average for the whole of Leeds
Statistical neighbours: clusters with a similar level of need according to CYPP indicators from the year 2010/11.
OBA: Outcomes Based Accountability
TaMHS: Targeted Mental Health in Schools Project

Summary:

- TaMHS continues to provide positive outcomes both anecdotally from schools and also from the evaluated data in this report. It remains popular with schools due the need of pupils in this area, the gap in previous services, the ease of access and visible outcomes. This can be seen clearly by the continuation, again, of the TaMHS services by all clusters from their own budgets following the two year seed funding.
- The evaluated data shows positive impact in performance measures of mental health improvement and school development as well as the related CYPP indicators of CPPs, LACs and attendance.
- The use of standard mental health assessments has begun a growth of commonly understood information in identifying need and measuring progress city wide in this area. This links strongly with the OBA approach in the city and is integrated into the CAF process.
- As a result of Year 1 outcomes a second expansion was funded which has just begun with the setup of 13 more commissioned TaMHS services. All services are expected to be setup by November 2013.
- TaMHS has also begun a pilot in September 2013, part funded by TaMHS underspend and NHS non recurrent funding, with the South and East CCG to allow direct referral from GP practices into the Guidance and Support groups of Brigshaw and Temple Newsam Halton. Interest has also been expressed from the West and North CCGs with a view to setting up pilots in those areas also, funded by the relevant CCG. Long term outcomes expected are quicker and easier access to appropriate support as well as longer term funding from CCGs into TaMHS.

Issues

Reported, recurring, themes include:

1) Pressure on the TaMHS service to provide a more complex, longer term service. TaMHS is commissioned, and staff selected on this basis, to provide early intervention, short term specialist mental health support. It fills a much needed gap in support. A range of factors puts pressure on the service to extend its remit which include:
   a) A lack of understanding by some services of the remit of school facing, short term & early intervention resulting in inappropriate referrals. E.g. referrals from social care teams
   b) A downward pressure on the specialist CAMHS budget reducing capacity.

c) A lack of other services to fill the gap between TaMHS and specialist CAMHS where neither service is suitable for longer term, more complex need support.

2) School development was a challenge at times due to
   a) Difficulties appointing to the school support post as a result of restrictions in the council requiring work arounds of two independent consultants in year 1. This led to more rushed and a higher volume of work in year 2 than was anticipated.
   b) Some confusion, impacted by the above, in some clusters of the extent of the school development aspect and its requirements.
   c) Some schools unwilling to engage and some struggling to see the value that such an approach would bring on top of the specialist support.
3) Most clusters engaged well in all aspects of the project. Additional support was given where aspects of the cluster implementation were felt not to be meeting the project requirements. This included data reporting for monitoring, focus on evidence based support, short term and early intervention.

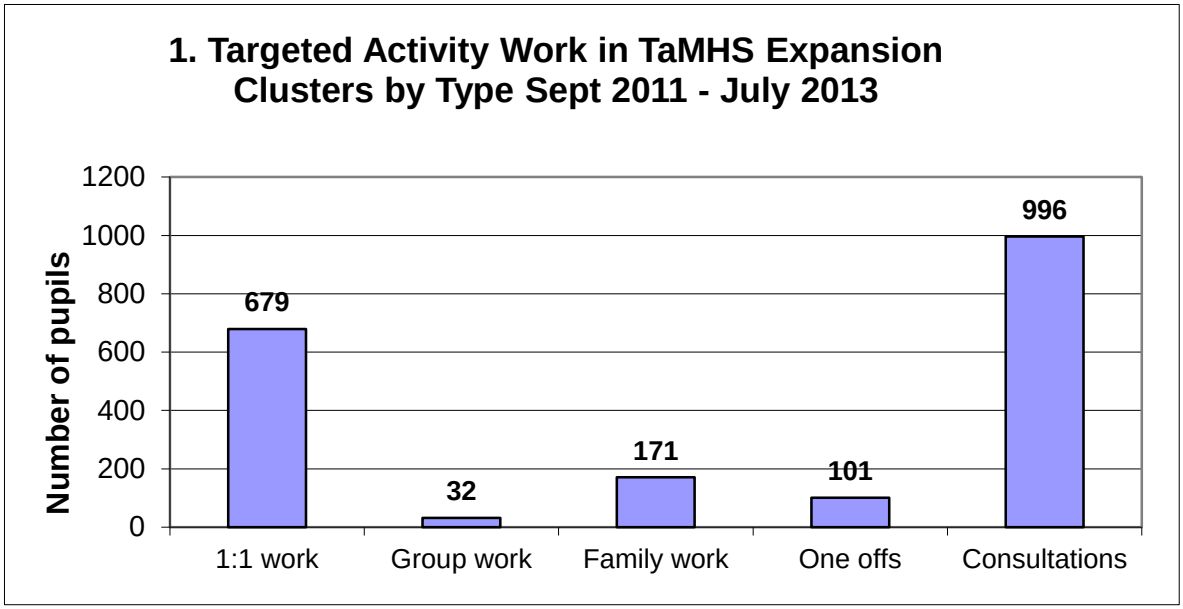
Clusters involved in the evaluated expansion:

- Aireborough
- Bramley
- CHESS & NEtWORKS (joint bid)
- Inner East
- Pudsey
- JESS
- NEXT
- Open XS

Performance Measures

How much did we do? (activity)

- **Guidance and Support Referrals** (Case Discussions) [1]
  - In the 9 clusters 233 G&S meetings were held between September 2011 and July 2013 with 2003 referrals (not just TaMHS, but total referrals)
- **Targeted activity work**



This shows a total of 1979 pupils supported through direct and indirect contact (there may be some double counting of pupils in this total)

- **CAMHS referrals**:
  - 20 as identified by CAMHS service
- **Training & support**
  - 601 school and TaMHS staff trained in 47 training sessions
  - 112 school support visits to develop in school capacity

[1] To demonstrate effective multi agency working and outputs, including 'indirect clinical activity'.

How Well Did We Do It and Is Anyone Better Off? (outcomes)

- **Pupil & Family progress**
  - **SDQ**[2]

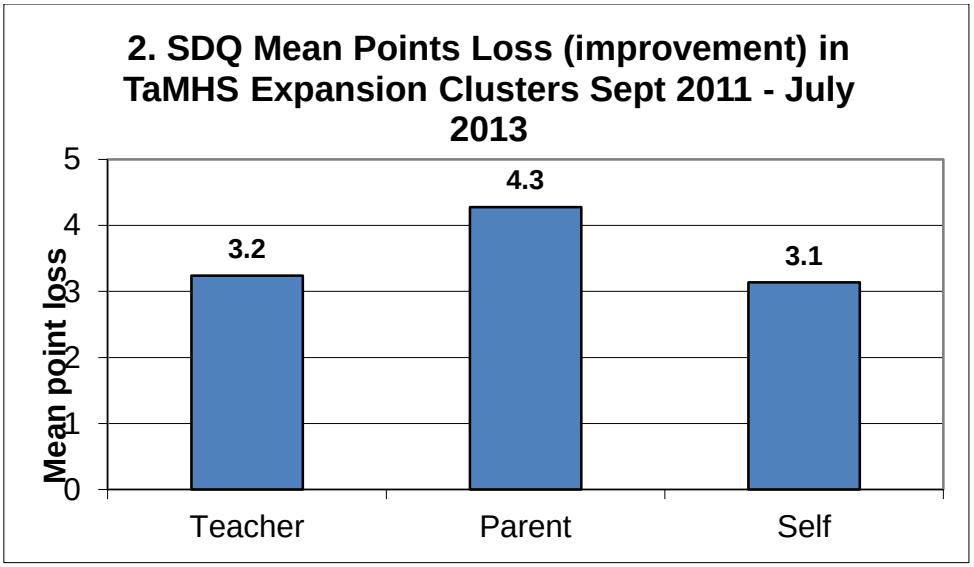
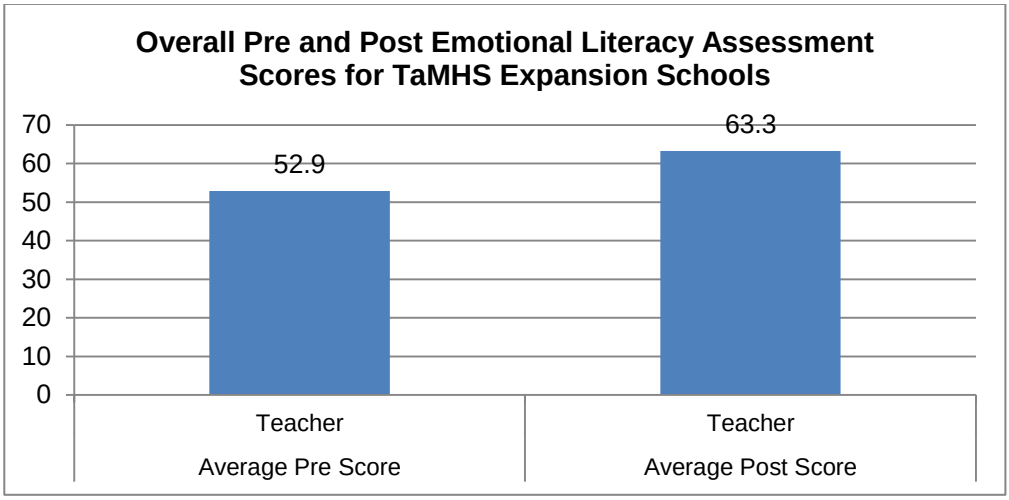


Chart 2 shows good positive change from all 3 perceptions[3]

UPDATE: Please see Appendix 2 for an SDQ pre and post category analysis

- **Emotional Literacy**

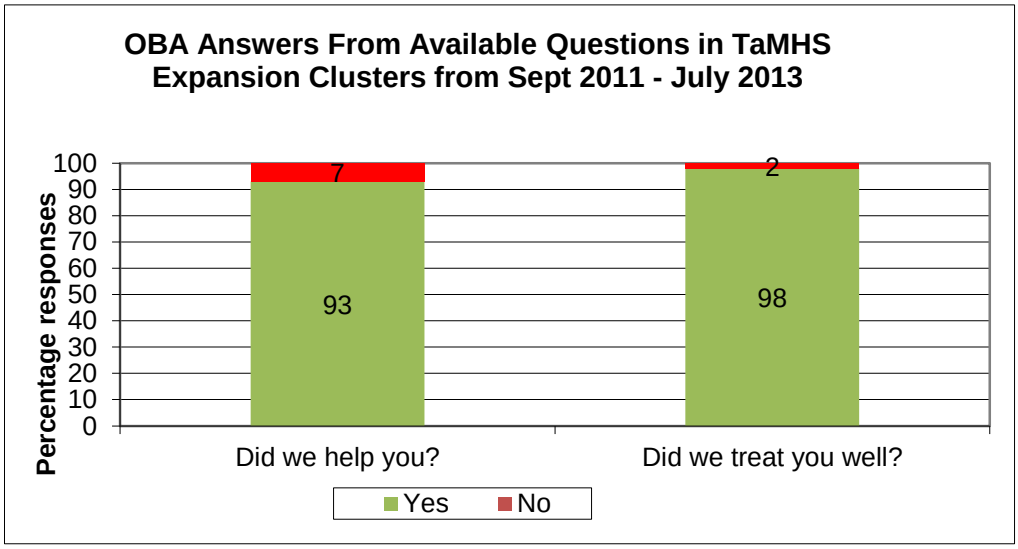
Emotional Literacy assessments were predominantly used, following training, by schools to identify need, plan targeted SEAL based group work and demonstrate progress. Data returns were low from schools[4]. No parent scores were returned and few pupil scores so only the teacher/ staff (most commonly used for planning and measuring progress) scores are included below.



The average increase of 10.4 points is a very large improvement demonstrating considerable impact using the assess/ plan / deliver/ measure outcomes approach.

[2] Strength and Difficulties Questionnaire. Widely used validated mental health assessment www.sdqinfo.com. Point scores are all for average pupil improvement with 3 different perceptions.
[3] Comparison average improvement in year two of the pilot was: Brigshaw & TNH: Pupil 5 points, Parent 2.5 Teacher 4.9; The Place2Be: 4.9, 3.6, and 2.7 respectively. These were seen as very good.
[4] As a result finance transfers will be dependent in part on data returns from schools in the new expansion.

- **Goals Based Outcomes** (Family Work)
  - 4.1 points average improvement on a 10 point scale.
- **OBA Questions**



This shows excellent positive user feedback. 93% and 98% respectively answered yes.

- **Case Study excerpts** (Further case studies from each cluster can be found in Appendix 1)

Aireborough
Issues: Highly anxious with low self-esteem and generally unhappy. Previous school based support not been effective. SDQ scores: Parent: High; Pupil: High. **Actions**: 9 sessions of 1:1 counselling including creative work to explore emotions, significant life events and family issues. **Outcomes:** Relaxed, confident, open and much more comfortable with self. SDQ scores: Parent: Normal; Pupil: Normal. Teacher comment: "really noticed a vast improvement in his self-confidence, ability to work independently and had a really positive parents evening meeting" Parent feedback: "he is so much better at coping now you have been a huge help to our family." Pupil feedback: "I need someone to just listen".

Bramley
Issues: Parent drug use; emotional abuse; stress/anxiety. SDQ scores: Teacher: High, Self: High. **Actions:** 1:1 Counselling 10 sessions. **Outcomes:** SDQ scores: Teacher: Borderline, Self: Normal. *"client feels he is now able to walk away from arguments"*

CHESS & Networks
Issues: Anxiety. SDQ scores: Parent: High; Teacher: High, Self: High **Actions:** 8 sessions of Person Centred Therapy **Outcomes:** SDQ scores: Parent: Borderline, Self: High (increased). Client found counselling useful & didn't want to end

Inner East
Issues: Anger and consequent behaviour at school and at home. SDQ scores: Teacher: High **Actions**: Counselling for 7 sessions to discuss bereavement, impact of behaviour, school issues, develop strategies **Outcomes:** Improvement in understanding of issues and subsequent behaviour. SDQ scores: Teacher: Normal. Attendance from 78% to 100%.

JESS
Issues: Loss SDQ scores: Parent: High **Actions:** Psychotherapy for 11 sessions **Outcomes:** SDQ scores: Parent: Normal. Attendance from 55% to 86.6%. "Now attends school everyday and has been removed off the list for fast track prosecution"
Issues: Behaviour **Actions:** Family Support-Working through Anger Management toolkit (There's a Volcano in My Tummy) for 42 weeks **Outcomes:** Parent commented that the

help and support has been excellent. The family are "happier" and have "learnt a great deal on how to support X when the difficult times arrive. Assessment from 1 (close to not at all meeting aims) to 5 (halfway to meeting needs)

NEXT
Issues: Family relations - parents separated. SDQ score: Self: Borderline. **Actions:** Play therapy/counselling 8 sessions **Outcomes:** *"It was good being able to talk to someone about feelings and things - very helpful, a good experience."* SDQ score: Self: Normal. Did we help? "*Yes*" Did we treat you well? *"Yes"*

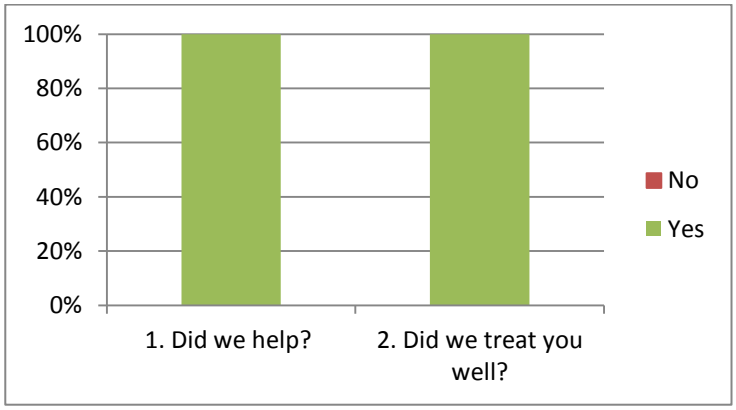
Open XS
Issues: Domestic violence; withdrawn; difficulties concentrating in class; nightmares; wetting the bed. SDQ scores: Teacher: High; Parent: High **Actions:** 12 sessions of Person Centred approach using art **Outcomes: H**elped to understand that client was not a bad person but had been injured by events in life; more aware that they had choices in life and more significantly the power to control and change certain thoughts and behaviours; nightmares and bed wetting reduced dramatically; SDQ scores: Teacher: Normal (Above average); Parent: High (reduced). Class teacher: "There has been a vast improvement in S's behaviour and attitude to learning in class. Thanks!"

Pudsey
Issues: Sexual assault; self harming; specialist CAMHS referral has been rejected; Looked After; anti depressant medication; not attending city centre counselling support due to anxiety of using public transport; fortnightly GP appointments; suicidal feelings; difficulties concentrating at school; SDQ score: Self: High. Low Mood assessment: clinical level of depression. Goals Based Outcomes: 3/10 **Actions:** 9 sessions**:** "My Plan" (safety plan) shared with GP, friends and family; exercise plan, progressive relaxation and mindfulness, include good friend in sessions, systemic therapy skills, to externalize anger. **Outcomes:** *"it's (confidence) like a big sphere glowing and growing inside of me, and out of me….I'm strong now….I'm happy again and feel more confident than I ever did before (the assault)".* SDQ score: Self: Normal. Goals Based Outcomes: 8/10. Improved concentration and motivation. No longer on medication. Long term support identified. No longer self harming. No longer feeling suicidal.

- **CAMHS referrals**
  - 100 % accepted

- **School Development**

User Consultation Feedback from TaMHS Strategic and Operational Leads. 4 questions were asked:



3. Main themes from "What was the best thing?"
   - Emotional Literacy Assessment and Targeted SEAL training "We also found the Emotional Literacy training really good and the resources provided have been useful."

- Action planning process “The meetings have been helpful as we have been able to share ideas and thoughts with colleagues from other settings. The Action Plan helped us to understand which areas we could improve further”
- The support on offer “you offer informative information and sound advice”
- ‘The results have been phenomenal and had made an enormous difference - a definite shift in cases which previously would have escalated to social care.’ - Head Teacher and Cluster Chair

4. Main themes from “How could we do better next time?”[5]
    - More resources “More TAMHS therapists/counsellors per cluster!” “Maybe more resources for working with groups. I find we never have enough”
    - Speedier and more detailed information “We needed more of an explanation as to what we were doing before being asked to co write the plan.”

Training feedback: average ratings of OBA Questions

- Did we help? Very Good (Average score of 5.1/6)
- Did we treat you well? Excellent (Average score of 5.5/6)

- **OFSTED Reports**

The new Ofsted framework (Sept 2012) no longer has the category “Care, Guidance and Support” that the pilot evaluation used to demonstrate progress. The current categories of *Behaviour and Safety* and *Spiritual, Moral, Social and Cultural* would not allow pre and post comparison. An examination of recent Ofsted inspections have not shown any reference to TaMHS support even where the TaMHS setup has been praised by Ofsted inspectors in conversation with a head teacher.

[5] As a result we are exploring engaging post graduate University students to support in school group work in the next expansion. We are also outlining the school development process earlier to schools as well as reviewing the process.

TaMHS Indicators Impact

The indicators from the CYPP for the TaMHS Project are:

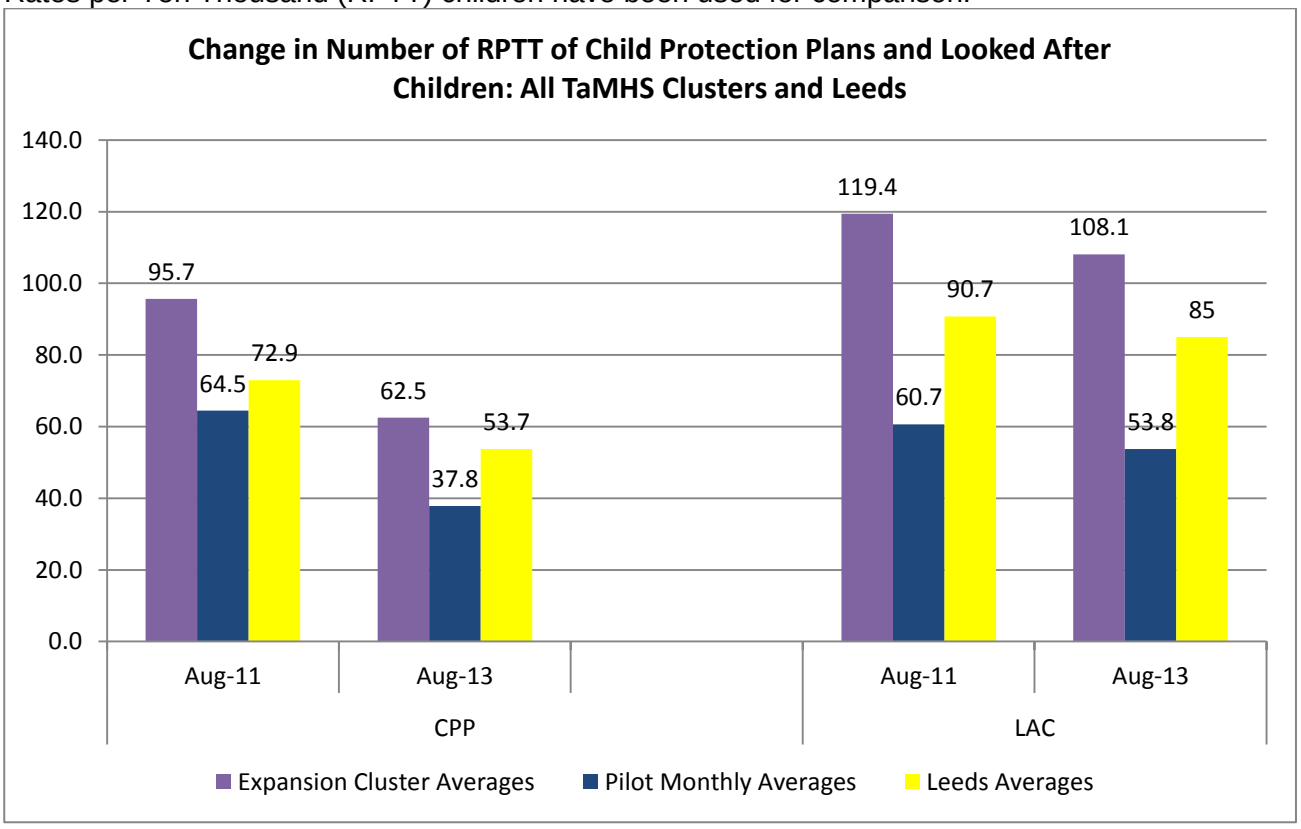
- Numbers of Looked After Children (LAC)
- Numbers of Child Protection Plans (CPP)
- Attendance

Cautions

- TaMHS works indirectly on these indicators alongside other targeted, cluster based support, hence the mental health focus of the performance measures. As TaMHS is early intervention few pupils who are on a CPP or who are Looked After are directly supported. It is the prevention of early mental health issues escalating into more enduring issues that TaMHS focuses on.
- TaMHS works in some of the most deprived clusters in the city which have very high rates of CPP, LAC and non attendance so figures may be skewed by the large numbers (These clusters were prioritised due to high level of need).
- TaMHS is a targeted project. Attendance is a universal measure. Hence attendance data pre and post TaMHS support is also included for a more direct measure of impact.

CPP & LAC Indicators

Rates per Ten Thousand (RPTT) children have been used for comparison.



CPP

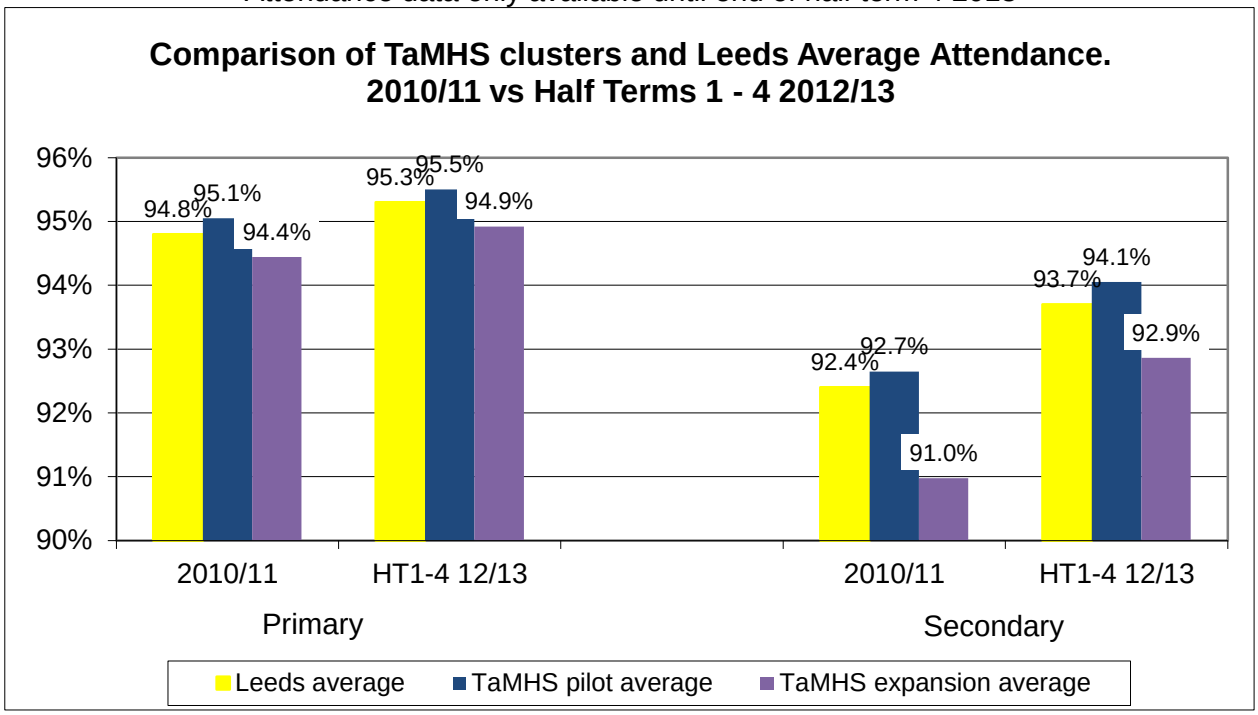
TaMHS Expansion clusters: gap narrowed with the Leeds average from 23. 2 to 8.8 RPTT
TaMHS pilot clusters: outperforms and narrows the gap with the Leeds average from -8.4 to -15.9 RPTT.

LAC

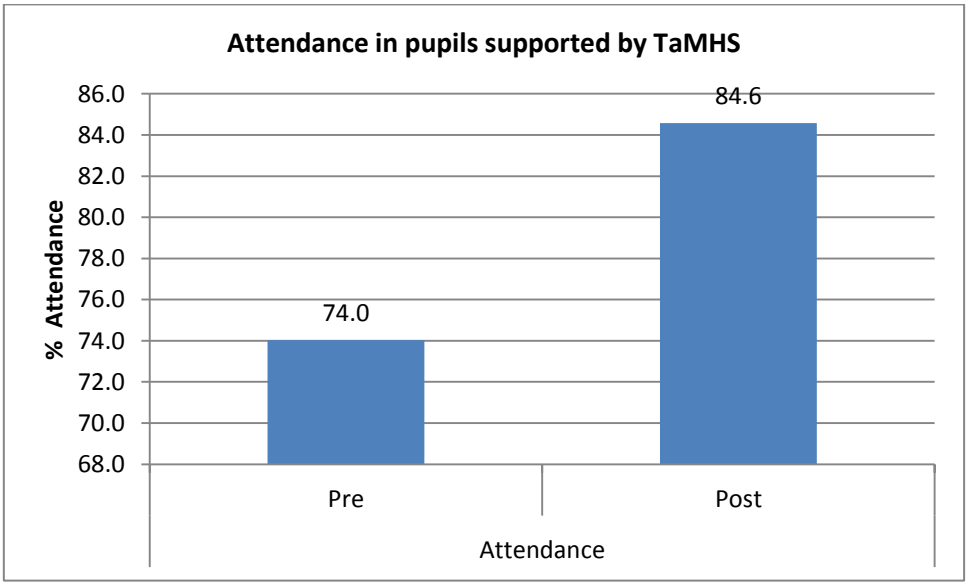
TaMHS Expansion clusters: gap narrowed with the Leeds average from 28.7 to 23.1 RPTT
TaMHS pilot clusters: outperforms and narrows the gap with the Leeds average with the gap from -30 to -31.2 RPTT.

Attendance:

Attendance data only available until end of half term 4 2013



Primary: TaMHS expansion (0.5% improvement) and Leeds average (0.5% improvement): gap stays the same. Both narrow the gap very slightly on TaMHS pilot (0.4% improvement) which outperforms both of them.
Secondary: TaMHS expansion clusters (1.9% improvement) narrows the gap on Leeds average (1.3%). TaMHS pilot clusters (1.4% improvement) outperforms the Leeds average with the gap slightly increasing from -0.3% to -0.4%.



Pupils directly support by TaMHS show much larger increases in attendance with an average increase of 10.6%. This is 8 times the Leeds average increase.

Appendix 1

Case Study excerpts

Aireborough

Issues: Self Harm. Previous sexual abuse. Parent SDQ score, normal, but below average, . Self SDQ score borderline. Previous counselling. **Actions:** Extended 1:1 counselling. Communication with home and school about self harm risks. **Outcomes:** Self harming stopped. Client understood issues were not her fault: "*Counselling has helped me a great deal and led me to a happier place"* Parent: "*thank you so much for all your help. M is definitely a much happier person these days"* Self SDQ score lower borderline, Parent SDQ score above average normal. Improvement in confidence and worry self rating.

Bramley

Issues: Domestic Violence, Behaviour. SDQ score: Teacher: Borderline **Actions:** 12 Sessions 1:1 counselling. Extending sessions due to bereavement in family **Outcomes:** Teacher SDQ score: Normal. Client says found it useful to focus on the effects of anger on their body/thinking/behaviour.

CHESS & Networks

Issues: Anger outbursts; behaviour issues; self harm and suicidal comments; poor relationships between parent and child; child protection concerns SDQ score: Teacher: Very High Parent: Very High **Actions: O**ne-to-one support; Family Support Worker support to parent: exploration of family issues; 1:1 'Triple P' parent support; anger management and relaxation strategies; signposting the family to extra-curricular activities for the children to access in the local community **Outcomes:** Parent: "big improvements" "the best two days ever" "very, very helpful" "the support received was the support I had wanted and wish it had happened sooner." SDQ score: Teacher: Borderline Parent: High

Inner East

Issues: Anxiety issues **Actions:** Consultation Clinic with family and young person to assess current situation; Liaison with referrer and G.P; Referral made for young person to access counselling support. Joint work with mum and young person around graded exposure strategies in the home; Co-facilitated Escape parenting course; adult counselling for parent: **Outcomes:** Assessment scores show reduction from 'high' to 'borderline'

JESS

Issues: Behaviour **Actions:** Psychotherapy for 8 sessions **Outcomes:** Assessment remains 'high'; Attendance from 87.8% to 88.1% "Successful referral into CAMHS - assessed by Complex Assessment Team."
Issues: Anxiety (parent) Return to Work **Actions:** Family Support/Practical Support- Signposting. Case co-shared with Cluster Therapist. **Outcomes:** Mum-successfully attended Training Course-now in employment. Attends therapy. Assessment shows average improvement to meeting goals.

NEXT

Issues: Anxiety **Actions:** Consultation with school staff. **Outcomes:** Referral to specialist CAMHS

Open XS

Issues: Anxiety. SDQ scores: Teacher: Borderline Parent: Normal (below average) **Actions:** 8 sessions Integrative Therapy **Outcomes:** SDQ scores: Teacher: Normal **(**above average) Parent: Normal (above average) Did we help? *"Yes"* Did we treat you well? *"Yes"* Pupil wrote "you have really helped me very much. I understand my feelings better and can say how I feel". School staff said that pupil's behaviour has improved dramatically.

Pudsey

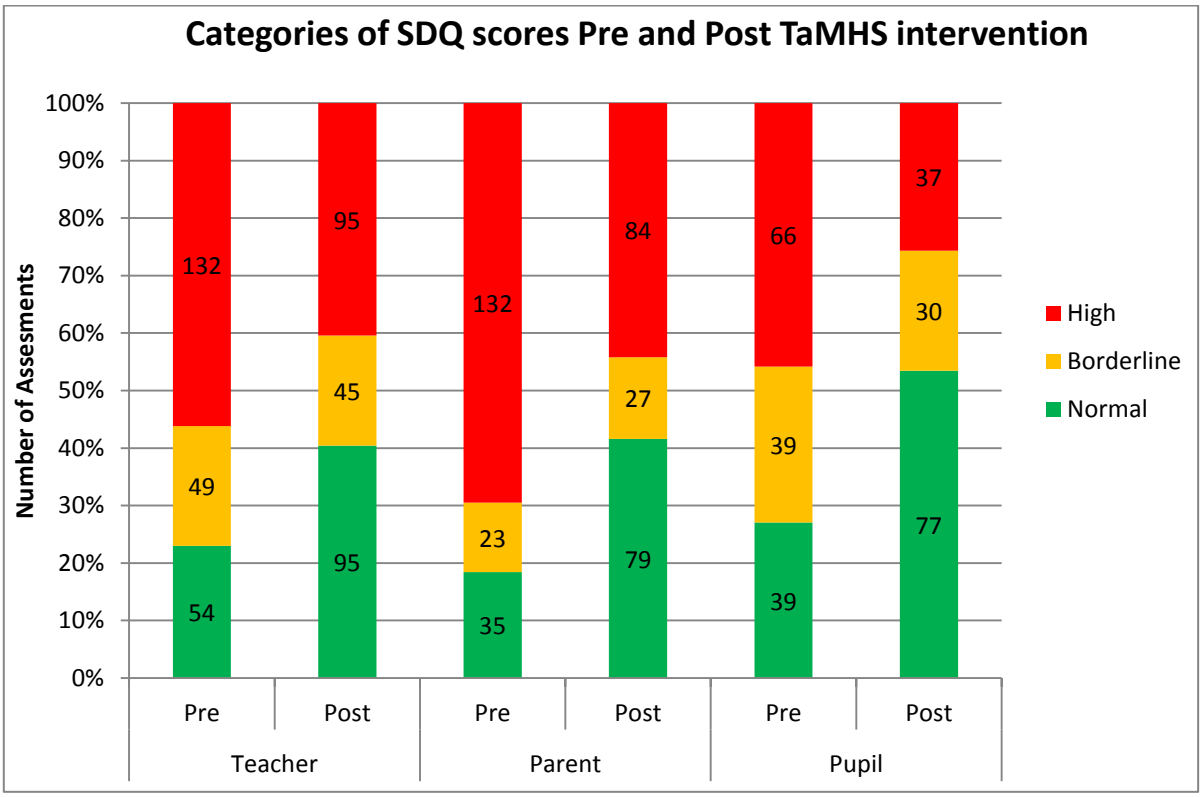
Issues: Anger outbursts; tearful; poor sleep and eating routines; concerning physical appearance; previous Family Outreach Worker input; parental severe depression multiple attempted suicide; existing CAF **Actions:** 11 sessions: focus on friendships, self esteem and confidence; Goals Based outcomes; contract on self care; relaxation skills; anger management techniques; encouraging positive thoughts and self talk (CBT); sign posted to Willow young carers groups

Outcomes: Some improvement in mood but on-going issues. Continued individual support at Willows; support strategies for school staff; referral for parent to Children in Leeds panel for more intensive support in order to resolve family circumstances.

Appendix 2
TaMHS Expansion #1 SDQ Category Analysis

Completed to help demonstrate the range of need coming into TaMHS and the outcomes we can expect in terms of reducing high and borderline categories of need according to SDQ assessments. Overall it shows that:

1. *The majority of Teacher and Parent pre assessments were in the High category (one indicator of 'clinical' level of need and CAMHS referral)*
2. *Most pre scores from all perceptions were in the High category. 'Normal' scores still feature in TaMHS referrals. This and High scores demonstrate that assessment scores alone cannot identify relevant referrals. The multi professional discussion is essential.*
3. *The High category was reduced and the normal category increased from all perceptions in post support scores.*
4. *A high majority of pupils attending TaMHS support showed an improvement. 'Self' scores showed lowest improvement. A widely held view is that the pre scores can be less accurate but post scores are more accurate due to increased self awareness and relationship building. This impacts on the positive change recorded. This is also reported in emotional literacy pupil scores so can be identified as a real trend.*
5. *Of Teacher High pre scores just under half improved a category or more. Of borderline scores over half improved to normal, a small number worsened.*
6. *Of Parent High pre scores just under half improved a category or more. Of borderline scores 2/3 improved to normal*
7. *Of Self High pre scores, half improved a category or more. Of borderline scores over half improved to normal, a small number worsened.*



Teacher scores

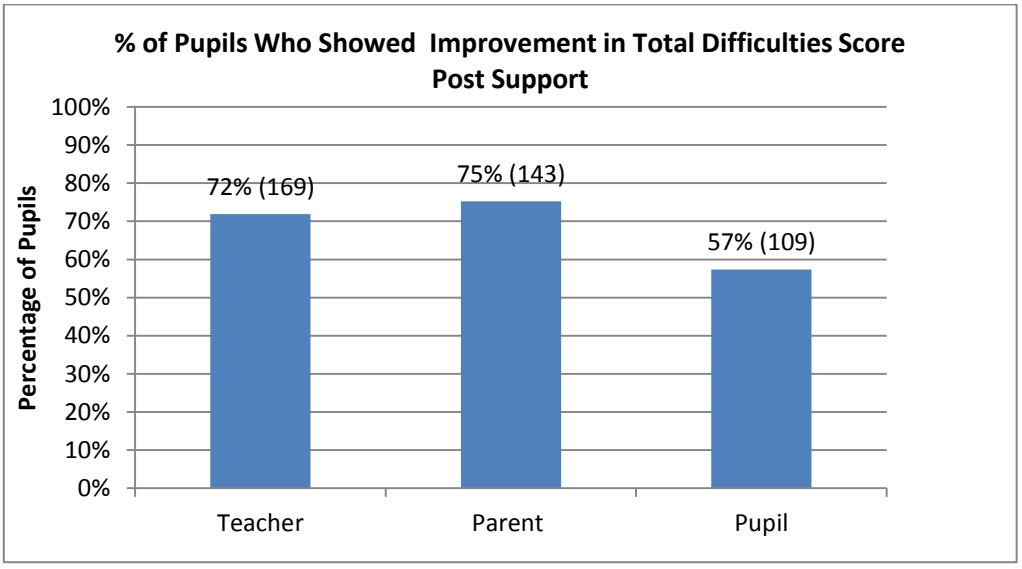
56% were in the **high** category pre intervention	**21%** were in the **borderline** category pre intervention	**23 %** were in the **normal** category pre intervention
Post intervention: **9%** moved to **normal** **12%** moved to **borderline** **35%** stayed **high**	**Post intervention:** **13%** moved to **normal** **5%** stayed **borderline** **3%** moved to **high**	**Post intervention:** **19 %** stayed **normal** **2 %** moved to **borderline** **3 %** moved to **high**

Parent scores

69 % were in the **high** category pre intervention	**12 %** were in the **borderline** category pre intervention	**18 %** were in the **normal** category pre intervention
Post intervention: **16%** moved to **normal** **10%** moved to **borderline** **43%** stayed **high**	**Post intervention:** **9%** moved to **normal** **3%** stayed **borderline** **0%** moved to **high**	**Post intervention:** **16%** stayed **normal** **1%** moved to **borderline** **1%** moved to **high**

Pupil Scores (Age 11+ only)

46 % were in the **high** category pre intervention	**27 %** were in the **borderline** category pre intervention	**27 %** were in the **normal** category pre intervention
Post intervention: **10%** moved to **normal** **13%** moved to **borderline** **23%** stayed **high**	**Post intervention:** **17%** moved to **normal** **7%** stayed **borderline** **3%** moved to **high**	**Post intervention:** **26%** stayed **normal** **1%** moved to **borderline** **0%** moved to **high**



Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 16 December 2014

Subject: Work Schedule – December 2014

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to consider the progress and ongoing development of the Scrutiny Board's work schedule for the current municipal year.

2 Main issues

2.1 Further to the discussions held at the beginning of the current municipal year, work has progressed to include some of the areas identified by the Scrutiny Board into a structured work schedule for the remainder of the municipal year. An outline of the areas to be covered in forthcoming meetings area as follows:

<u>December 2014</u>

- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (second session)

<u>January 2015</u>

- Leeds Mental Health Framework & draft action plans
- Maternity Services Strategy for Leeds
- LYPFT – Care Quality Commission (CQC) Inspection outcome
- LTHT – Progress against CQC inspection outcomes/ recommendations
- Primary Care provision in Leeds (NHS England: West Yorkshire Area Team) – second session

February 2015

- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (third session)
- Review of Homecare – final report & recommendations for Executive Board
- LYPFT – Care Quality Commission (CQC) Inspection action plan
- LCH – Care Quality Commission (CQC) Inspection outcome

March 2015

- Primary Care provision in Leeds (NHS England: West Yorkshire Area Team) – third session
- LCH – Care Quality Commission (CQC) Inspection action plan

April 2015

- Child and Adolescent Mental Health Services (CAMHS) – commissioning and provision in Leeds (final report)
- LTHT – Progress against CQC inspection outcomes/ recommendations
- LYPFT – Progress against CQC inspection outcomes/ recommendations
- LCH – Care Quality Commission (CQC) Inspection outcome

2.2 The details outlined above should be considered as an indicative rather than definitive work programme. A number of areas (in particular work associated with CQC inspections) are dependent on the outcome of work from third parties and may therefore be subject to change. It is also important to retain sufficient flexibility in the Board's work programme in order to react to any specific matters that may arise during the course of the year.

2.3 The Scrutiny Board has also considered Requests for Scrutiny elsewhere on the agenda. The outcome of these discussions needs to be reflected in the future work schedule of the Scrutiny Board.

Working Groups

2.4 The Scrutiny Board has established two working groups, one focusing on Adult Social Care matters, while the other working group considers proposed changes and development of local health services.

2.5 It is planned that both working groups will meet again in early 2015.

Minutes from Executive Board and the Health and Wellbeing Board

2.6 There are no minutes from the Council's Executive Board and Leeds' Health and Wellbeing Board to be considered at this meeting.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and its appendices.
b) Identify any specific matters to be incorporated into the work schedule for the remainder of the current municipal year.

c) Prioritise any competing demands and agree the future work schedule for the Scrutiny Board.

4. Background papers[1]

4.1 None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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