

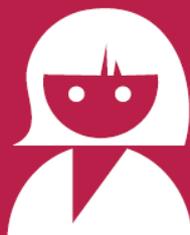
Inpatient Provision for Children and Young People with Mental Health Problems

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EDUCATION
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Research area:
Children and
Young People's
Mental Health



About the author

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Acknowledgements

Natalie Perera, Executive Director and Head of Research at the Education Policy Institute. Natalie worked in the Department for Education from 2002 to 2014 where she led on a number of reforms, including childcare and early years provision and the design of a new national funding formula for schools. Between 2014 and 2015, Natalie worked in the Deputy Prime Minister's Office. Natalie is the principal author of the EPI's Annual Report and of 'The implications of the National Funding Formula for schools'.

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About the Education Policy Institute

The Education Policy Institute is an independent, impartial and evidence-based research institute that aims to promote high quality education outcomes, regardless of social background.

Education can have a transformational effect on the lives of young people. Through our research, we provide insights, commentary and critiques about education policy in England - shedding light on what is working and where further progress needs to be made. Our research and analysis will span a young person's journey from the early years through to higher education and entry to the labour market. Because good mental health is vital to learning, we also have a dedicated mental health team which will consider the challenges, interventions and opportunities for supporting young people's wellbeing.

Our core research areas include:

- Accountability and Inspection
- Benchmarking English Education
- Curriculum and Qualifications
- Disadvantaged, SEND, and Vulnerable Children
- Early Years Development
- School Funding
- School Performance and Leadership
- Teacher Supply and Quality
- Children and Young People's Mental Health
- Education for Offenders

Our experienced and dedicated team works closely with academics, think tanks, and other research foundations and charities to shape the policy agenda.

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Foreword

It is hard to think of a much more traumatic experience for a child or a parent than admission to inpatient mental health care. While such intensive treatment is rarely necessary, it is important for those who do need admission that the capacity and quality of the system is of a high standard.

The Education Policy Institute has explored what is currently known about the child and adolescent mental health inpatient service, using existing research and available data to establish a picture of current levels of provision.

We have identified where recent improvements have been made, for instance the reduction of the use of police cells for young people in mental health crisis. We have also highlighted where there is more to be done, such as ensuring there is consistent provision of intensive community support across the country and tackling workforce shortages.

This report is intended to bring further clarity to the policy debate around hospital admission for children and young people with mental health problems, providing evidence to enable appropriate scrutiny of the system. In the past, we have known too little about the outcomes and standards in our mental health service. This is now slowly improving and the Education Policy Institute will play a part in improving this understanding and evidence base.

Rt. Hon David Laws
Executive Chairman
Education Policy Institute

Executive summary

Introduction

Over the past year, the Education Policy Institute has been exploring children and young people's mental health care in England. We have highlighted some of the challenges facing the system, such as a rise in demand for services and the 'treatment gap' whereby services, on average, turn away 23 per cent of children and young people referred to them for treatment.¹

One aspect which has received less attention in recent years is inpatient care. Also known as 'Tier Four' services, these are facilities for children and young people with mental health problems who require hospital admission. These can be separate facilities or part of a larger facility that includes units for adults or outpatient services. The Education Policy Institute has analysed the literature and available data to establish what is currently known about the state of inpatient mental health services for children and young people. Information in this report is derived from national datasets including the NHS Digital monthly Mental Health statistics and the NHS England *Five Year Forward View for Mental Health* Dashboard. We have also included data provided by NHS England on request, and information from the existing literature.

Children in inpatient care

There were 2,434 admissions of children and young people aged 18 or under with mental health conditions into hospital between October and December 2016. This has fallen in each quarter since data was first collected, in the period April - June 2016, when there were 4,399 admissions.² The most common reason for admission is an eating disorder.³

Capacity of inpatient services

There were 1,440 child and adolescent mental health service (CAMHS) inpatient beds in the NHS in England in December 2015, a 71 per cent increase since 1999.⁴ Nearly half (approximately 47 per cent) of inpatient beds are run by independent providers, compared to only a quarter (25 per cent) in 1999.⁵

As this report highlights, the question of whether there are enough beds is not simply a matter of overall capacity but also the distribution of beds by geographical region and speciality. On average, there are 2.5 beds per 100,000 total population in England. The North East has the greatest level of

¹ Children and Young People's Mental Health: The State of the Nation, Education Policy Institute (then known as Centre Forum), April 2016: <https://epi.org.uk/report/children-young-peoples-mental-health-state-nation/>

² Mental Health Five Year Forward View Dashboard, NHS England, Quarter 3 (October to December 2016) published May 2017: <https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/>

³ Hospital Admitted Patient Care Activity, 2015-16, NHS Digital, November 09, 2016, Primary Diagnosis 3 character: <http://content.digital.nhs.uk/article/2021/Website-Search?productid=23488&q=title%3a%22Hospital+Episode+Statistics%2c+Admitted+patient+care+-+England%22+or+title%3a%22Hospital+Admitted+Patient+Care+Activity%22&sort=Relevance&size=10&page=1&area=both#top>

⁴ There were an estimated 844 beds in 1999, 1128 in 2006, and 1264 in 2014 and 1440 in December 2015. Data based on periodic service reviews taken from House of Commons Debate, 3 December 2015 : Column 607: <https://hansard.digiminst.com/Commons/2015-12-03/debates/15120362000002/MentalHealthOut-Of-AreaPlacements> and from Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf> Due to spot purchasing arrangements this number is likely to fluctuate marginally.

⁵ Total population including adults. Sources: House of Commons Debate, 9 December 2015, cW, and Provision of child and adolescent mental health in-patient services in England between 1999 and 2006. O'Herlihy A et al, 2007 <https://www.rcpsych.ac.uk/pdf/A%204.2%20OHerlihy%20et%20al%202007%20camhs%20beds.pdf>

provision with 3.03 beds per 100,000 population, compared with 1.1 in the South West.⁶ The Royal College of Psychiatrists has proposed a proxy measure of appropriate bed numbers as between 2 and 4 beds per 100,000 population.⁷ The average ratio for England (2.5) is at the low end of this scale and two areas (Yorkshire and Humber and the South West) are below this ratio.

Problems with accessing beds

This geographical disparity has led to system capacity problems in the past year. In the last financial year, there were three occasions when no beds were available at all in at least one region of England:⁸

- 07/04/2016 South Region⁹ had no CAMHS beds available
- 28/04/2016 South Region had no CAMHS beds available
- 01/06/2016 London Region had no CAMHS beds available

Adult wards

One consequence of these pressures is that young people are sometimes admitted to adult mental health wards, even though providers have a duty to prevent this under the Mental Health Act 2007. Between October and December 2016 there were 83 under 18s treated on adult wards, and they spent a total of 2,700 days in adult hospitals.¹⁰ Experimental NHS data shows that, in 2016, children under 16 spent a total of 1,657 days on adult wards.¹¹

Community Care and delayed discharges

There is some evidence that, for many conditions, intensive community treatment is as effective, if not more effective, than hospital admission. It is government policy to increase access to such intensive support within the community,¹² and yet 64 per cent of inpatient care providers who responded to the 2014 NHS England Tier 4 Review reported that they did not have an intensive outreach team.¹³

Often young people who are ready to leave hospital are not discharged because the right mental health or social care support package is not available in the community, or because they cannot be transferred to a more appropriate hospital setting because that hospital is full.

Between October 2015 and February 2017, there were nearly 9000 wasted days in NHS children's mental health hospitals where the child or young person was waiting to leave but they could not be

⁶ Data provided in House of Commons Written Answer, 9 February 2016

⁷ Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf> citing evidence from the Care Services Improvement Partnership 2007 and Cotgrove et al, Royal College of Psychiatrists, 2004.

⁸ Data provided in March 2017 in response to an Education Policy Institute information request

⁹ NHS England South Region covers the South East, South Central and South West regions

¹⁰ Mental Health Five Year Forward View Dashboard Q3 2016/17, published May 2017, NHS England: <https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/>

¹¹ Mental Health Services Monthly Statistics, NHS Digital. Most recent report for March 2017 published 20 June 2017: <http://www.digital.nhs.uk/catalogue/PUB30000>

¹² Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing, NHS England and Department of Health, 2015:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

¹³ Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

discharged. These figures are on the increase: the number of delayed days in the period December 2016 – February 2017 was 42 per cent higher than the same period the previous year.¹⁴

Quality of care

The Education Policy Institute has also explored the quality of care offered in inpatient mental health services for children and young people. Quality standards are grouped into Type 1, 2 and 3. Failure to meet Type 1 standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law. On average, 93 per cent of Type 1 standards were met, the same percentage as the previous year. This indicates substantial room for improvement, as on average services failed to meet 7 per cent of these standards.¹⁵

Workforce

Workforce shortages are a particular problem in inpatient services. One in 9 units (12 per cent) did not meet the minimum standard for staff to patient ratios.¹⁶

Nearly a quarter of units (24 per cent) did not meet a workforce standard that: *“the unit is staffed by permanent staff, and unfamiliar bank and agency staff are used only in exceptional circumstances”*.¹⁷ Performance has deteriorated since 2014-15, when 17 per cent of services did not meet the standard. Moreover, 19 per cent of CAMHS inpatient pay costs are Bank and Agency staff, which indicates that recruitment of permanent staff provides an ongoing challenge to providers seeking to improve the quality of care.¹⁸

Conclusion

The Government has recognised the need to provide more inpatient capacity in England, and to revise the geographical distribution of beds. This is an appropriate response to the current geographical disparity highlighted in this report. It is important, however, that there is now a sustained focus on the management of the inpatient estate across the country to make the best use of existing capacity and to monitor whether and where capacity should be increased.

The Government and NHS England should also set consistent standards across the country for the availability of intensive support within the community to help prevent the need for hospital admission. Information on access to such services should be collected and monitored centrally.

One of the most significant challenges to quality improvement and increased capacity will be the recruitment of permanent staff. The forthcoming mental health workforce strategy will need to address the significant shortfalls in staffing numbers if promised growth in service capacity is to be achieved.

¹⁴ Data provided by NHS England to the Education Policy Institute in March 2017

¹⁵ Quality Network for Inpatient CAMHS Annual Report (QNIC) Cycle 15: Editors: Hannah Craig, Jasmine Halvey and Thomas Johnstone, Royal College of Psychiatrists, 2016: <https://www.rcpsych.ac.uk/pdf/QNIC%20Final%20report%202016.pdf>

¹⁶ Quality Network for Inpatient CAMHS Annual Report (QNIC) Cycle 15: Editors: Hannah Craig, Jasmine Halvey and Thomas Johnstone, Royal College of Psychiatrists, 2016: <https://www.rcpsych.ac.uk/pdf/QNIC%20Final%20report%202016.pdf>

¹⁷ This is measured by whether the unit employs over 15 per cent of staff as agency staff during the week or if more than one member of staff on a shift are from an agency.

¹⁸ NHS Benchmarking CAMHS report 2016: <https://www.nhsbenchmarking.nhs.uk/news/camhs-benchmarking-2016-findings-published>

Part 1: Young people in inpatient care

A young person with a mental health problem is likely to be admitted into hospital if their disorder means that they are at high risk of serious self-harm or aggression and this cannot be managed closer to home. Admission is also considered if the child or young person needs more intensive treatment than can be provided in a community setting, or if they need a 24-hour assessment by a team within the hospital.

Data on the numbers of young people in inpatient care is published annually, monthly and quarterly in different formats. These datasets were established in 2016¹⁹ and are still classified as 'experimental statistics'. Nevertheless, they provide an insight into the current numbers of young people in hospital because of mental health problems.

In the year from April 2016 to March 2017, there were 4,512 people aged 18 or under in contact with mental health services who had had a spell in hospital.²⁰ During the month of March 2017, there were 1,164 young people aged 18 or under in hospital because of a mental health condition.²¹

The quarterly data provides the best comparison over time. In October to December 2016, there were 2,434 admissions of under 18s into hospital with mental health conditions, and these young people spent a total of 102,567 days in hospital during this period.²² As shown in Figure 1.1, the number of young people in hospital has dropped between Quarter One (the first quarterly data collection) and Quarter Three. Figure 1.2, however, demonstrates that the total number of 'bed-days' increased in Quarter Three. As we only have data for one year, it is not possible to speculate on the reason for this difference, which may be due to seasonal fluctuation.

Figure 1.1: Total number of admissions of under 18s into CAMHS inpatient services

¹⁹ A national minimum dataset with monthly figures was established from January 2016. NHS England published a Quarterly Dashboard for the Five Year Forward View, which was first published in October 2016 and collected figures from April – June 2016.

²⁰ Mental Health Services Monthly Statistics: Final March 2017, Experimental, NHS Digital, June 20, 2017: <http://www.digital.nhs.uk/catalogue/PUB30000>

²¹ People aged 0-18 with an open hospital provider spell at the end of the Reporting Period, Mental Health Services Monthly Statistics: Final March 2017, published June 20, 2017, NHS Digital: <http://www.digital.nhs.uk/catalogue/PUB30000>

²² Mental Health Five Year Forward View Dashboard, NHS England, Quarter 3 (October to December 2016) published May 2017: <https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/>

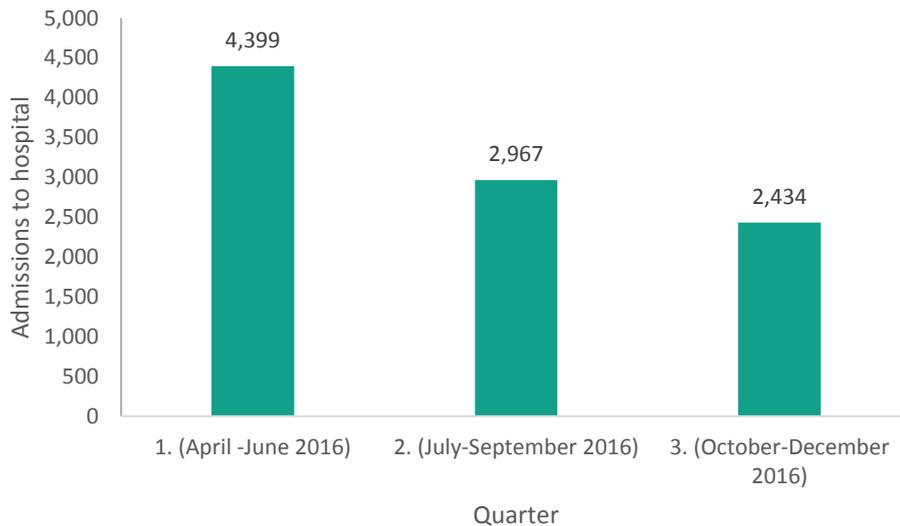
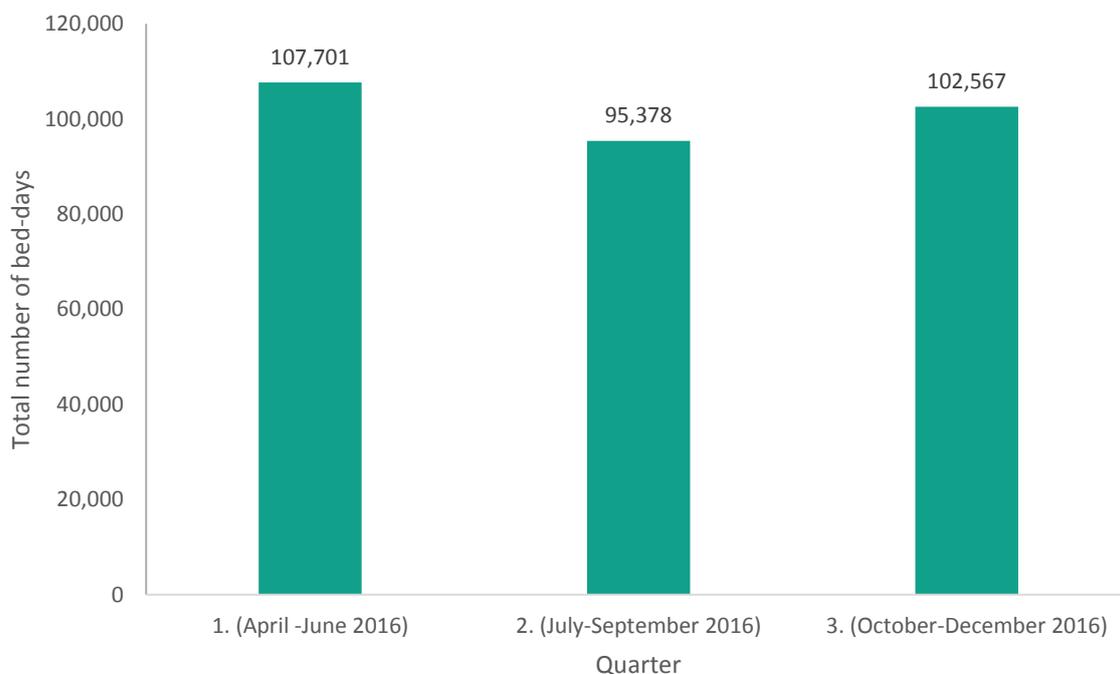


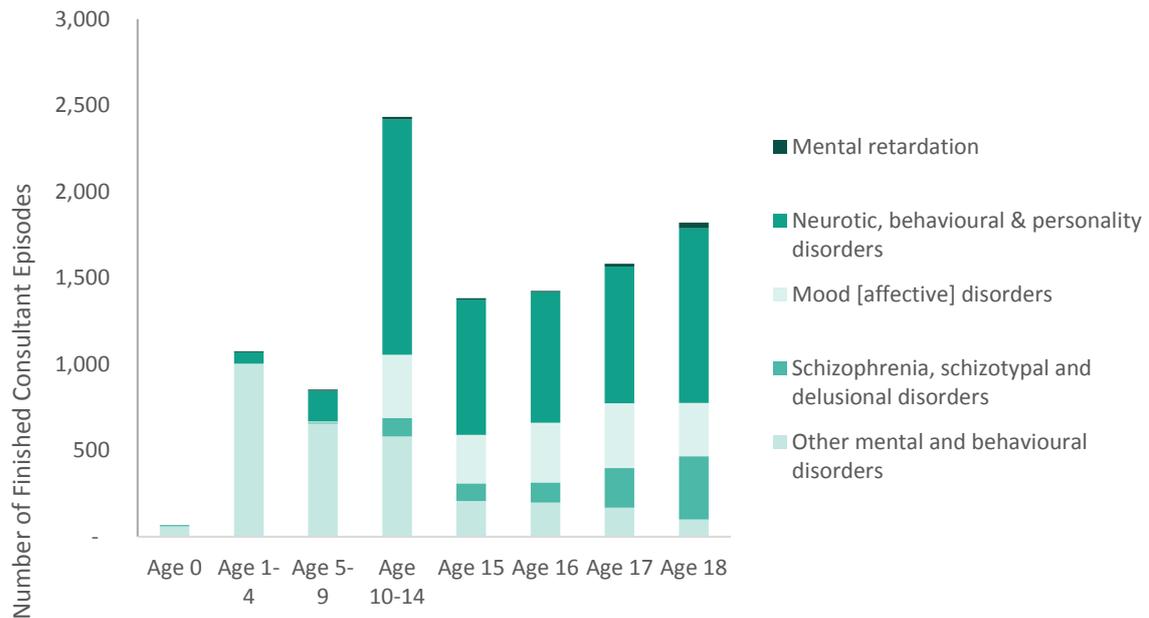
Figure 1.2: Total number of bed-days for under 18s in CAMHS inpatient wards



Hospital Episode Statistics are collected on all hospital admissions in England, including mental health. These provide a breakdown of the ages and conditions of young people admitted to hospital with a primary mental health diagnosis.²³

Figure 1.3: Finished Consultant Episodes for under 18s in hospital with a primary mental health diagnosis in 2015-16

²³ Hospital Admitted Patient Care Activity, 2015-16, NHS Digital, November 09, 2016: <http://content.digital.nhs.uk/article/2021/Website-Search?productid=23488&q=title%3a%22Hospital+Episode+Statistics%2c+Admitted+patient+care+-+England%22+or+title%3a%22Hospital+Admitted+Patient+Care+Activity%22&sort=Relevance&size=10&page=1&area=both#top>



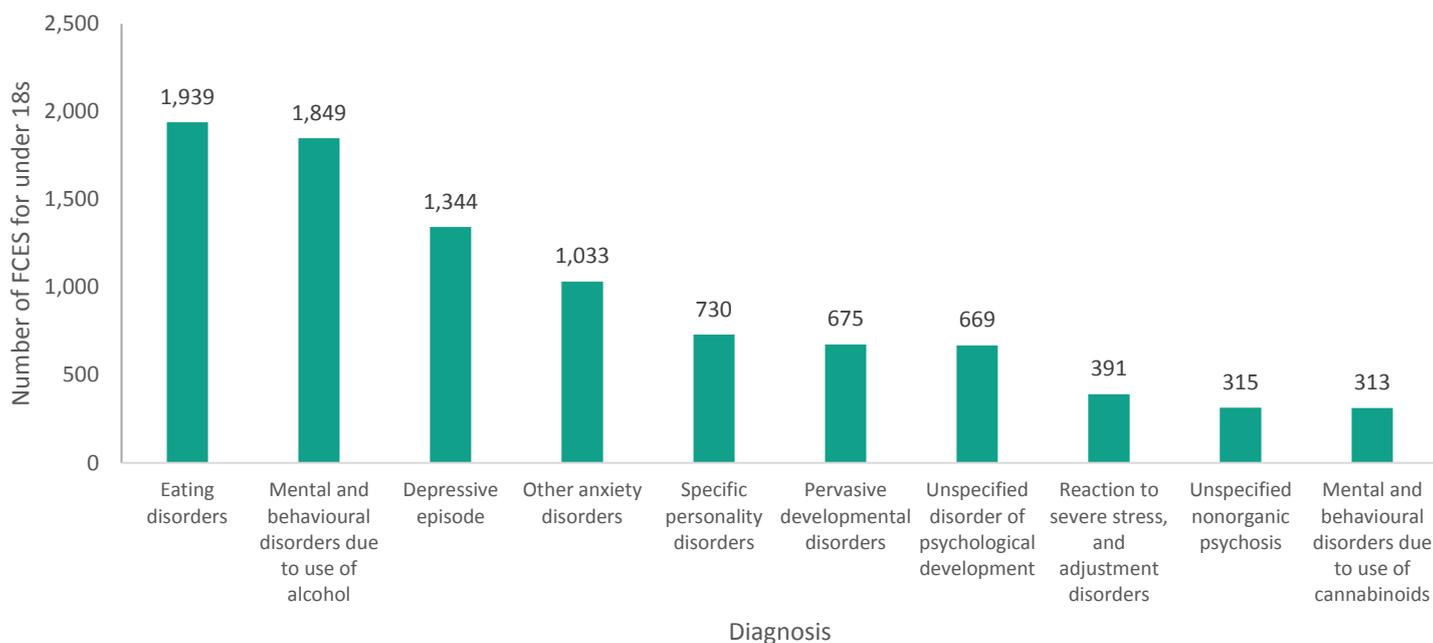
Note: A Finished Consultant Episode is the NHS term for a period of care for a patient under a single consultant at a single hospital. It is not an individual count of the number of patients, but the total number of hospital 'episodes'. These diagnostic categories are the terms used by NHS Digital in their statistics. They are broken down into a wide range of further diagnostic categories (see Figure 1.4). For example, those aged 1-4 may be admitted for eating disorders, conduct disorders, speech and language difficulties or other developmental disorders.

The majority (58.4 per cent) of those in inpatient care are aged between 15 and 18. The data for those aged under 14 is grouped into categories so it is not possible to compare admissions for those aged 14 with those aged 15 but it appears that the numbers in inpatient care rise with each year of age.

The most common category listed as a reason for admission was 'neurotic, behavioural and personality disorders', representing 64.6 per cent of all admissions. The more detailed breakdown of the diagnoses of children in inpatient care in Figure 1.4 below shows that young people are in hospital for a wide range of diagnoses.²⁴

Figure 1.4: The ten most frequent primary diagnoses for under 18s in hospital

²⁴ Hospital Admitted Patient Care Activity, 2015-16, NHS Digital, November 09, 2016, Primary Diagnosis 3 character: <http://content.digital.nhs.uk/article/2021/Website-Search?productid=23488&q=title%3a%22Hospital+Episode+Statistics%2c+Admitted+patient+care+-+England%22+or+title%3a%22Hospital+Admitted+Patient+Care+Activity%22&sort=Relevance&size=10&page=1&area=both#top>



Note: FCEs are Finished Consultant Episodes (see note for Figure 1.3). This is the diagnostic breakdown in Hospital Episode Statistics 3 character code and description.

Figure 1.4 includes the top ten most common diagnoses for child and adolescent mental health inpatient care, representing 69.2 per cent of the total. As the figure shows, the most common reason for admission is an eating disorder. Other frequent diagnoses include disorders relating to drug or alcohol use, depression, anxiety or psychosis.

There is very little consistent data collected about the demographics of children and young people in inpatient care. Much of what we know comes from periodic reviews of the services. For example, according to a study conducted in 2008, most inpatients were girls (66 per cent). Almost one in five young people in hospital (19 per cent) were from a BAME background.²⁵

While some people spend only a few days in hospital, others can have much longer stays. According to a 2014 NHS England review of inpatient services, known as the 'CAMHS Tier 4 Review', the average length of stay across all units was 116 days in 2013. This varied from around 60 days in general adolescent units to around 275 days in medium secure units.²⁶ According to the NHS Benchmarking CAMHS Benchmarking report 2016, length of stay has increased in the last year, although the precise data has not been made public.²⁷

25 The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study, Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO), Tulloch et al, May 2008:

<http://www.rcpsych.ac.uk/pdf/COSI%20CAPS.pdf>

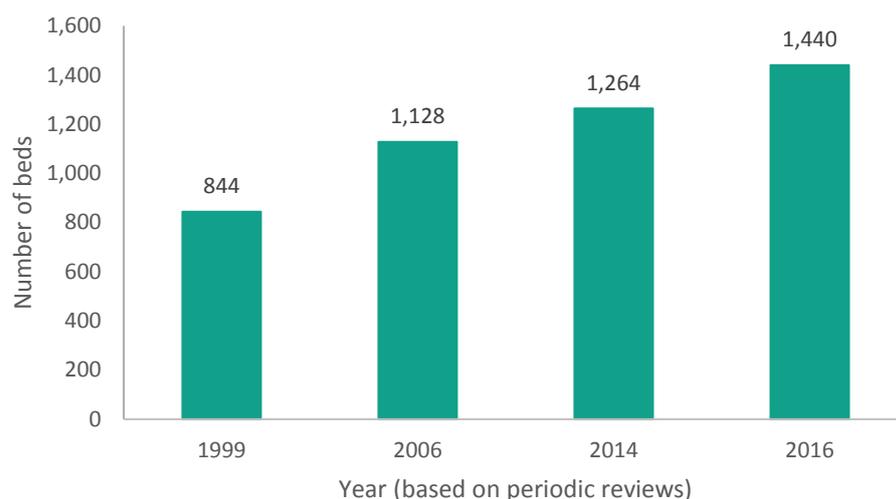
26 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

27 CAMHS Benchmarking report 2016, NHS Benchmarking: <http://www.nhsbenchmarking.nhs.uk/news/view-article.php?id=205>

Part 2: Capacity in Child and Adolescent Inpatient Mental Health Services

There are around 1,440 child and adolescent inpatient beds in the NHS in England. As shown in Figure 2.1, this has risen substantially since 1999.²⁸

Figure 2.1: Estimated total number of child and adolescent inpatient mental health beds in England



Nearly half (approximately 47 per cent) of inpatient services are provided by independent providers, according to data from 2014-15.²⁹ This had increased from 36 per cent in 2006, and 25 per cent in 1999.³⁰ While little is known about the difference in quality between public and independent sector providers, the increase in private sector beds has historically been associated with inadequate planning, where local commissioners purchase beds in private sector units when needed rather than as part of a planned system. This could mean that “*no single commissioner [was] responsible for the overall quality and safety of services in a unit*”.³¹ Research into independent sector provision of inpatient services for people with a learning disability found that patients detained within the independent sector were 30% more likely to experience an assault and 60% more likely to be restrained than inpatients in NHS Units³².

Figure 2.2: Percentage of child and adolescent mental health beds provided by the independent sector

²⁸ There were an estimated 844 beds in 1999, 1128 in 2006, and 1264 in 2014 and 1440 in December 2015. Data based on periodic service reviews taken from House of Commons Debate, 3 December 2015 : Column 607:

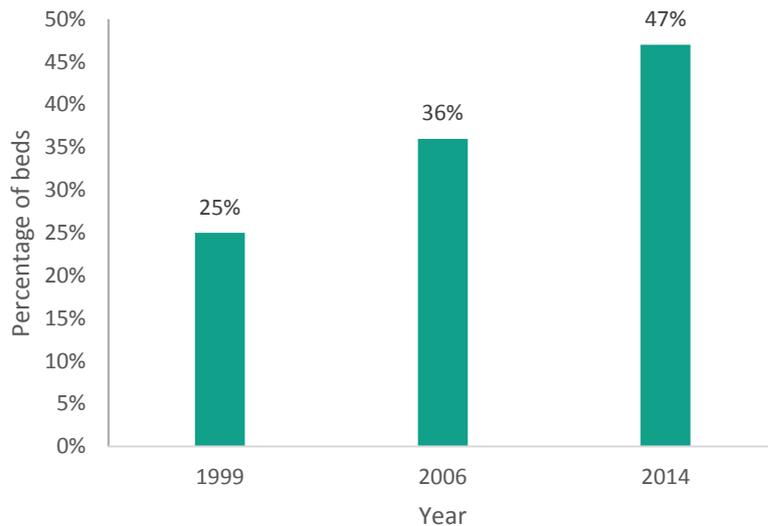
<https://hansard.digiminstor.com/Commons/2015-12-03/debates/15120362000002/MentalHealthOut-Of-AreaPlacements> and from Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf> Due to spot purchasing arrangements this number is likely to fluctuate marginally.

²⁹ Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

³⁰ Provision of child and adolescent mental health in-patient services in England between 1999 and 2006. O'Herlihy A et al, 2007 <https://www.rcpsych.ac.uk/pdf/A%204.2%20OHerlihy%20et%20al%202007%20camhs%20beds.pdf>

³¹ Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

³² The 2012 Institute of Health and Lives report, Assessment and Treatment Units and Other Specialist Inpatient Care for People with Learning Disabilities in the CountMe-In surveys, 2006 to 2010, (Glover & Olson 2012), cited in A Trade in People: The inpatient healthcare economy for people with learning disabilities and/or Autism Spectrum Disorder, Mark Brown, Elaine James and Chris Hatton, Lancaster University, 2017: <http://wp.lancs.ac.uk/cedr/files/2017/06/A-Trade-in-People-CeDR-2017-1.pdf>



The question of whether there are enough beds to provide sufficient care for those who need to be admitted into hospital has been frequently debated over the last two decades. A Health Select Committee report as far back as 1997 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’*.³³

In 2014 another Select Committee report came to similar conclusions to that published in 1997:

“there are major problems with access to... inpatient services, with children and young people's safety being compromised while they wait, suffering from severe mental health problems, for an inpatient bed to become available”.

In parallel with the Select Committee inquiry, NHS England undertook its own review of child and adolescent mental health inpatient services (also known as Tier 4 services, hence the review is known as the Tier 4 review). The CAMHS Tier 4 review was established due to concerns which emerged after NHS England took over the commissioning of inpatient services in 2013, including:

- Quality concerns about a small number of services;
- Closure to admissions (due to staffing, complexity of cases or quality issues) impacting upon capacity;
- Problems in accessing beds when needed;
- Children and young people having to travel long distances to access a bed;
- Anecdotal information suggesting some reductions in NHS community or Local Authority children’s services may be impacting on demand;
- Poor environmental standards in some services;
- Disparity in education input to children's mental health hospitals; and

³³ Health Select Committee report 1997, quoted in Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

- Continuing inequity in provision across the country.

The 2014 review found in many areas there were difficulties in accessing beds, but stated:

“It is... impossible to conclude definitively whether the current level of bed provision is sufficient to meet the need”.

The review reached this conclusion as pressures on beds were found to be related to a number of reasons as well as the total number of beds. These included:

- variations in practice around admissions;
- availability of intensive community services;
- management of delayed discharges;
- changes in commissioning arrangements from a local to a national approach;
- bed closures; and
- staffing problems.

The review also found that the geographical distribution of beds across the country was uneven. Some areas had no inpatient beds available within a 50-mile radius.³⁴

Distribution of beds by geographical area and sub-speciality

To add further complexity to the question of whether there are enough beds, child and adolescent mental health service units vary by sub-speciality and by age of young person accepted. The different units include:

- General child and adolescent units which accept young people aged between 13 and 18 with a range of problems;
- Specialist units which deal with particular needs, such as children under 13, or those with eating disorders or learning disabilities;
- High dependency and intensive care units, which provide care for young people with particularly complex needs who need closer supervision, some of which can form part of larger units; and
- Low and medium secure units, commissioned for young people who require a higher level of security due to their condition.

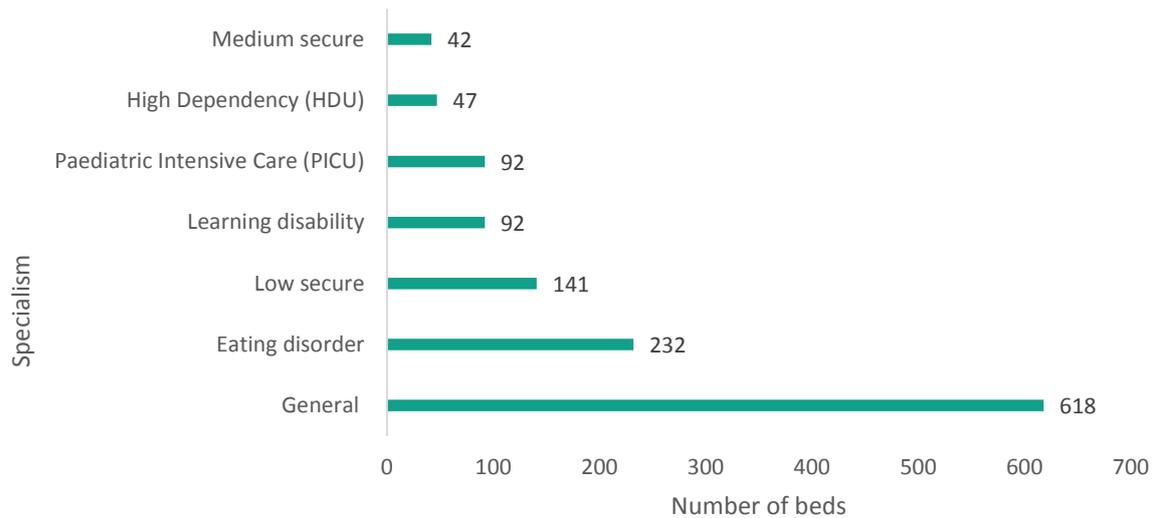
Historically, the separation and functioning of some of the more specialist units have not been well defined.³⁵

The 2014 review explored the distribution of inpatient beds in relation to sub-specialities as well as geographical location. The 1,264 commissioned beds, are broken down in Figure 2.3.

Figure 2.3: Number of child and adolescent inpatient beds by sub-speciality in 2013

34 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

35 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>



This further complicates the picture as to whether there is an appropriate distribution of beds across the country. Due to the specialised nature of some of these services, such as those for children under 13 and for patients with a learning disability, patients would be expected to travel some distance to access them, just as patients with physical health needs sometimes have to travel to specialist hospitals like Great Ormond Street. Nevertheless, the review described the geographical distribution of some of these sub-speciality categories (Paediatric Intensive Care Units, learning disability and low secure care) as “patchy” and having been driven by providers rather than commissioned in a planned way.

The review concludes 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”.

Current geographical distribution

As shown in Figure 2.4, inpatient provision is still highly geographically variable.³⁶ On average, there are 2.5 beds per 100,000 population in England. The North East has the greatest level of provision with 3.0 beds per 100,000 population, compared to 1.1 in the South West.

Figure 2.4: Child and adolescent inpatient mental health beds per 100,000 population by specialist commissioning area

³⁶ Data provided in House of Commons Written Answer, 9 February 2016



The Royal College of Psychiatrists have proposed a proxy measure of appropriate bed numbers as between 2 and 4 beds per 100,000 population.³⁷ This is an imprecise ratio (it would vary depending on the mix of ages and conditions seen and the geographical area). Nevertheless, the average ratio for England (2.5) is at the low end of this scale and two areas (Yorkshire and Humber and the South West) are below the scale.

Problems with accessing beds

This geographical disparity has led to problems in the last year in young people getting access to the beds they need. Data provided to the Education Policy Institute by NHS England based on weekly measurement of capacity over the last financial year, found that in this period there were three incidents when no beds were available at all in at least one region of England. These were:

- 07/04/2016 South Region had no beds CAMHS available
- 28/04/2016 South Region had no beds CAMHS available
- 01/06/2016 London Region had no beds CAMHS available

The consequences of such inconsistent provision of beds across the country can include:

- Young people inappropriately supported in the community;³⁸
- Admissions to paediatric hospital wards;³⁹
- Children being admitted to adult wards (see below); and
- Children being admitted to hospital a long way from home (see below).

³⁷ Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf> citing evidence from the Care Services Improvement Partnership 2007 and Cotgrove et al, Royal College of Psychiatrists, 2004.

³⁸ This has led examples of young people running away or an anorexic patient who lost a further ten per cent of her body weight. House of Commons Health Select Committee Inquiry into Children's and adolescents' mental health and CAMHS, October 2014

³⁹ Staff on paediatric wards are not well trained in handling a patient's mental health needs. This has led to risks for patient and staff safety, inappropriate restraint and unsafe bed bays with access to means of self-harm such as glass. House of Commons Health Select Committee Inquiry into Children's and adolescents' mental health and CAMHS, October 2014

Adult wards

Section 31 of the Mental Health Act 2007 places a duty on hospital managers to treat patients aged under 18 in a hospital environment suitable to their age and needs.⁴⁰ Discrete accommodation within an adult mental health ward is permissible, but only if appropriate CAMHS support, safeguarding measures and age appropriate facilities are made available. The Crisis Care Concordat, published by the Coalition Government in 2014 explains that this means that children under 18 should not be on an adult ward, unless their “*particular needs made it absolutely necessary*”.⁴¹ The legal change came into effect in 2010 and led to a reduction of young people being seen on adult wards from 357 in 2011/2 to 219 in 2012/13, but this was followed by a rise in subsequent years to 391 in 2014/15, an indication that the legal duty has not been effective.

The NHS England Mental Health Five Year Forward View Dashboard provides information on the number of under 18s treated on adult wards and the total number of nights spent on those wards by quarter. The latest information is for Quarter Three 2016-17 (October to December 2016). For this Quarter, there were 83 under 18s treated on adult wards, and they spent a total of 2,700 days in adult hospitals.⁴² This has remained relatively stable since Quarter Two (July to September 2016), when the equivalent figures were 90 and 2,654 respectively. The total number of ‘bed-days’ spent in adult hospitals, however, has risen in Quarter 3, which means that the young people that have been admitted have spent a longer amount of time on adult wards.

Figure 2.5: Total number of young people aged under 18 on adult inpatient wards by Quarter

40 Mental Health Act 2007: <http://www.legislation.gov.uk/ukpga/2007/12/section/31>

41 Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis, UK Government, 2014: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

42 Mental Health Five Year Forward View Dashboard Q3 2016/17, published May 2017, NHS England: <https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/>

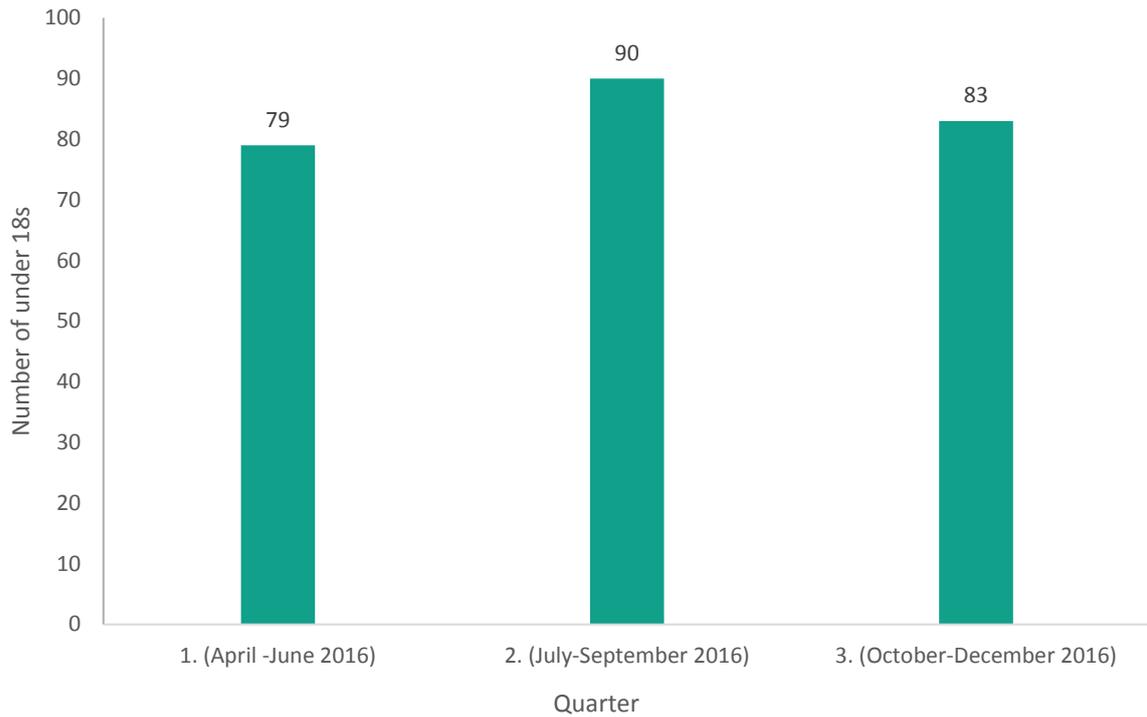
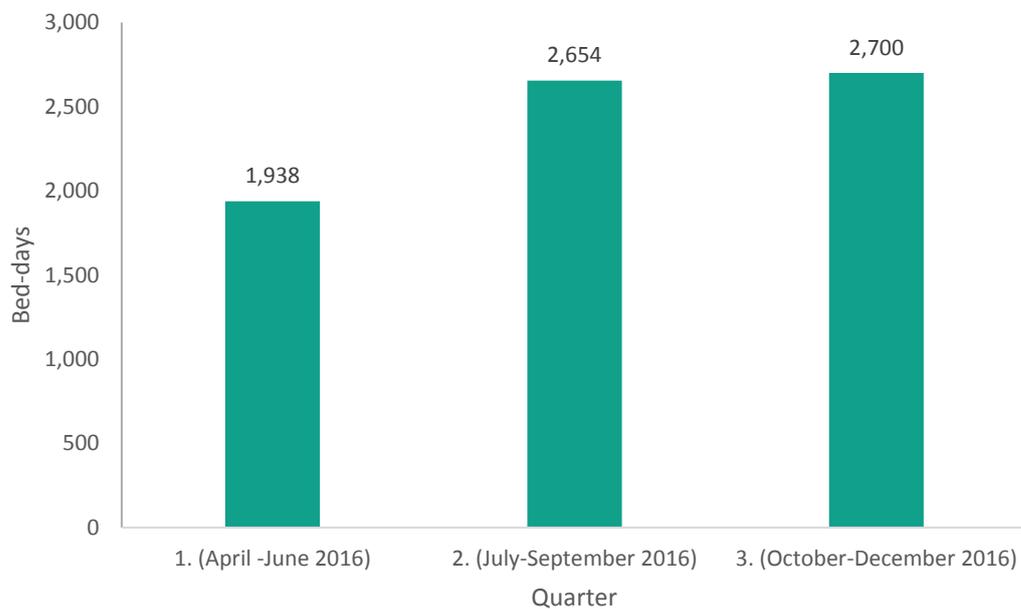


Figure 2.6: Total number of bed-days spent by those aged under 18 on adult inpatient wards by Quarter

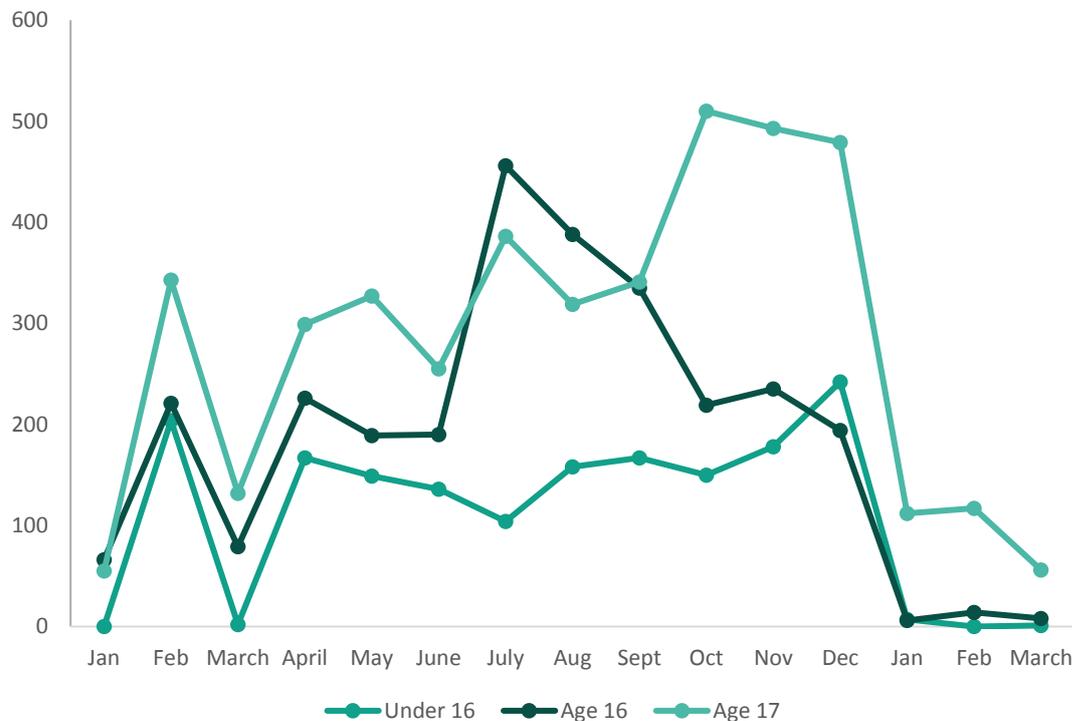


Monthly statistics have also been collected by NHS Digital over the last year, although these are classed as experimental statistics and are difficult to compare over time. This data is, however, broken down by age so that it is possible to see which of those young people being admitted to adult wards are aged 17, 16 or under 16.

In March 2017, there were 65 days spent by a young person aged 17 and under on adult wards, 56 of which were spent by 17 year olds, 8 by those aged 16, and one day by a child under 16. These

figures have fluctuated over the last year, reflecting the small numbers of young people involved. Nevertheless, it is clear from this data that while the majority of those on adult wards are older teenagers, a substantial minority of these are aged under 16. Although the data is experimental, it shows that in 2016 there were 1,657 days spent by a child under 16 on an adult ward.⁴³

Figure 2.7: Number of bed days spent on adult wards by month



The consequences of such admissions to the young people involved can be severe. The 2014 Select Committee heard examples such as a child witnessing a successful suicide attempt and another child being assaulted by an adult patient.⁴⁴

Out of area placements

The government's Crisis Care Concordat states that when a child is admitted to hospital it should be "*close to home, friends and school*" unless these are contributing factors to the patient's mental health crisis.⁴⁵

At present, there is no agreed national definition of what is considered an inappropriate out of area placement for a young person under 18 in inpatient care and no official statistics on the number of young people affected. The government has a national ambition to eliminate inappropriate Out of Area Placements in mental health services for adults in acute inpatient care by 2020-21 and has

⁴³ Mental Health Services Monthly Statistics, NHS Digital. Most recent report for March 2017 published 20 June 2017:

<http://www.digital.nhs.uk/catalogue/PUB30000>

⁴⁴ House of Commons Health Select Committee Inquiry into Children's and adolescents' mental health and CAMHS, October 2014

⁴⁵ Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis, UK Government, 2014: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

begun to collect data to monitor progress on this issue. As yet, there is no equivalent data collection for young people.

The NHS has recently begun to collect information on the number of children and young people being admitted to inpatient care a long way from their home. There were 331 hospital stays for children which were 50 or more kilometres from their home in March 2017.⁴⁶ These stays are not officially classed as 'out of area placements', as some may be within the commissioned area for the service and some may be necessary due to the specialist nature of the treatment received. Nevertheless, there are likely to be young people within this group who are being treated a long way from their family because of a lack of inpatient beds closer to their home.

Places of safety and police cells

Under the Mental Health Act 1983, people who have been detained must be taken to a 'place of safety' for mental health assessment. In the past, this has often been a police cell due to a dearth of health based places of safety (usually located in mental health hospitals or in A&E departments). These places of safety are not part of the inpatient estate for children and young people, as they are assessment units for young people in crisis who may or may not then be admitted to hospital after assessment.

According to data provided by police forces, 43 children under 18 were taken to police cells as a place of safety in 2015-16. Performance has improved over the last year, from 161 under 18s taken to a police cell as a place of safety in 2014-15 to 43 in 2015-16, a 73 per cent decrease over the year.⁴⁷ The incidents in 2015-16 were in the following areas:

- Bedfordshire
- Cheshire
- Cleveland
- Derbyshire
- Devon and Cornwall
- Dyfed-Powys
- Essex
- Gloucestershire
- Greater Manchester
- Gwent
- Kent
- Lincolnshire
- London
- South Wales
- Staffordshire
- Thames Valley
- West Mercia
- West Yorkshire

⁴⁶ Open ward stays, distance >=50km at end of RP, aged 0-18, Mental Health Services Monthly Statistics: Final March 2017, June 20, 2017, NHS Digital: <http://www.digital.nhs.uk/catalogue/PUB30000>

⁴⁷ National Police Chiefs' Council Lead for Mental Health. Data provided individually by police forces: <http://www.npcc.police.uk/documents/S136%20Data%202015%2016.pdf>.

- Wiltshire

Lincolnshire had the most incidents where young people were taken to police cells (8 in total).

A 2014 survey by the Care Quality Commission (CQC) found that around 134 of the 161 health-based places of safety in England (around 83 per cent) said that they would admit under 18s. 56 (35 per cent) would not accept young people under the age of 16⁴⁸ This meant that over 20 per cent of upper tier local authority areas⁴⁹ were not served by a place of safety which accepts young people under the age of 16. Only 44 per cent of respondents to the survey said their place of safety was 'never inaccessible'.⁵⁰

The CQC produced a map to make it easier for the police to know where the nearest health based place of safety was available. The map was updated in March 2017. According to this latest data, of the 165 places of safety in England, 136 (82 per cent) accept under 18s. 52 places of safety (32 per cent) would not accept under 16s.⁵¹ This shows there has been little change since 2014. The map demonstrates the limited availability of places of safety, for example there is only one place of safety in Cornwall which accepts up to two people of any age, meaning that it may often be full. There is no place of safety available in Devon for those aged under 18 and in Norfolk for those aged under 16.

The Government has taken steps to address this issue. The Policing and Crime Act 2017 made it illegal to take a child to a police station as a place of safety.⁵² In 2016, the Government also announced £15 million to deliver more health-based places of safety.⁵³ Successful sites include Lincolnshire and West Yorkshire which saw the highest number of incidents of young people being taken to police cells in 2015-16. Nevertheless, more places of safety are likely to be needed to address capacity problems in other areas if the goal of no young person being taken to an inappropriate setting is to be achieved.

Recent Policy Solutions

Following the Tier 4 review, the Government provided £7 million additional funding in 2014/15 for NHS England to provide over 50 additional CAMHS Tier 4 beds for young inpatients in the areas with the least provision. In addition, NHS England introduced new national protocols for referrals and discharge, dedicated 'case managers' to oversee admissions, and a new bed monitoring system to make the best use of available bed capacity. NHS England also began a review of the procurement and commissioning of inpatient beds to establish the long-term needs for beds, with the aim of ensuring that services are made available in the right places based on the needs of the local population.⁵⁴

48 Survey conducted in 2014: <http://www.cqc.org.uk/media/new-map-health-based-places-safety-people-experiencing-mental-health-crisis-reveals-restrictio>

49 In some areas of England, local government is divided between a county council (upper tier) and a district council (lower tier), which are responsible for different services. In other areas, there is a single unitary authority instead.

50 Right here, right now: People's experiences of help, care and support during a mental health crisis. Care Quality Commission, 2015: http://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf

51 Map of health-based places of safety, Care Quality Commission, updated March 2017: <http://www.cqc.org.uk/media/new-map-health-based-places-safety-people-experiencing-mental-health-crisis-reveals-restrictio>

52 Section 81, The Police and Crime Act 2017: <http://www.legislation.gov.uk/ukpga/2017/3/section/81/enacted>

53 <https://www.gov.uk/government/news/government-announces-successful-bids-to-15-million-mental-health-fund>

54 House of Commons Debate 3 December 2015, Column 606

This review has led to the announcement in the *Next Steps on the NHS Five Year Forward View* delivery plan, published in March 2017, that:

“For children and young people, NHS England will fund 150-180 new CAMHS tier four specialist inpatient beds in underserved parts of the country to reduce travel distances for treatment, rebalancing beds from parts of the country where more local CAMHS services can reduce inpatient use.”⁵⁵

The document indicates that this will not be a net increase of 150-180 beds, as some will be decommissioned in areas of the country that have traditionally had a higher number of beds.

⁵⁵ Next Steps on the NHS Five Year Forward View, NHS England, March 2017: <https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/>

Part 3: Community alternatives to hospital admission

Inpatient care is not always the best option for a young person. NHS policy aims towards avoidance of admission wherever possible, and minimisation of lengths of stay, because of concerns that:

- admission could be a frightening or disturbing experience;
- it separates the child from their home environment;
- the nature of the inpatient environment can involve high levels of disturbance, such as deliberate self-harm;
- being with young people with similar disorders can potentially reinforce difficulties;
- admission undermines the parents' ability to support the child;
- admission risks institutionalisation of the child;
- the child could be missing out on social, educational and occupational opportunities; and
- there are risks of stigma and labelling.⁵⁶

For the above reasons, admission can cause worsening symptoms for some young people, which can then mean a patient is less likely to be discharged because of concerns for their welfare. Admission is also avoided due to the high cost of inpatient care. The NHS Benchmarking 2016 report found that the average cost of a CAMHS admission is £61,000.⁵⁷

Evidence on the efficacy of treating young people with mental health problems in hospital is mixed. Reviews of research into the outcomes of inpatient stays conclude that such care is effective, although the underlying research is often based on small sample sizes or non-standardised outcome measures. Studies of general CAMHS inpatient units have shown positive health gain and sustained improvement in psychiatric symptoms.⁵⁸ However, in randomised controlled trials based on patients with anorexia nervosa, inpatient care and community provision show similar results which has led to a debate about the value of inpatient treatment for this disorder. For young people with psychosis, intensive care in the community appears to be as effective as admission.

For the above reasons, any discussion of capacity within inpatient care also needs to consider the availability of appropriate care in the community. Some areas provide intensive community services which can help young people avoid admission to hospital, or to be discharged from hospital back to their local community. They can track high-risk patients in the community or provide back up support for young people remaining with their families or in the care of their local authority. These services are often described as 'Tier 3 plus' or 'intensive outreach' services.

The Royal College of Psychiatrists recommends that *"Intensive outreach services should be comprehensively commissioned by responsible commissioning groups and health boards to ensure an even distribution around the UK"*.⁵⁹

56 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

57 CAMHS Benchmarking report 2016, NHS Benchmarking: <http://www.nhsbenchmarking.nhs.uk/news/view-article.php?id=205>

58 The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) May 2008 Tulloch et al. Part of a programme of research about CAMHS inpatient care conducted by the Royal College of Psychiatrists' Research and Training Unit.

59 Survey of in-patient admissions for children and young people with mental health problems: Young people stuck in the gap between community and in-patient care. Faculty of Child and Adolescent Psychiatry, Royal College of Psychiatrists Faculty Report CAP/01 March 2015: <http://www.rcpsych.ac.uk/pdf/RCPsych%20report-%20Young%20People%20Stuck%20in%20the%20Gap%20Between%20Community%20and%20In-Patient%20Care.pdf>

It is government policy to increase access to such intensive support within the community. For example, the government's 2015 strategy to improve services, *Future in Mind*, states that it will start "implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care".⁶⁰

The Five Year Forward View for Mental Health, the report of an independent taskforce reporting to NHS England in 2016, recommends that:

*"By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme".*⁶¹

These services are currently not provided consistently across the country. 64 per cent of inpatient care providers who responded to the NHS England Tier 4 Review reported that they did not have an intensive outreach team, even though units with access to such services show a consistently lower length of stay.⁶²

Current commissioning arrangements (whereby NHS England has a central budget for inpatient care and community services are funded locally) have been noted to provide a perverse incentive to disinvest in such intensive community facilities. This also reduces the incentive on local Clinical Commissioning Groups to arrange a swift discharge from inpatient care, which risks beds being occupied unnecessarily and puts further pressure on the inpatient care system.⁶³ NHS England has recently announced a second wave of pilot areas that will be given control of the specialist commissioning budget for child and adolescent inpatient services (a first wave of six areas was announced in July 2016).⁶⁴ The pilots are explicitly aimed at reducing the need for inpatient beds and cutting out of area placements. The second wave will start in October and the areas given control over CAMHS inpatient commissioning are:

- Surrey and Borders Partnership Foundation Trust (FT) – with Sussex Partnership FT, Cygnet Health Care, Elysium Healthcare, Huntercombe Group, Priory Healthcare and Partnerships in Care
- Northumberland, Tyne and Wear FT
- Leeds Community Healthcare Trust – with Bradford District Care FT, Leeds and York Partnership FT and South West Yorkshire partnership FT
- Hertfordshire Partnership FT

60 Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing, NHS England and Department of Health, 2015:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

61 Five Year Forward View for Mental Health, NHS England, 2016: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

62 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

63 House of Commons Select Committee Inquiry, Children's and adolescent mental health services and CAMHS, 2014:

<http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cmh-2014/>

64 NHS England announcement 23 June 2017: <https://www.england.nhs.uk/2017/06/new-sites-to-redesign-mental-health-services/>

- South London Mental Health and Community Partnership, a collaboration between South London and Maudsley FT, Oxleas FT and South West London and St Georges Mental Health Trust

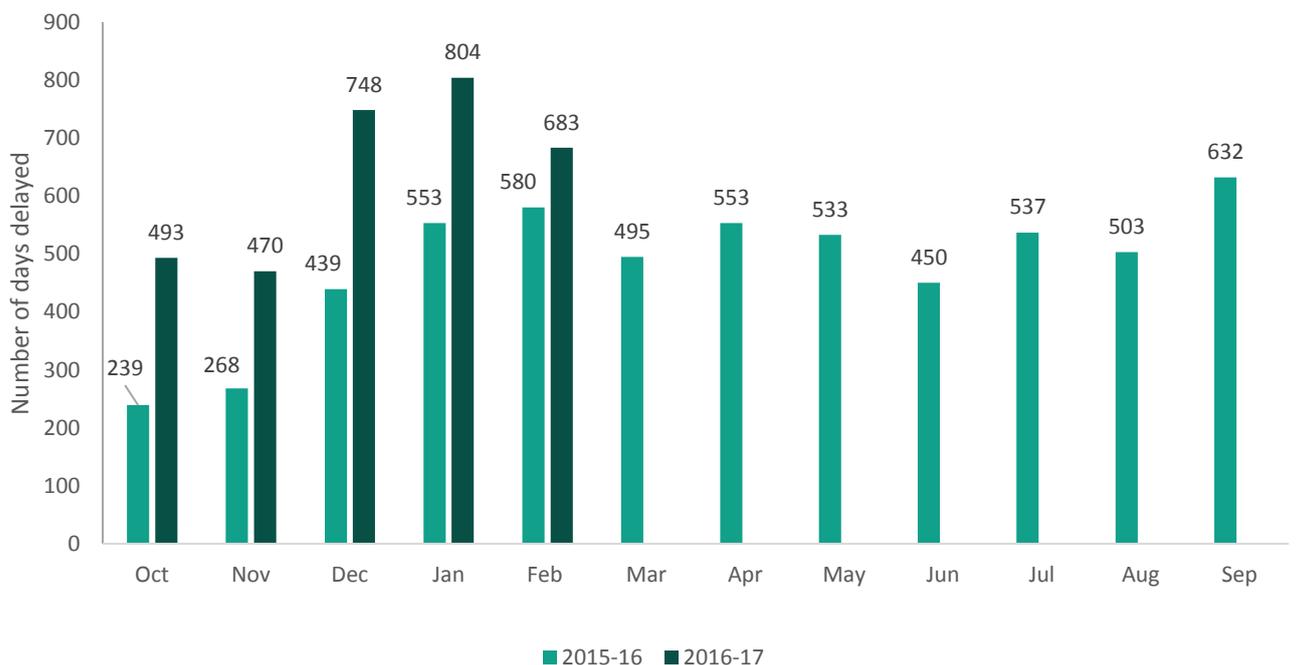
While this development is promising, it should be part of a wider national programme to establish and maintain consistent provision of intensive community services across the country.

Delayed discharges

Often problems in accessing an inpatient bed can be caused by other young people being kept in hospital because they are unable to transfer to another specialist hospital (for example one with different security levels) or be discharged back into the community.

Data obtained under the Freedom of Information Act by the Education Policy Institute from NHS England shows that, since October 2015, there have been nearly 9000 wasted days in NHS children’s mental health hospitals where the child or young person was waiting to leave but they could not be discharged. These figures are on the increase: the number of delayed days in the period December 2016 – February 2017 was 42 per cent higher than in the same period the previous year.

Figure 3.1: Number of delayed days in inpatient units in England by month



In their response to our request, NHS England noted that many of the delays are associated with problems in finding local authority funded social care placements. Another common reason is the delay in transferring young people to other services (such as a higher or lower security setting) due to bed pressures.

Part 4: Quality of care in inpatient services

In addition to our analysis of the capacity of the system, we have also investigated the quality of mental health hospital services for children and young people.

The quality of CAMHS inpatient services is measured through a benchmarking scheme run by the Royal College of Psychiatrists called the Quality Network for Inpatient CAMHS or QNIC, of which approximately 99 per cent of CAMHS providers are members. An annual self and peer review process is carried out based on a set of QNIC standards which have been developed by network members in consultation with service users and their carers.⁶⁵ 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; and
- monitoring of clinical standards.

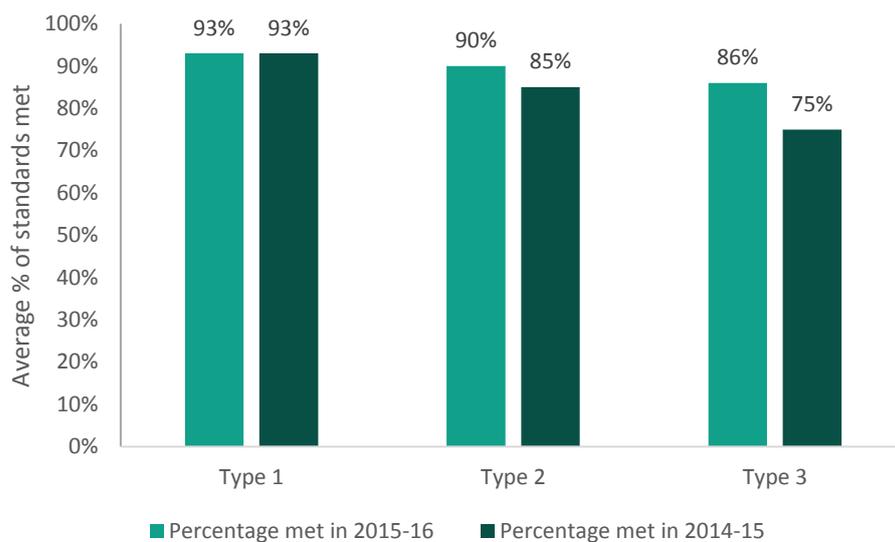
All criteria are rated as Type 1, 2 or 3.

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

Examples of the standards in each type are explored below.

Figure 4.1: Average percentage of QNIC standards met across all services by type in Cycle 15 (2015-16) and Cycle 14 (2014-15)

⁶⁵ Quality Network for Inpatient CAMHS Annual Report (QNIC) Cycle 15: Editors: Hannah Craig, Jasmine Halvey and Thomas Johnstone, Royal College of Psychiatrists, 2016: <https://www.rcpsych.ac.uk/pdf/QNIC%20Final%20report%202016.pdf>



As shown in Figure 4.1, in the latest annual report (covering the period from September 2015 to May 2016), services met a high proportion of the standards. Moreover, performance appears to have improved since the 2014-15 Cycle.

Nevertheless, these figures show that there is substantial room for improvement. Overall, services failed to meet 7 per cent of type 1 standards. Failure to meet these standards can result in a significant threat to patient safety, rights or dignity and/or would breach the law. Some examples include:

- 13 per cent of units failed to meet a standard on mixed sex accommodation which states that *“Male and female patients ... have separate bedrooms, toilets and washing facilities and young people do not pass through areas occupied by members of the opposite sex at night to reach the toilet and/or washing facilities”*. Performance on this standard has improved significantly (by 28 per cent since 2014-15). Nevertheless, the fact that 13 per cent of units failed to meet this standard means that too many patients are still having to share access to toilet and washing facilities with people of the opposite gender.
- 15 per cent of units are unable to provide information on how often young people are restrained and how this compares to benchmarks.
- More than half of units (52 per cent) failed to ensure that policies and procedures were in place to prevent young people using shared facilities at the same time as adults. This was often because units had trust wide policies which did not provide specific detail about young people.
- 21 per cent of units did not have a policy on the use of seclusion.

Meeting Type 2 standards is what is expected of an inpatient unit. Overall in 2015/16, 1 in 10 of the type 2 standards were not met. Examples of failures to meet Type 2 standards include:

- 39 per cent of units failed to meet the standard that staff and young people can control heating, ventilation and lighting in the unit.
- 16 per cent of units are not in a good state of repair with timely maintenance.

Restraint:

While the safety of patients and staff necessitates the need for restraint to be used in inpatient mental health settings, it is government policy to minimise the use of face-down restraint due to safety concerns.⁶⁶ A survey undertaken by the charity Mind found that, in August 2015, there were 9,600 uses of restraint reported across all mental health trusts and 15 independent mental health service providers in England.⁶⁷ It found that physical restraint, face down or prone restraint and seclusion were all used most frequently in child and adolescent mental health services in addition to some specialist adult services.

According to a Freedom of Information request by Agenda, an alliance campaigning on women and girls at risk, nearly one in five (17 per cent) girls in CAMHS were physically restrained in 2014/15, and they were more likely to be restrained than boys (13 per cent).⁶⁸ According to the Agenda investigation, girls were restrained face-down more than 2,300 times and were likely to face this repeatedly – with some trusts reporting an average of more than a dozen face-down restraints per female patient. There was variation between providers: in one trust, nearly three quarters of girls were restrained, with nearly a third restrained face-down; in others face-down restraint was not used at all.

Deaths in inpatient settings

Deaths relating to inpatient mental health care are rare. Data provided to the Education Policy Institute by NHS England shows that there were 10 deaths of children under 18 under the responsibility of inpatient services since April 2013. Of these, 6 were on home leave at the time of death.

Location of Incident	Number of Incidents
Inpatient ward	3
On home leave	6
Absconded	1

Age	Number of incidents
15	4
16	1
17	5

Year	Number of incidents
2013	3
2014	3
2015	2

⁶⁶ Positive and Proactive Care: reducing the need for restrictive interventions, Department of Health, 2014: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf

⁶⁷ Restraint in mental health services What the guidance says, Mind, 2015: <http://www.mind.org.uk/media/3352178/restraintguidanceweb.pdf>

⁶⁸ Freedom of Information request by Agenda, March 2017: <http://weareagenda.org/wp-content/uploads/2017/03/Restraint-FOI-research-briefing-FINAL1.pdf>

2016	2
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Gender	Number of incidents
Male	3
Female	7

The system for reporting and investigating such incidents has recently come under scrutiny. The *Five Year Forward View for Mental Health* highlighted that there is no independent pre-inquest process in place for investigating deaths of patients detained under the Mental Health Act. Internal investigations are carried out by provider organisations and these are of variable quality. The report notes that: “*Patterns of deaths that merit closer examination may thus escape public scrutiny...There is also very limited information available nationally on the number of children who have died in mental health settings*”. The review recommended that the Department of Health should widen the scope of the Healthcare Safety Investigation Branch to include deaths from all causes in inpatient mental health settings and to ensure independent scrutiny of investigations into deaths, analysis of trends and evidence of learning resulting in service improvement.

Education

In 2014, the Health Select Committee received evidence on the poor quality of educational provision in inpatient services and found confusion between the NHS and education services as to the responsibilities for providing education in these settings.⁶⁹ Ofsted is, for example, not always required to inspect such provision. Young people argued that there was not enough time spent on education in Tier 4 inpatient units, and that the quality of it was poor. The Committee also noted the importance of appropriate reintegration into school as part of discharge planning. As a result of the committee’s inquiry, the Department for Education undertook to conduct an audit of educational provision within residential child and adolescent mental health settings, but this has not yet been published.

Workforce

The quality of care is connected to adequate staffing levels and the competency and training of staff within services and therefore the Quality Network for Inpatient CAMHS includes standards on workforce. The Cycle 15 (2015-16) annual report found that one in 9 units (12 per cent) did not meet the minimum standard for staff to patient ratios. These are 1:2 for medium dependency, 1:1 for high dependency and 3:1 for the most highly disturbed patients.

The report also includes performance against a standard that: “*the unit is staffed by permanent staff, and unfamiliar bank and agency staff are used only in exceptional circumstances*”.⁷⁰

⁶⁹ Children’s and adolescents’ mental health and CAMHS, Health Select Committee Inquiry, October 2014: <https://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34202.htm>

⁷⁰ This is measured by whether the unit employs over 15 per cent of staff as agency staff during the week or if more than one member of staff on a shift are from an agency.

Nearly a quarter of units (24 per cent) were not meeting this standard. Performance on this measure has also deteriorated over the last year. (76 per cent of units compared to 83 per cent).⁷¹

According to the 2016 NHS Benchmarking report, 19 per cent of CAMHS inpatient pay costs are Bank and Agency staff.

This demonstrates the need for a sustained focus by the Government and Health Education England on increasing the number of trained staff available to work in child and adolescent mental health, particularly in inpatient care, thereby reducing reliance on temporary staffing. A workforce strategy is in development but has not yet been published. Claire Murdoch, Director for Mental Health at NHS England has said that more than 10,000 extra staff will be required to meet the service's "*growth agenda*" and that this will be "*challenging*".⁷²

⁷¹ Quality Network for Inpatient CAMHS Annual Report (QNIC) Cycle 15: Editors: Hannah Craig, Jasmine Halvey and Thomas Johnstone, Royal College of Psychiatrists, 2016: <https://www.rcpsych.ac.uk/pdf/QNIC%20Final%20report%202016.pdf>

⁷² Claire Murdoch, Director of Mental Health, NHS England, Interview with the Health Service Journal 23 June 2017

Part 5: Conclusion and policy questions

This report has catalogued the inconsistent provision of child and adolescent mental health inpatient services in England. The NHS has this year announced the intention to address these concerns by providing more beds and redistributing them across regions. It is essential that the level of inpatient services across specialities and regions is kept under review.

As this report has outlined, there are good reasons for inpatient services to be kept as a last resort, not least because of the disruption to a young person's education caused by admission to hospital and delays in discharge.⁷³ Therefore, the government and NHS England should also consider the wider provision of intensive outreach and crisis services within the community, given that two-thirds of inpatient care providers (64 per cent) who responded to the 2014 NHS England Tier 4 Review reported that they did not have an intensive outreach team.⁷⁴ This would reduce the demand on beds and provide care closer to young people's homes and communities. As the process of transforming child and adolescent mental health services continues, data on the consistent provision of these services should be collected and monitored at a national level. In addition, further training is needed for staff outside of specialist CAMHS, such as GPs, ambulance and A&E staff and the police who are likely to be first respondents to young people in crisis. New models of supporting young people in crisis such as street triage and crisis cafes should be replicated across the country.

The pressure on inpatient mental health care for young people cannot be treated separately from social care provision. Without adequate social care facilities to transfer young people into where needed, there will still be those facing delays in discharge from hospital.

While appropriate access to services is important, the quality of those services and the outcomes experienced by patients are also critical elements of any evaluation of the system. There are many examples of high quality care and the data indicates that the quality of services are improving, but there is still a long way to go before all services reach a high standard.

The quality of child and adolescent inpatient services has improved. Nevertheless, measurement against the Quality Network for Inpatient CAMHS (QNIC) standards demonstrates the need for a continued focus on quality. It is right that the Care Quality Commission has included more detailed inspections of CAMHS within its latest inspection framework. A new measure of patient experience should also be considered, to provide a barometer for the quality of care. More research is needed into the outcomes achieved by inpatient settings and best practice should be shared and evaluated on a more consistent basis in future.

The capacity of the system and the quality of provision cannot be separated from discussions about adequate staffing levels. The government should work with Health Education England to plan appropriately to address concerns about recruitment difficulties and high levels of temporary staffing.

⁷³ The Health Select Committee in 2014 highlighted concerns about the quality of education provided in inpatient settings. House of Commons Health Committee, Children's and adolescents' mental health and CAMHS, Third Report of Session 2014–15, 5 November 2014: <https://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf>

⁷⁴ Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report, NHS England, 2014: <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

This report has explored existing research and available data on the provision of inpatient care for children and young people with mental health problems. Much of the existing data, however, is experimental and there are significant gaps in what is measured. The Government should build on the introduction of the dataset in 2016 by including more information on the demographics of those in care, the length of stay in services, delayed discharges and workforce numbers to enable greater transparency and scrutiny of the mental health system. The new dataset is a step in the right direction but more variables should be collected in order to help the government and NHS England to plan more effectively for service improvement and to enable external scrutiny to hold the system to account.