Getting It right for Young People Experiencing a Mental Health Crisis

Dr Guy Northover,

GIRFT National clinical lead CYP urgent care and crisis pathways.

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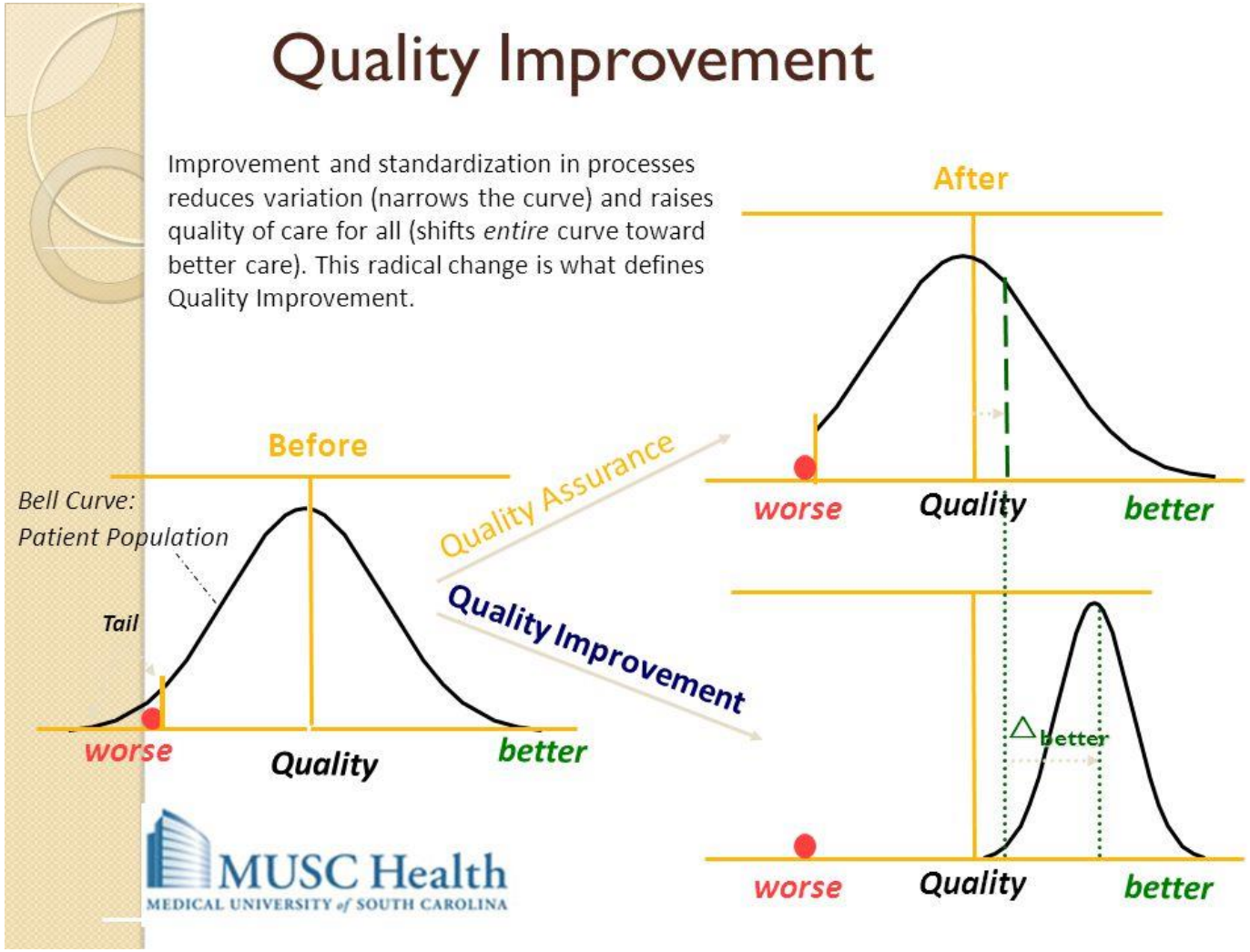
Unwarranted Variation

- ***Getting It Right First Time: Tackling unwarranted variation to improve quality of patient care while also identifying significant savings.***

- Harrison (2018) 100's studies looking at clinical variation but no distinction between warranted vs unwarranted. (implies all variation is unwarranted)

- **Requires clinical teams in Trusts as well as commissioners to understand what good evidence based care looks like** and work together across the local health economy to deliver the change.



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QI at service level

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

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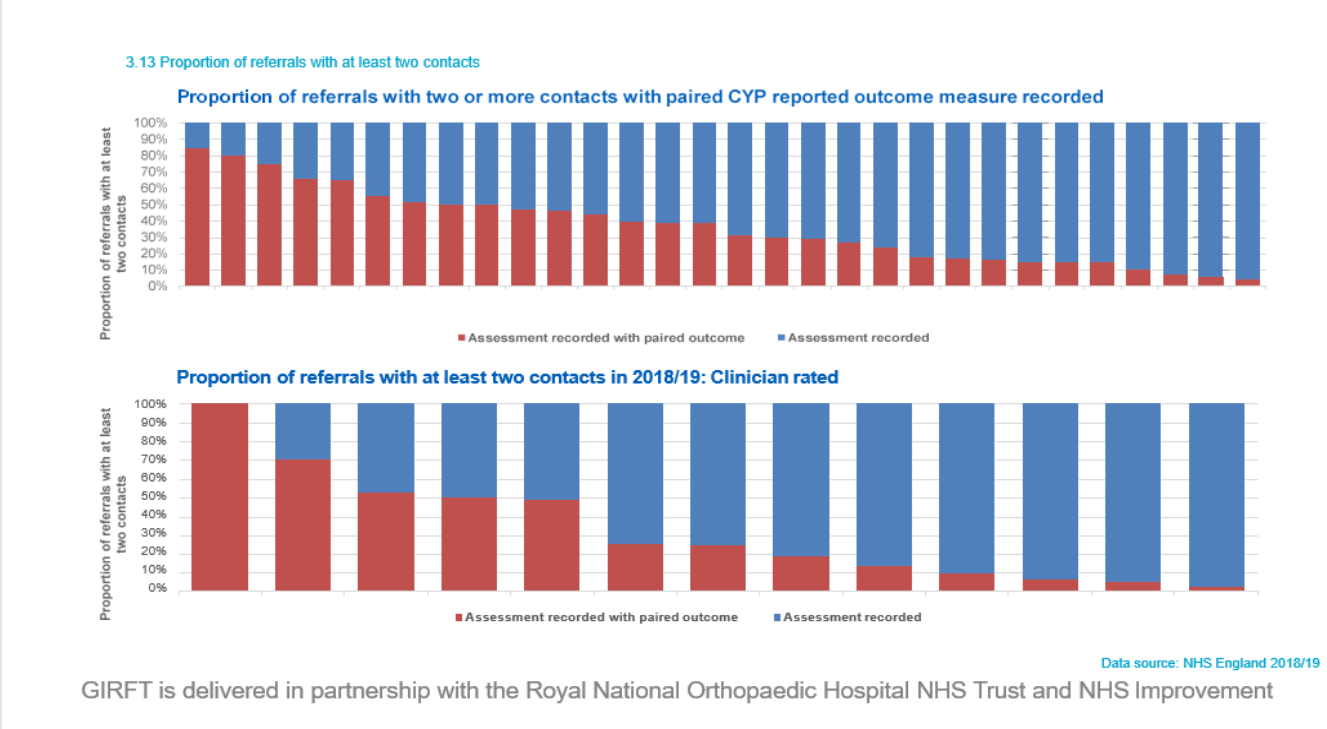
NHS

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

Inherent in quality improvement is the monitoring of outcome measures



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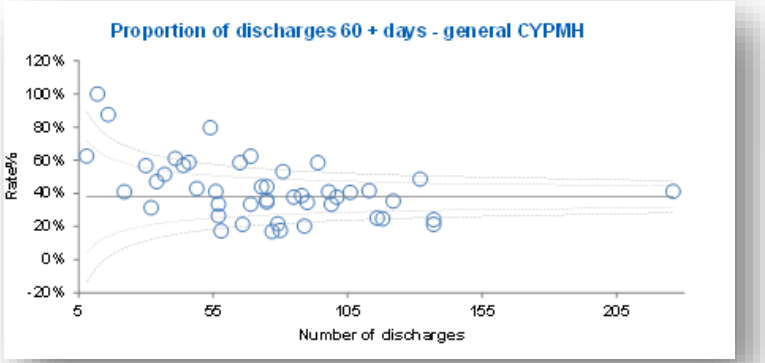
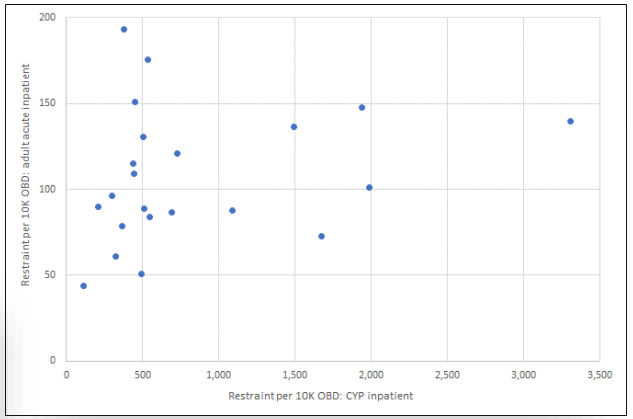
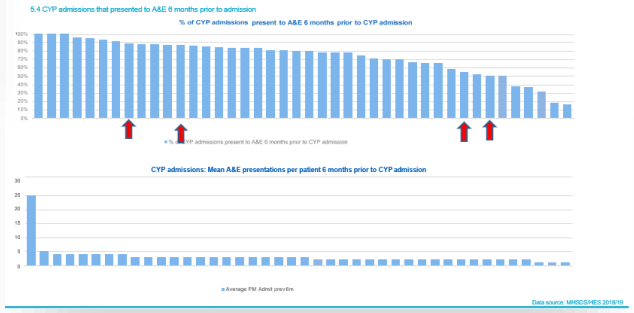
- Process driven outcome measures are common (waiting times, number of referrals, number of discharges etc)
- Clinical outcome measures far less common
- You have to know what a good clinical outcome is!

There are however interesting findings







- Significant variation in Length Of Stay
- Restraint 5.7 times more likely in adolescent units than adult units in same trust: (exponentially increases too)
- Poorly defined cross service crisis pathways

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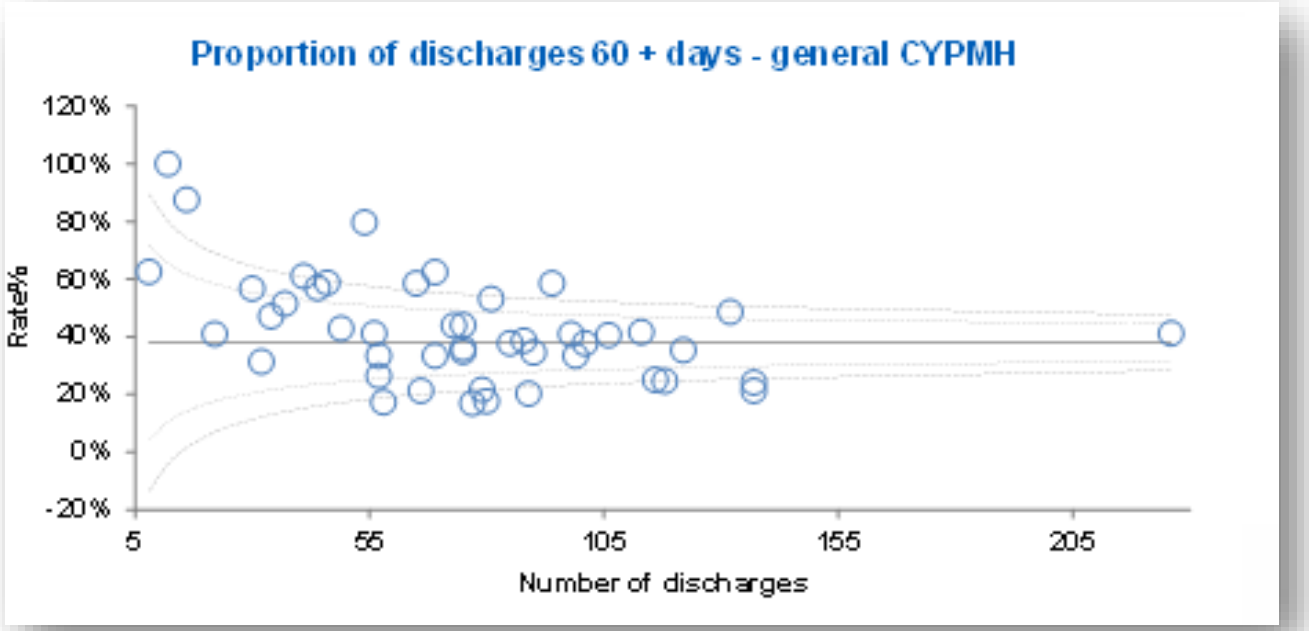

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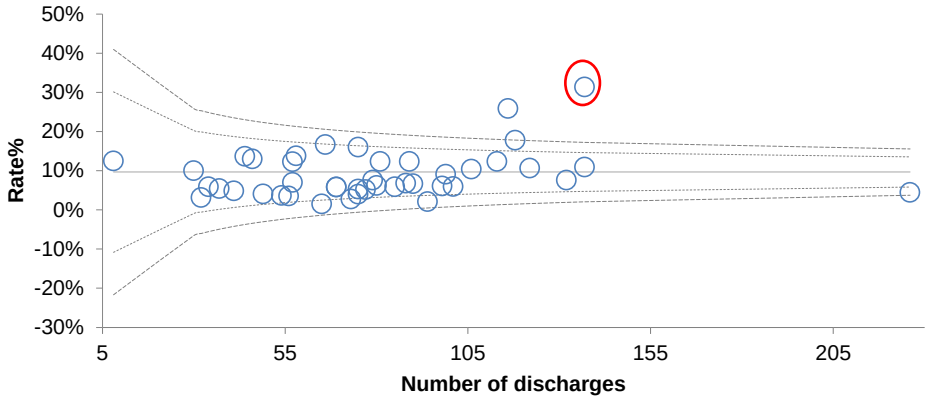
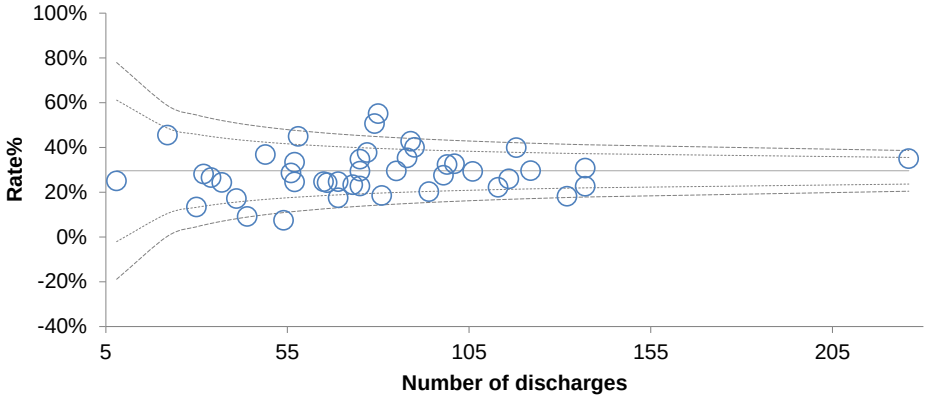
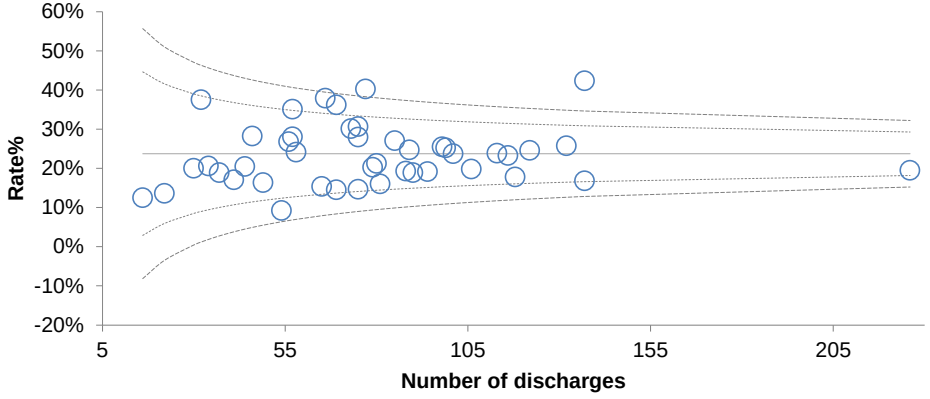
Proportion of discharges less than 7 days - general CYPMH



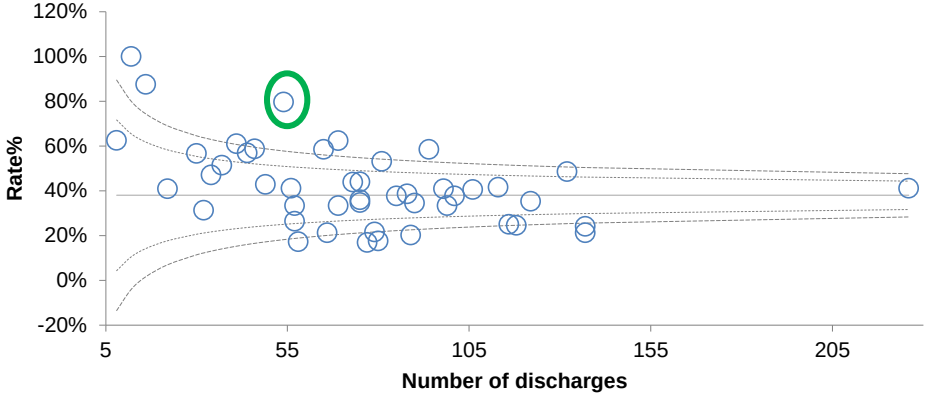
Proportion of discharges 7 to 28 days - general CYPMH



Proportion of discharges 29 - 59 days - general CYPMH

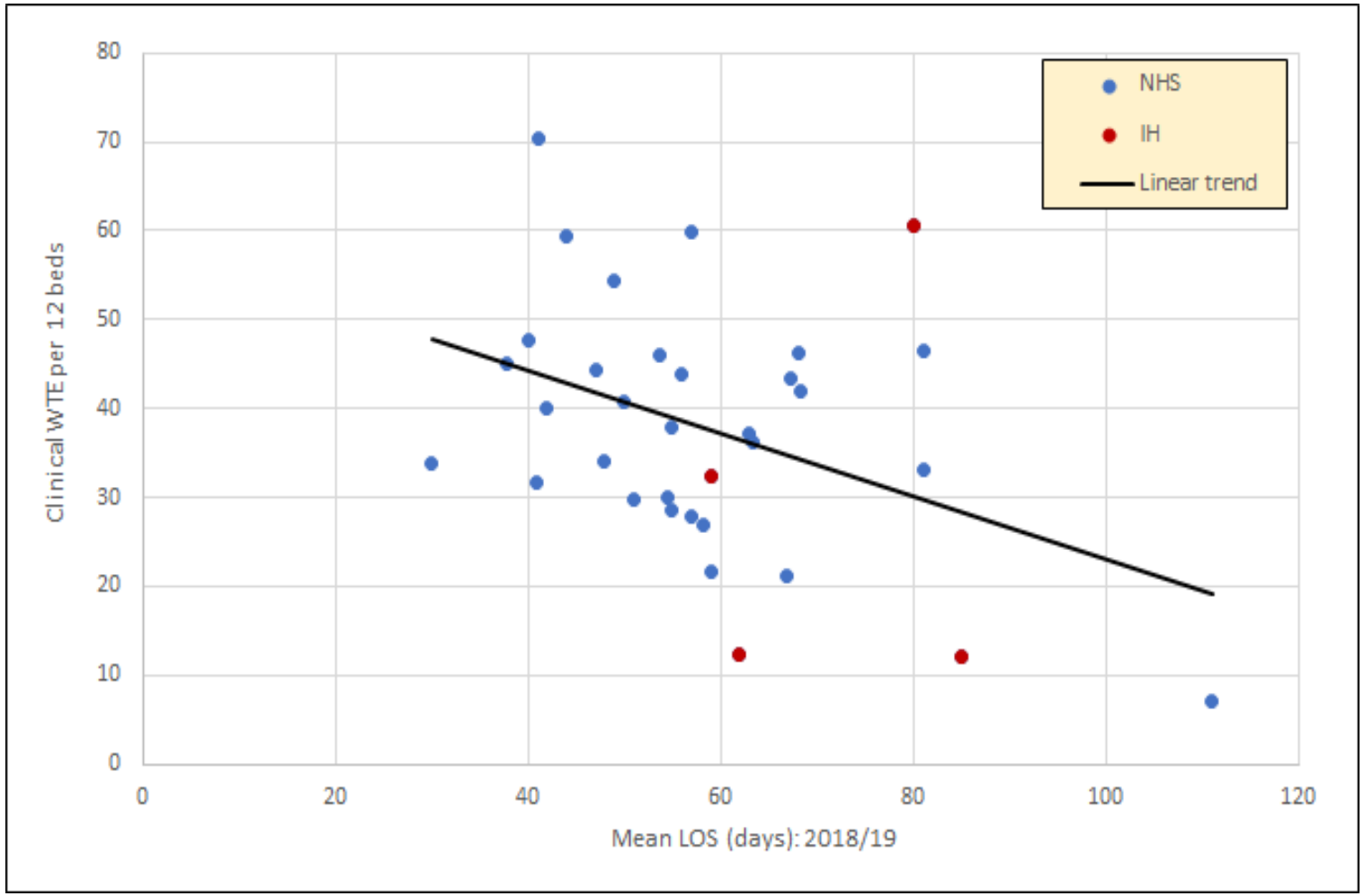


Proportion of discharges 60 + days - general CYPMH



Data source: NHS Benchmarking Network 2018/19

- Biggest impact on LOS was staffing levels within the inpatient unit.



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Improvement	Standard			Target		
	Target	Activity opportunity *	Gross notional financial opportunity**	Target	Activity opportunity *	Gross notional financial opportunity**
Free up inpatient capacity for those who most need it (through continued investment in community services) (recommendations 1, 4 and 5) Opportunity = Reduce acute MHCYP hospital length of stay *It should be noted that the target lengths of stay shown here include all CYP hospital admissions. Lack of robust data precluded a seperate calculation related specifically to very long lengths of stay (60+ days).* Base data: NHSBN April 18 - Mar 19. *Cost estimated based on average CYPMHS bedday cost (18/19 ref costs uplifted to 20/21 prices)*	*National average* 55.6 days length of stay	14200 beddays	£11.39m	*Best quartile* 48.3 days length of stay	26100 beddays	£20.94m
Total			**£11.39m**			**£20.94m**

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Length of Stay General admission and eating disorder units only

- **There must be a clear strategy and plan on reducing the proportion of young people remaining on the inpatient unit for more than 60 days.**

- The plan must include promotion and development of effective alternatives to an inpatient admission including provision through social care and education. Rapid and appropriate access to therapeutic support on the inpatient unit and an ability to ensure a more rapid discharge from hospital with ongoing intensive support in a community setting.

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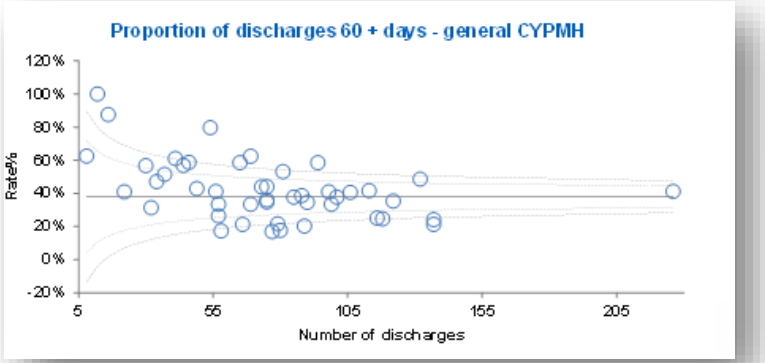

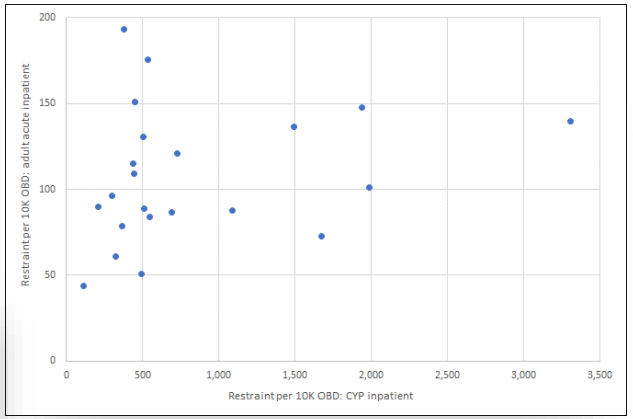

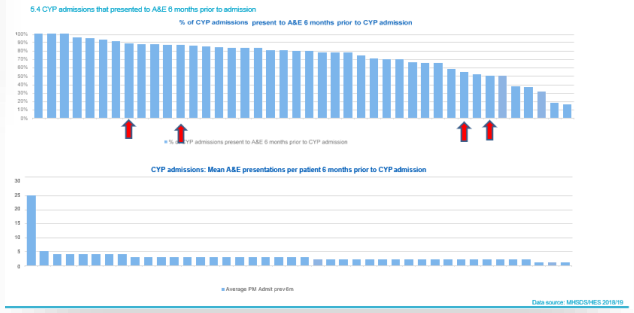

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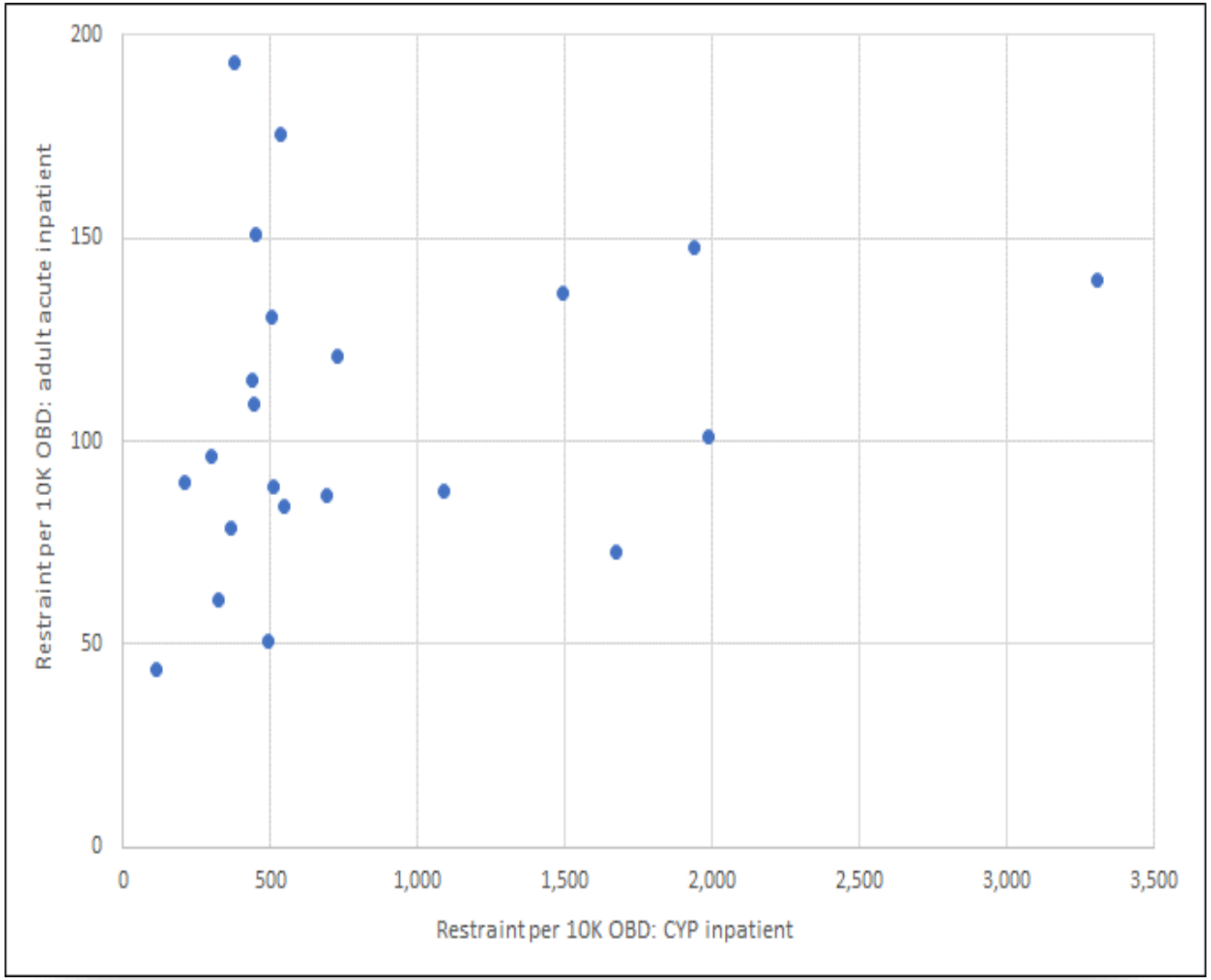

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Use of Restraint

- **All provider organisations must focus on reducing the incidence of restraint, prone restraint, and seclusion and should:**
  - ensure levels in the CYP inpatient population are no higher than in the adult inpatient population.
  - have a clear plan in place to reduce incidents of restraint and seclusion Improvement activity should be based on benchmarking with peers aiming for milestones year on year to achieve a position in the top decile.

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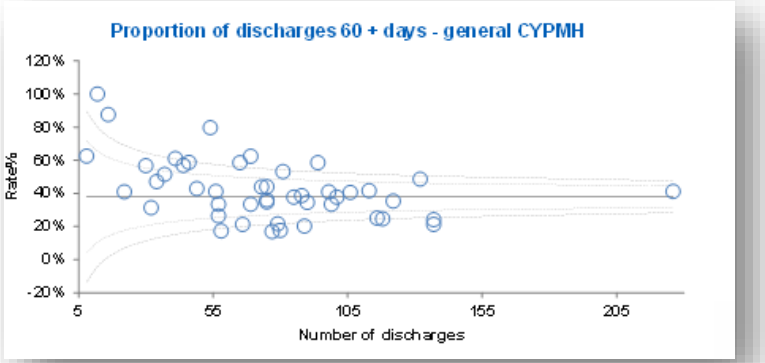

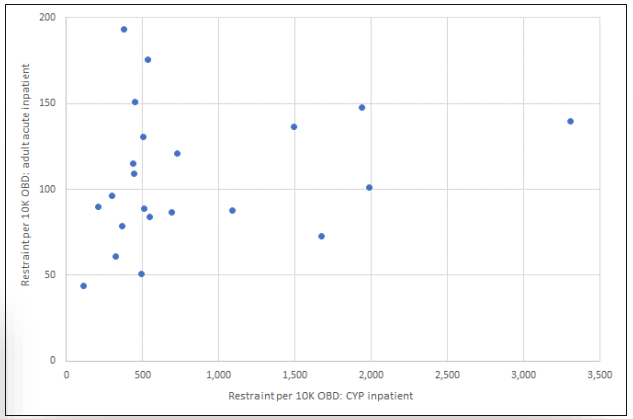

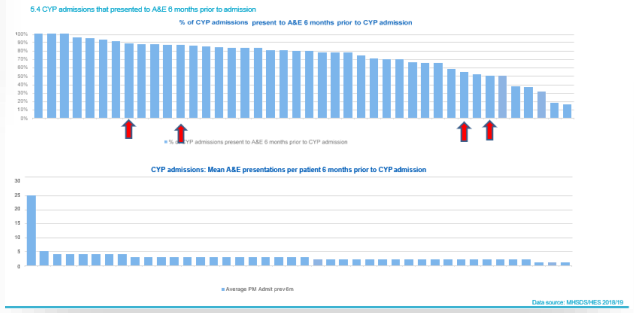

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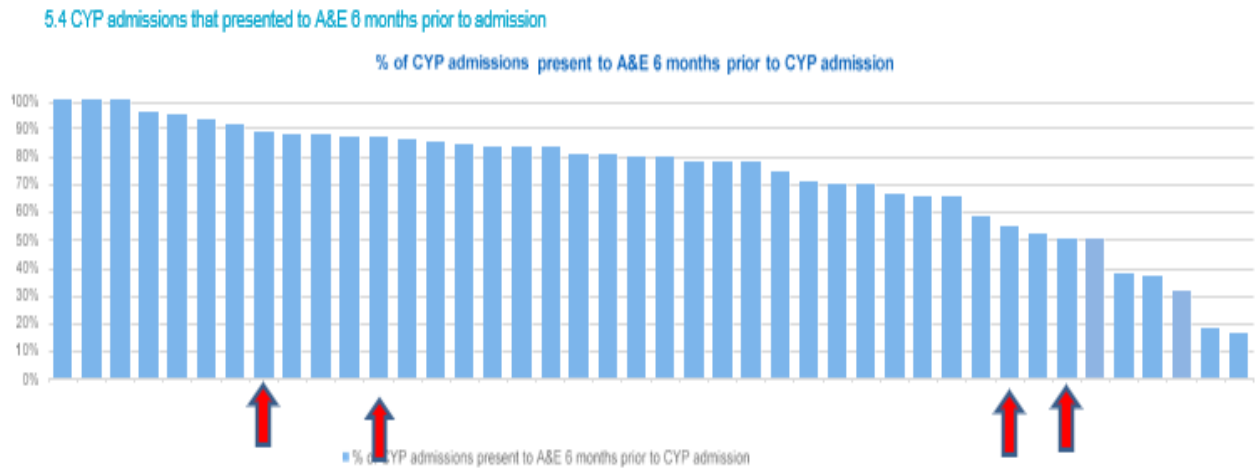

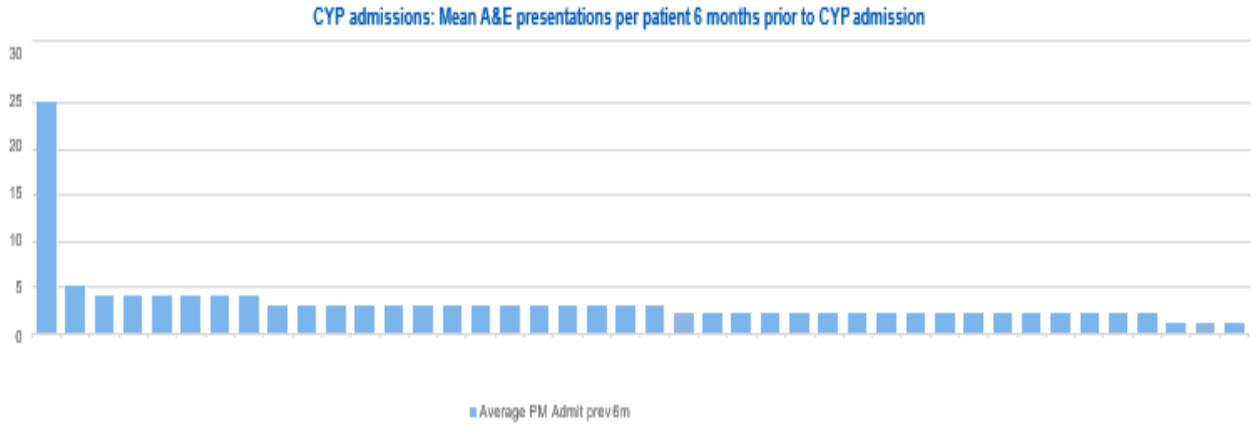

Data source: MHSDS/HES 2018/19

- Poorly defined cross service crisis pathways

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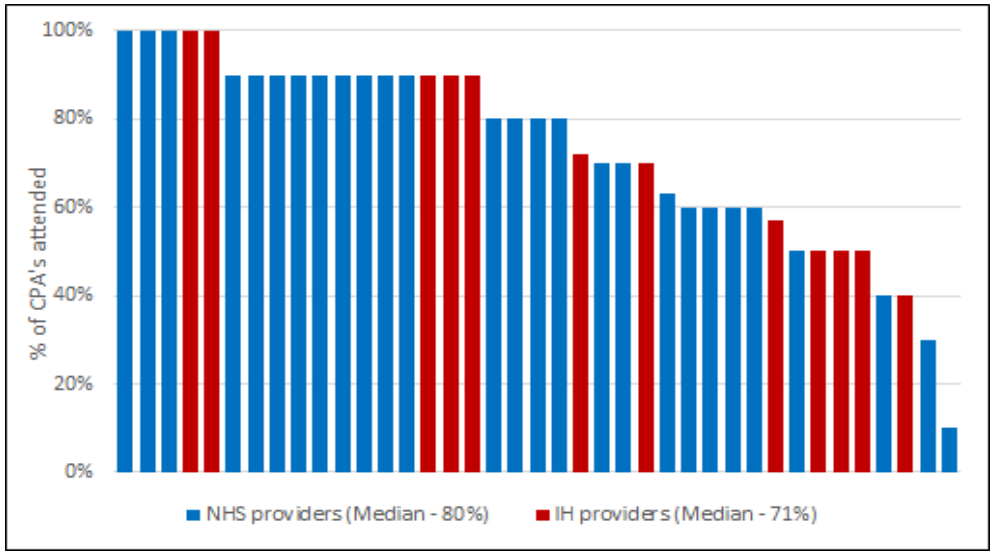
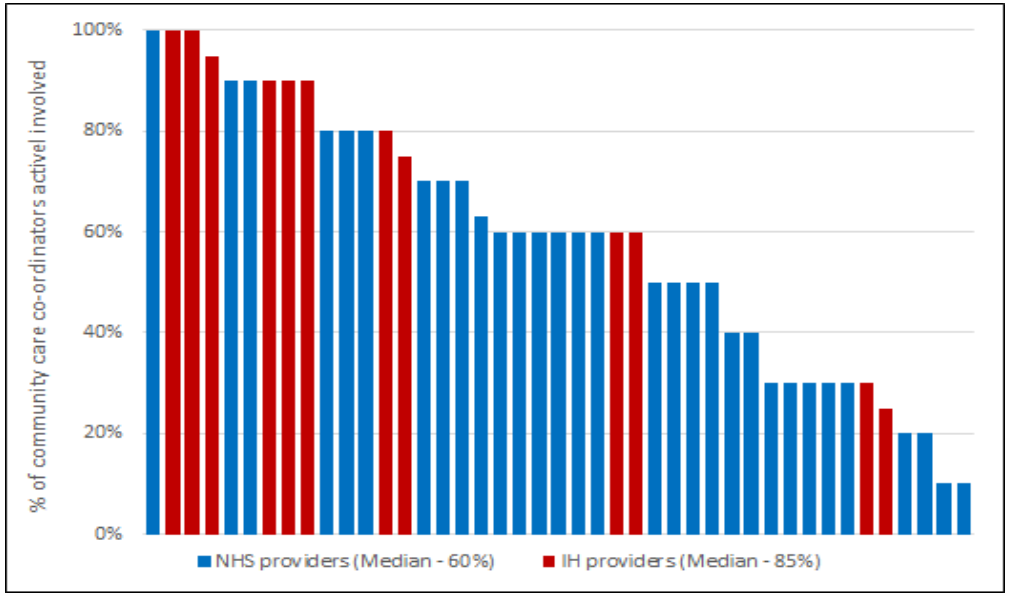
Lack of comprehensive urgent care pathways

- CYP urgent care pathway is complex
  - crisis service,
  - inpatient services,
  - home treatment teams,
  - crisis avoidance services,
  - paediatric liaison services
- Acute hospital must be part of the pathway
- Use of day hospitals and hospitals at home





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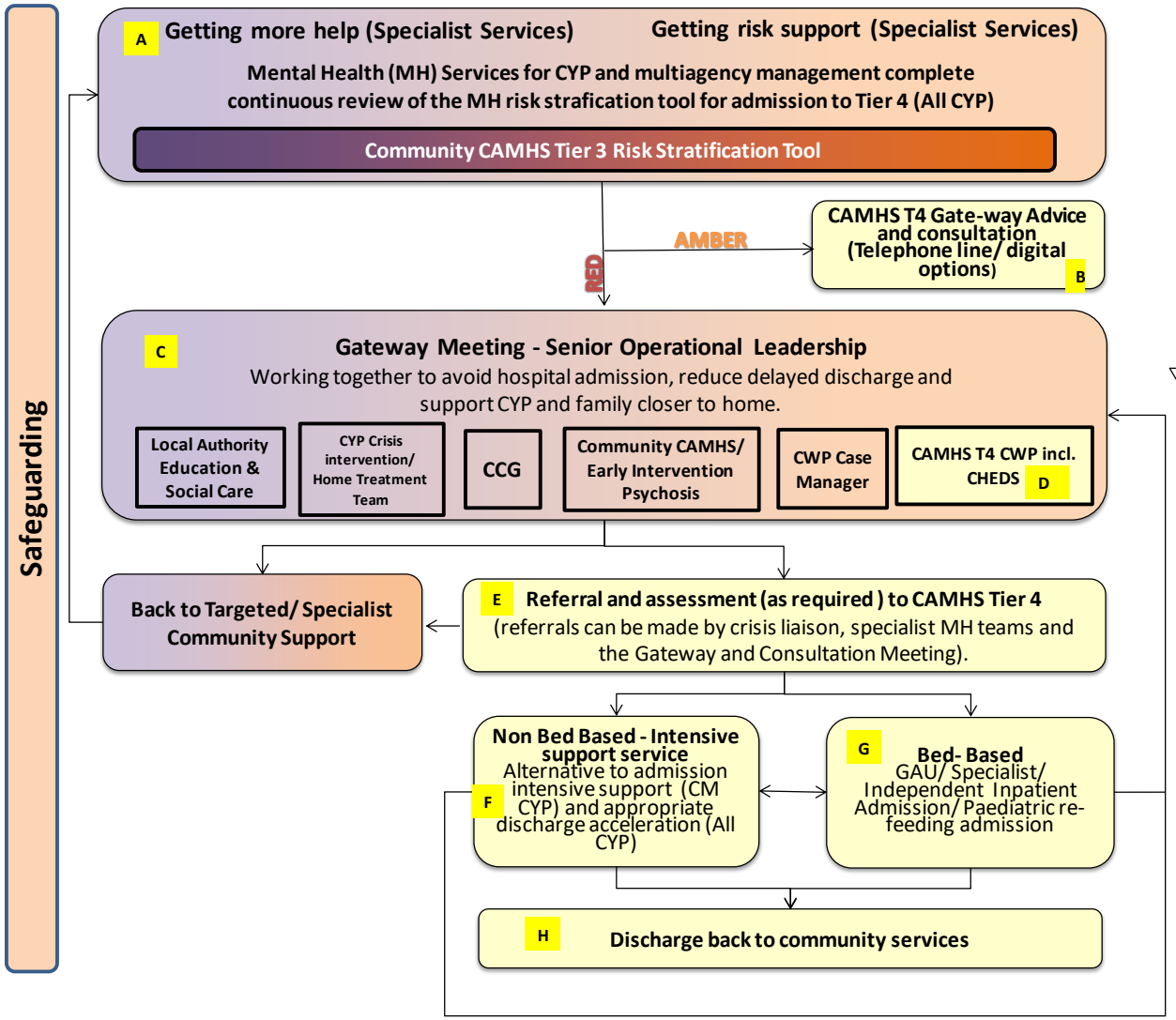
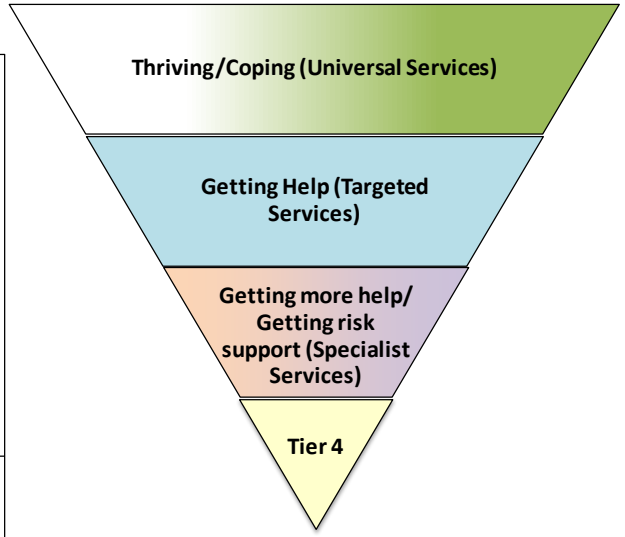
Comprehensive urgent care pathway.

- **The crisis and urgent care pathways, including inpatient admissions must remain seamless**
  - with consistent treatment plans, objectives, and care coordination.
- **There must be a robust preadmission assessment process**
  - including input from the inpatient unit, crisis services, community team and when necessary, the local authority.
  - The aim of the assessment process should be to ensure that the young person is receiving the right care in the least restrictive way possible.
- **The urgent and crisis care pathways, must work across physical and mental health organisations in a seamless and effective way**
  - with a recognition best outcomes are not always achieved in a mental health setting

Cheshire and Merseyside
Health and Care Partnership

The Clinical Pathway





Next Steps

- Pathway development DRAFT Psychosis in Children & Young People Pathway
- Gateway metrics
- Repository of best practice
- Data driven clinically led visits to trusts/provider collaboratives who remain outliers