Better Data, Better Care: Understanding & Using Information To Support CYP Urgent Care and Inpatient services

- Dr Guy Northover

GETTING IT RIGHT FIRST TIME

Why we need to use our data in CYPMH

- **There is no consistent model of CYPMH community or urgent care**
  - Differing funding arrangements
  - Differing commissioner engagement (NHS/LA/Voluntary)
  - Differing understanding of what good looks like
- **Arguably fastest growing area of healthcare**
  - Lots of innovation and improvement
  - Long waits, less than optimal access for CYP
- **Quality Improvement**
  - Trusts with effective QI programmes more likely to be outstanding
  - QI is everyone's business
- **Lack of research/identified best practice models**
  - E.g. impact from being treated far from home
  - Evidence of crisis models

What is GIRFT

- Builds on multiple other initiatives and learning over the years
- Aims to reduce unwarranted variation and promote best practice examples
- Uses national datasets (e.g.NHSBN, MHSDS, SPECCOM) and a specific supplemental questionnaire to analyse variation and to create individual data packs for each local trust/provider collaborative
  - Data packs developed to explore key lines of enquiry, significant clinical lead oversight, comparative, deep understanding of limitations and clinical messages
- Sent out for local discussion and then deep dive visit undertaken
- Outcomes from the visit are owned by the trust but with support from GIRFT regional teams
- All of that then leads to a national report to promote best practice and reduce unwarranted variance

CYP specific

- Urgent care and crisis pathway: inpatient units and crisis services
  - Although data pack considered community services
  - Some recommendations focus on crisis avoidance services not just crisis services
- General admission and eating disorder units only
  - Children units not included in recommendations
  - Separate addendum for forensic and LD units
- Independent sector fully engaged
- Data packs and deep dive visits developed at trust and provider collaborative level.

Deep Dive Visits

- Deep dive undertaken at provider collaborative level
  - 3 hour PC deep dive
  - Followed by 1 hr for each member of the PC if requested.
- Data packs developed both at a PC comparative level and individual trust level.
- Improvements and learning expected from both provider collaborative approaches and trust level approaches.
- Additional pack and report produced for learning disability and secure estate.

National Report recommendations

- 20 recommendations,
  - Each recommendation has an associated suggested action plan, identification of metric to demonstrate improvement and suggested timescale for completion
  - It is not nationally mandated for the actions to be implemented but they have arisen from identification of best practice and will drive effectiveness and quality.
- Development of gateway metrics
  - To be held on model mental health to allow ongoing benchmarking of services with clear clinical interpretation

Quick note on Quality Improvement

	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)

- Data from GIRFT supplemental questionnaire 2018/19

Data collated from 3 questions on supplemental questionnaire and not backed up with qualitative interview so results to be interpreted with caution.

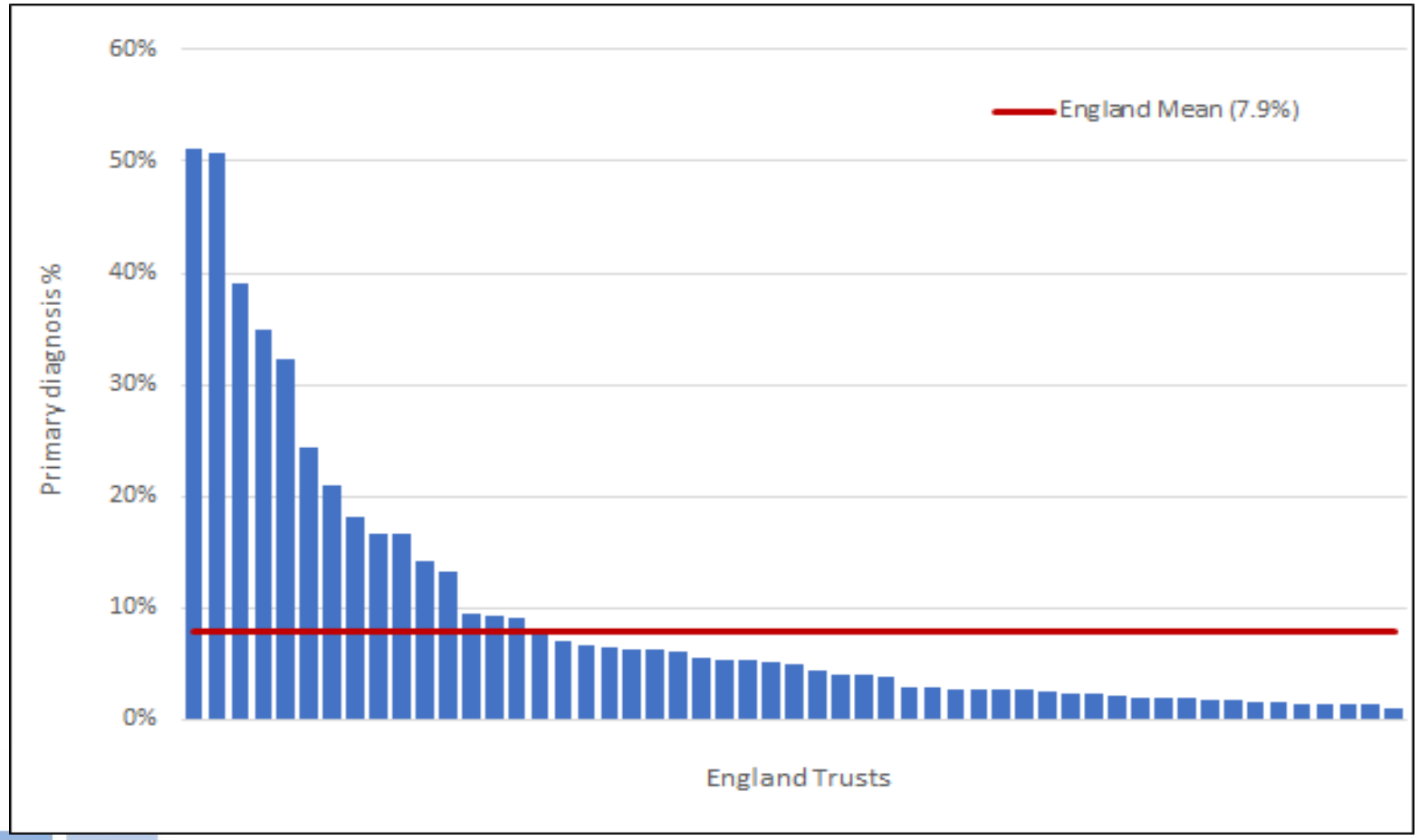
3 data focused findings and recommendations

- Recording of diagnosis
- Use of outcome measures
- Length of stay

Recording of diagnosis

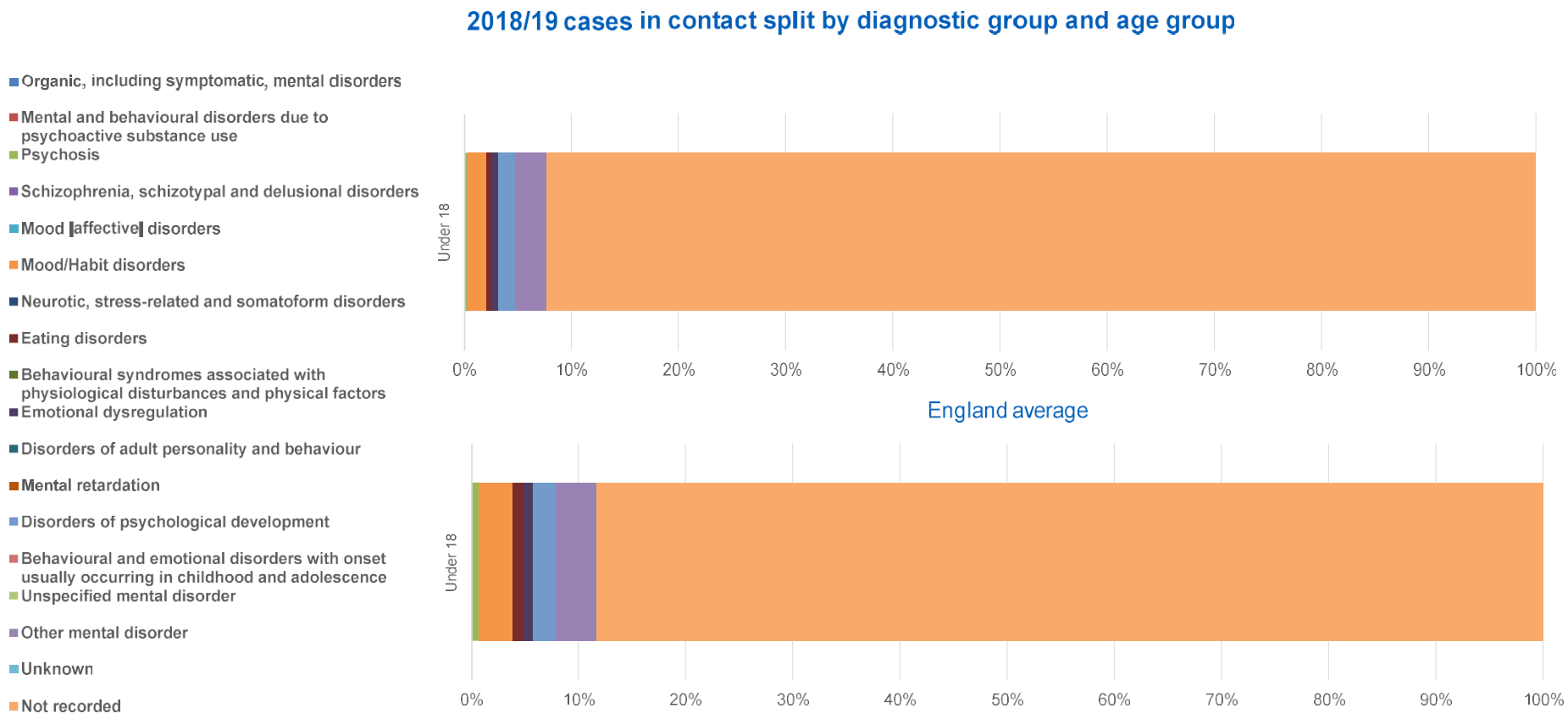
- Very poor levels of data collection for diagnosis in CYP
- Recommendation:
  - A national approach to a definition of diagnosis/reason for admission should be developed through the CYPMH policy team/Specialist Commissioning Team/NHS digital and adopted by all services.

Percentage of patients with a recorded diagnosis within the MHSDS



Data source: MHSDS 2018/19

2.8 Number of cases in contact during 2018/19 split by diagnostic and age group



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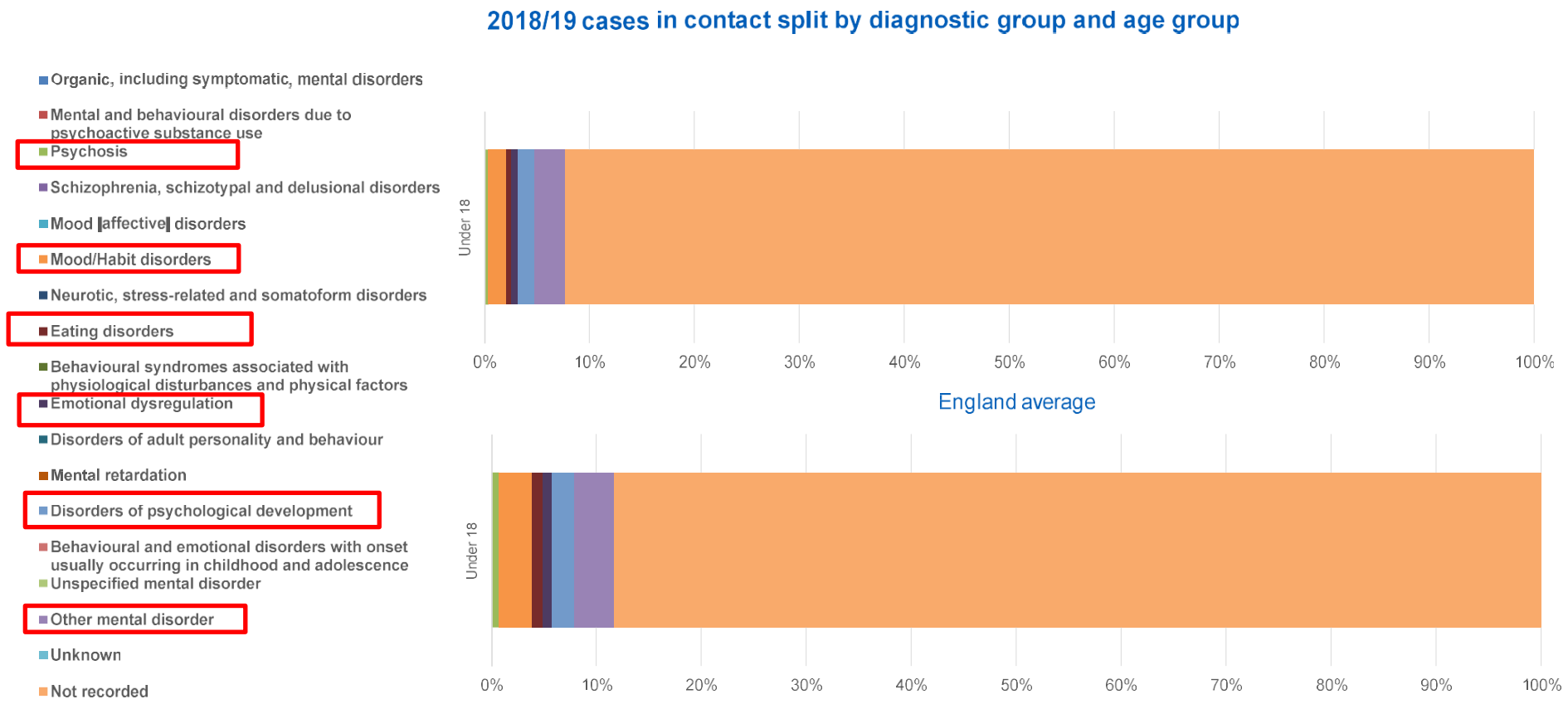
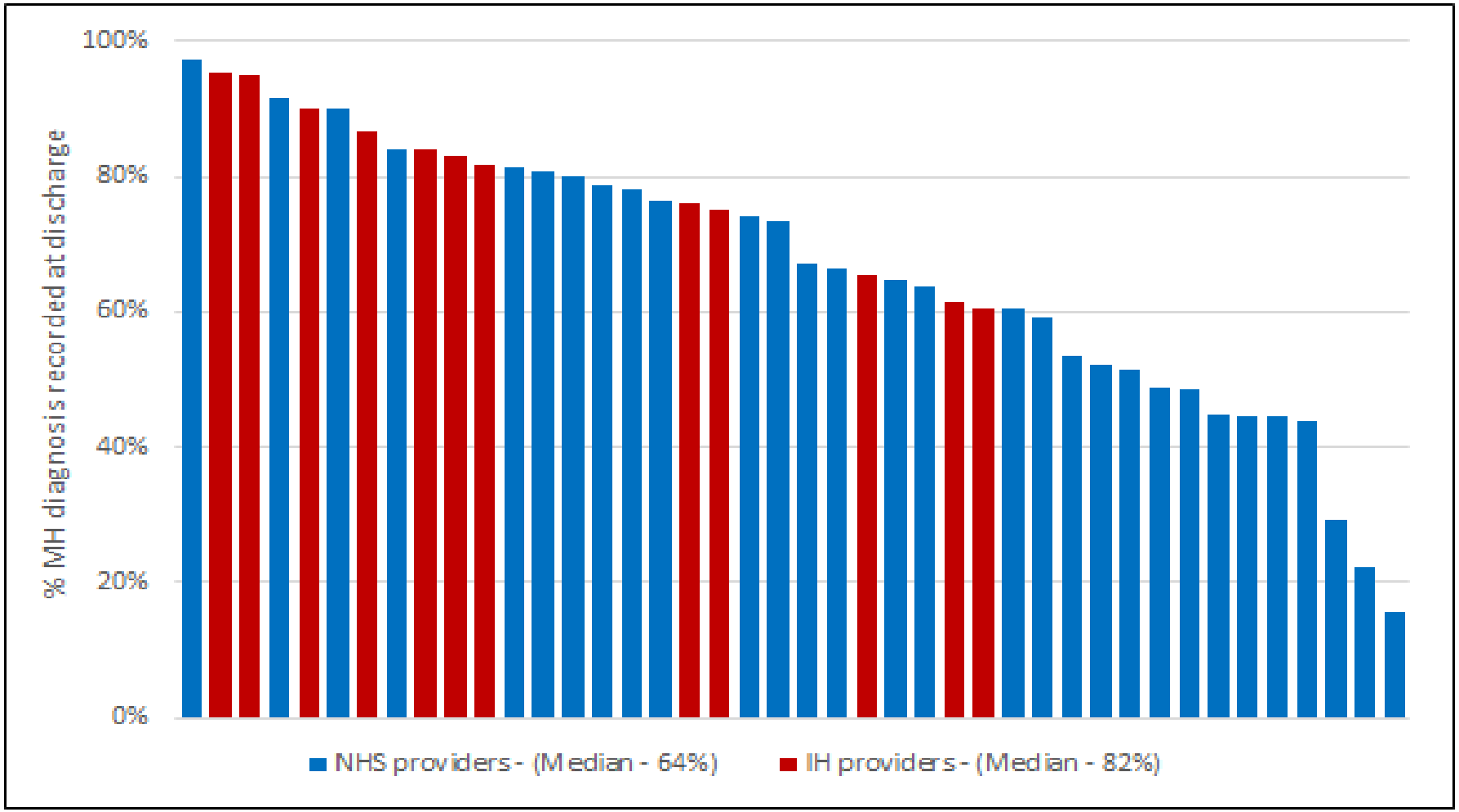


Data source: MHSDS 2018/19

Recorded diagnosis at discharge.



Data source: MHSDS 2018/19

Debate:

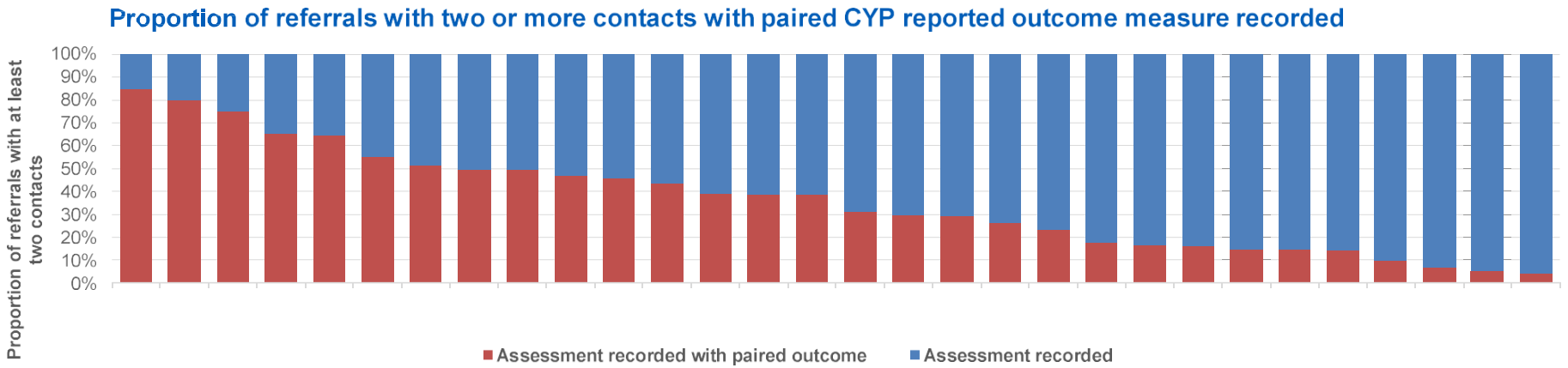
- Should we be recording diagnosis more frequently in CYP?
  - Diagnosis does not always accurately reflect the complexity/treatment package
    - How can formulations be used for data collection. Use of current view or SNOMED CT
  - Diagnosis may change through life-course but stigmatise young people for life
- What is your local understanding of need based on?
  - Referrals?
  - Capacity?
- What is your local productivity/effectiveness based on?
- What is your role in ensuring that there is a clear national understanding of CYP MH services?

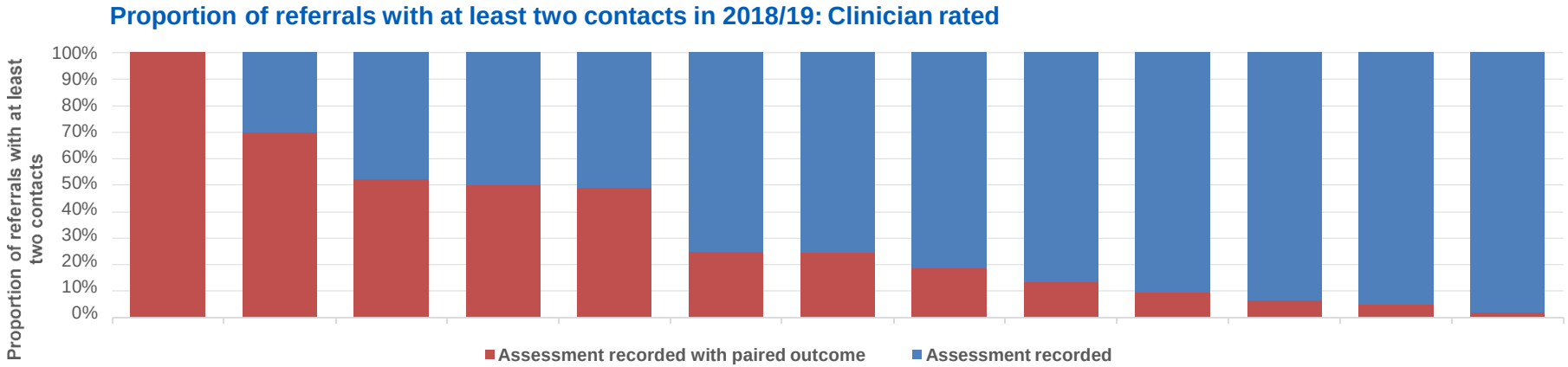
Data Quality and Use

Collection and use of data must be improved across the urgent care pathway.

- All NHS commissioned services must have effective data collection processes to:
  - understand the reason for acceptance into a service, interventions offered and outcome of interventions.
  - This data must be flowed to the MHSDS

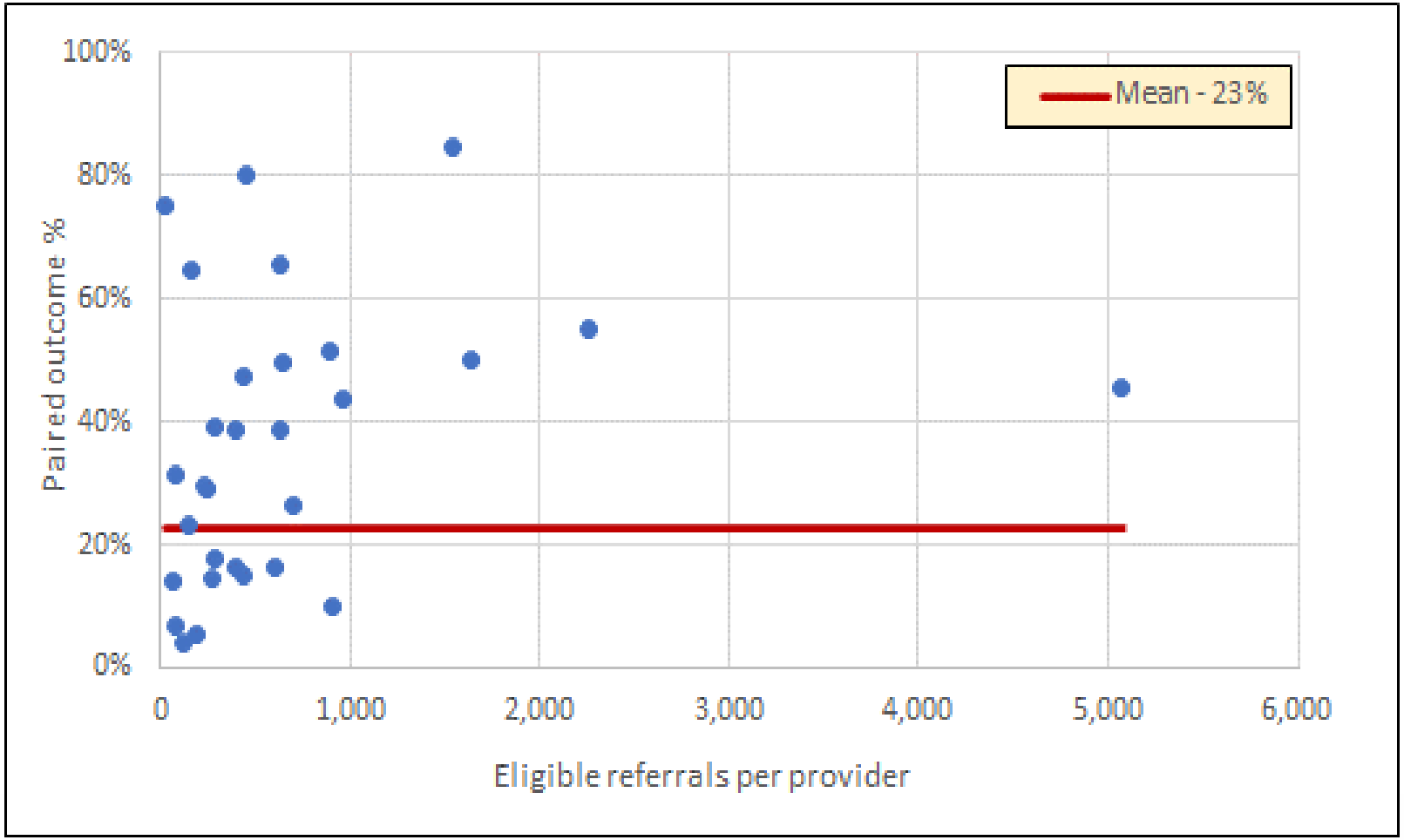
3.13 Proportion of referrals with at least two contacts





Data source: NHS England 2018/19

Paired outcome measure (patient)



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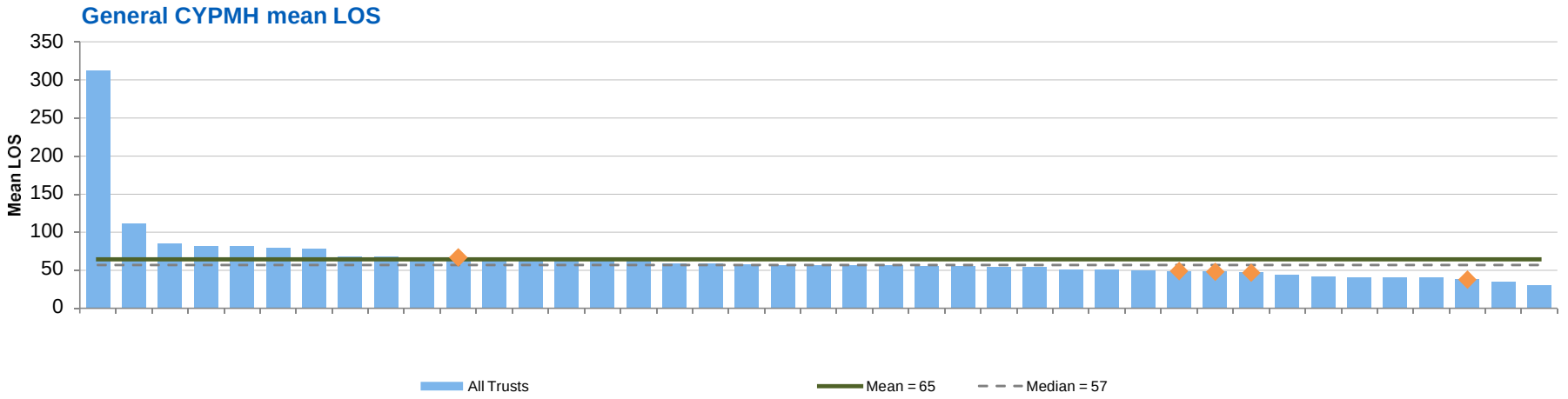
Data source: NHS England 2018/19

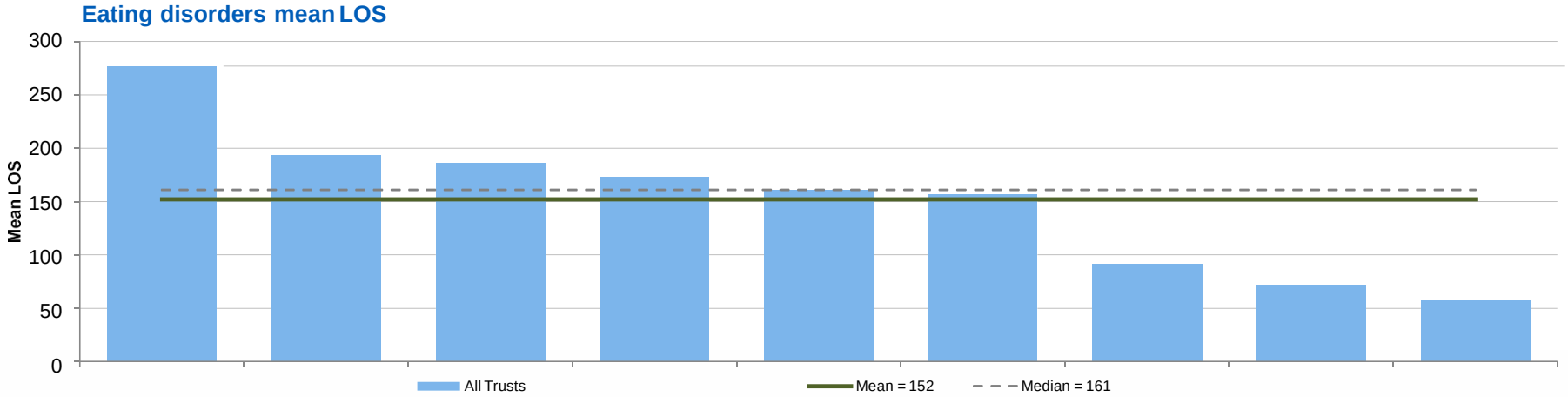
Length of Stay Data

- General admission and eating disorder units only

Trusts with Eating Disorder inpatient services

4.12 Mean length of stay for discharges during 2018/19



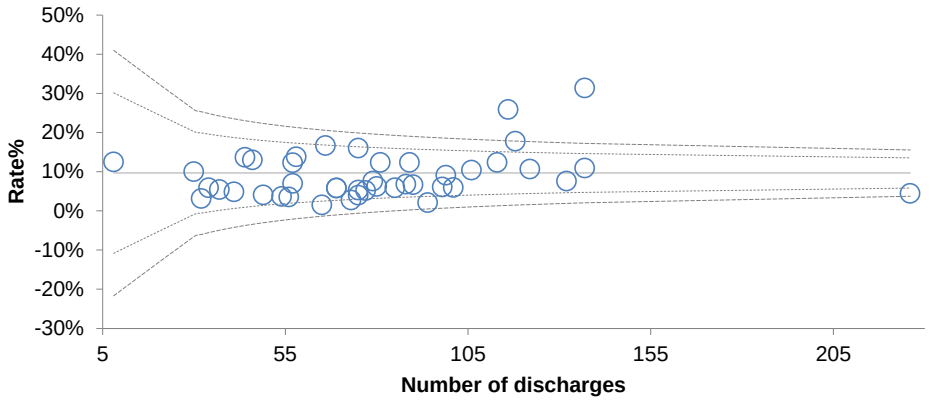


Data source: NHS Benchmarking Network 2018/19

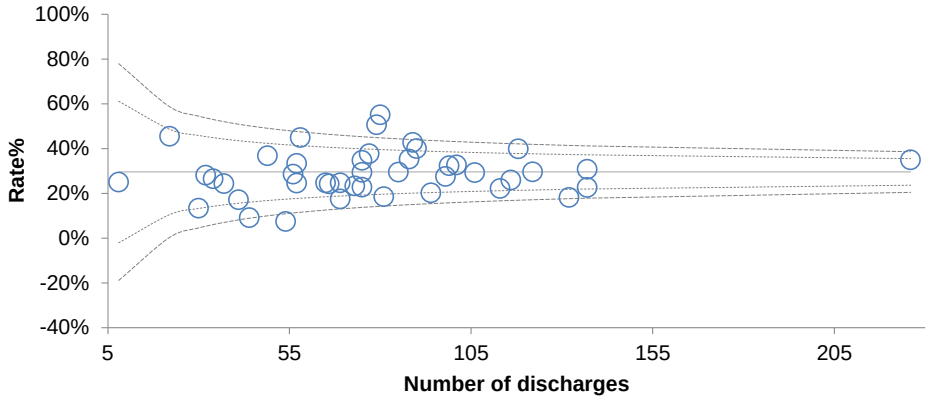
Why is this important?

- If we were to bring all units to the median point (middle value) or below, (55.6 days)
  - Free up 14200 bed days, the equivalent to 300 new beds nationally. (based on 2018/19 data)
- Double this if all units were within the best quartile range (48.3 days)
  - Equivalent of opening up 600 new beds.
- However at a local level need to remain cautious; local data collection and the understanding of what is driving LOS
  - E.g. stratification of data

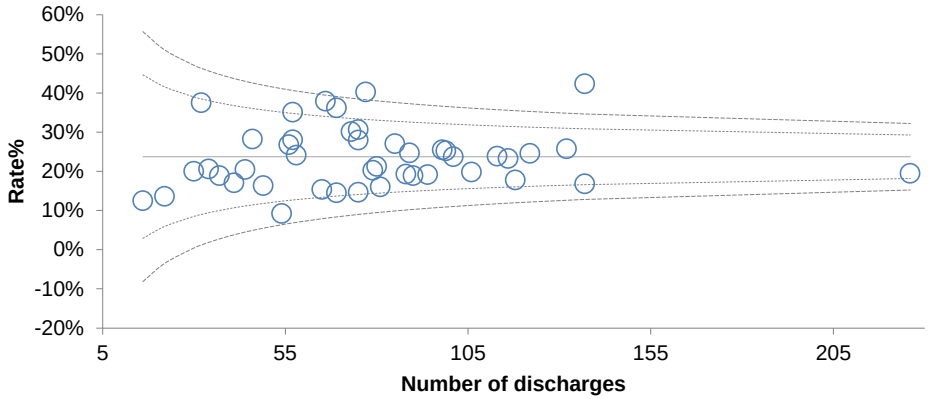
Proportion of discharges less than 7 days - general CYPMH



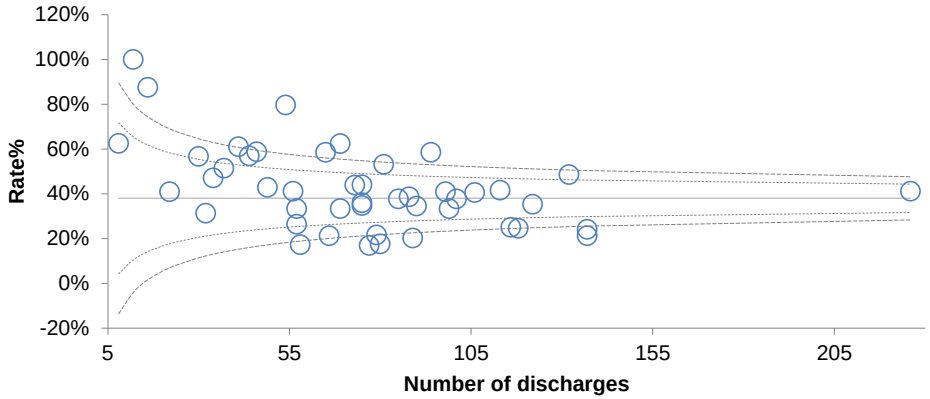
Proportion of discharges 7 to 28 days - general CYPMH



Proportion of discharges 29 - 59 days - general CYPMH



Proportion of discharges 60 + days - general CYPMH



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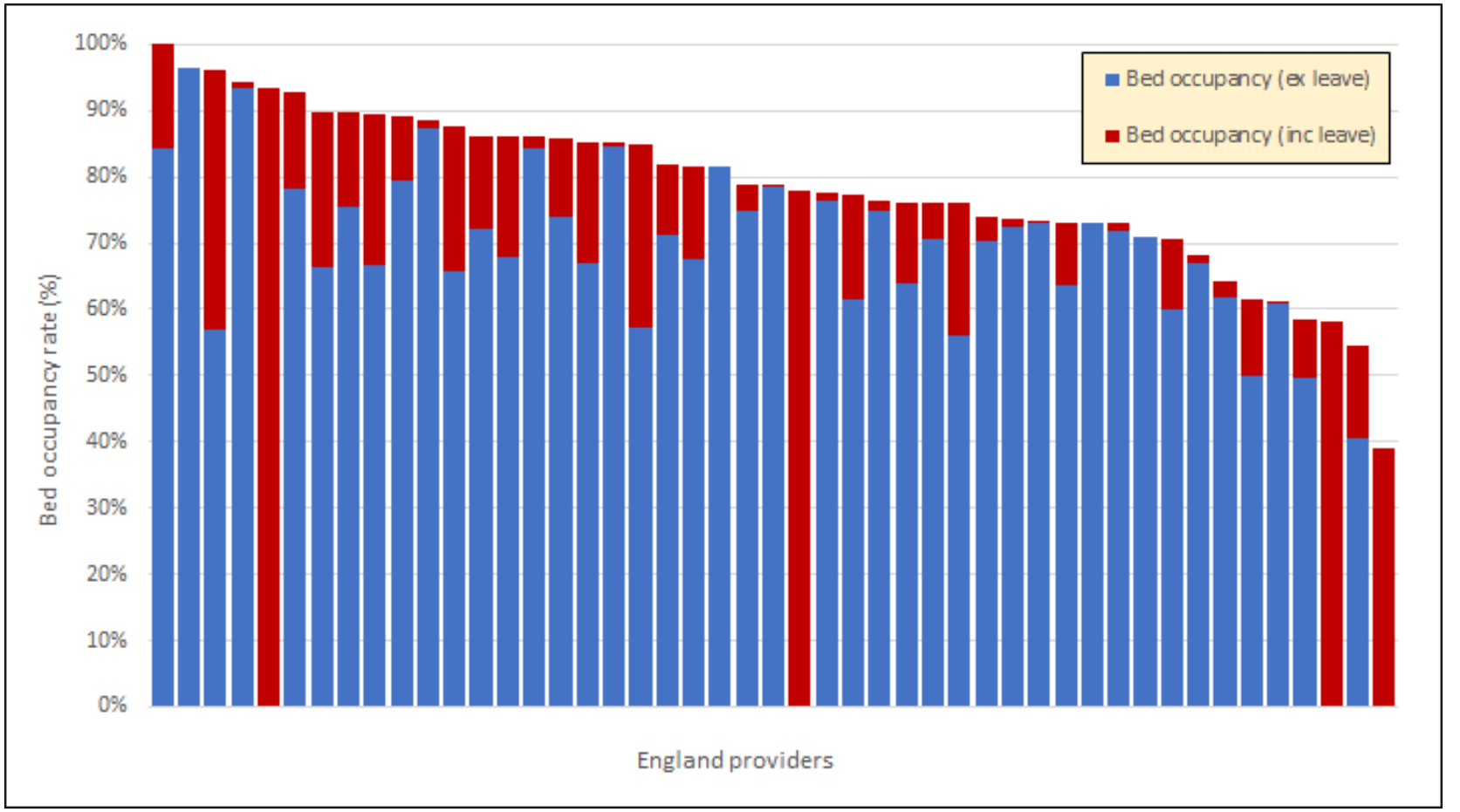
Data source: NHS Benchmarking Network 2018/19

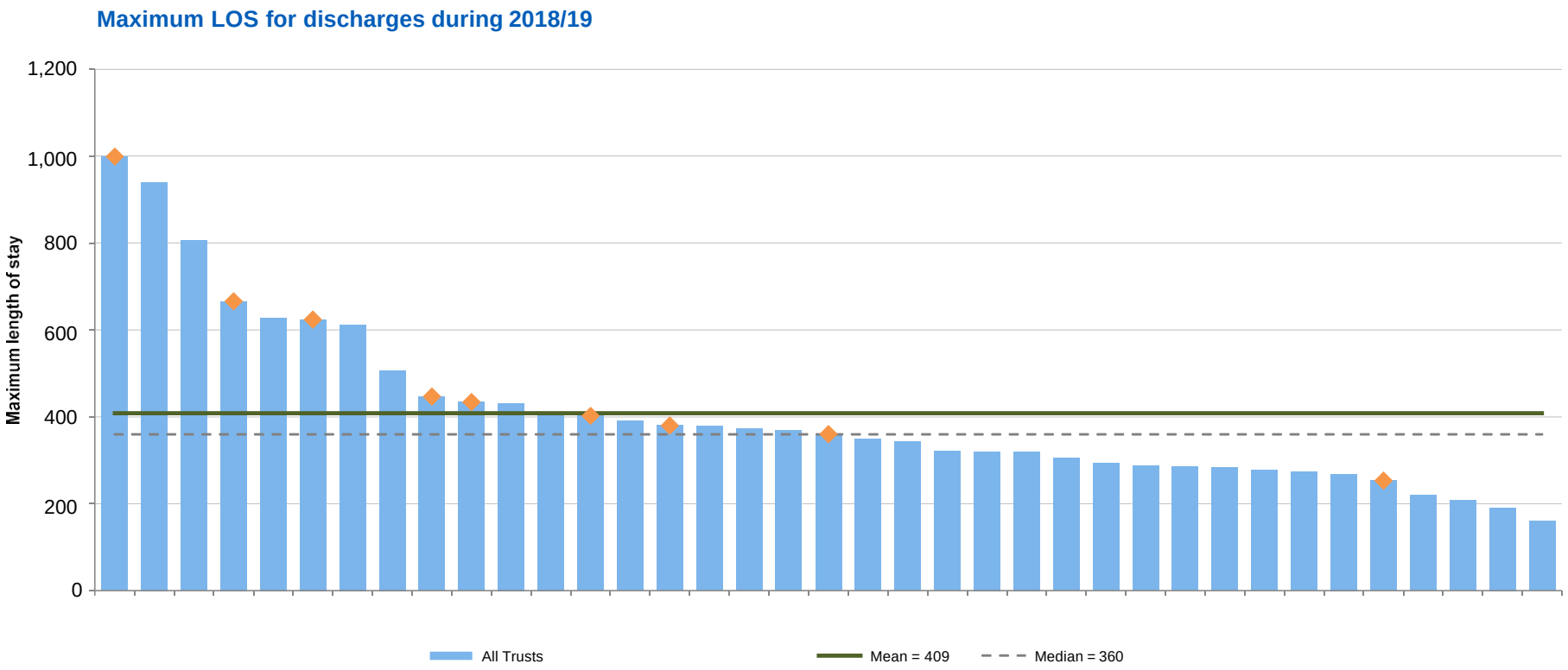
Bed Occupancy



Data source: MHSDS 2018/19

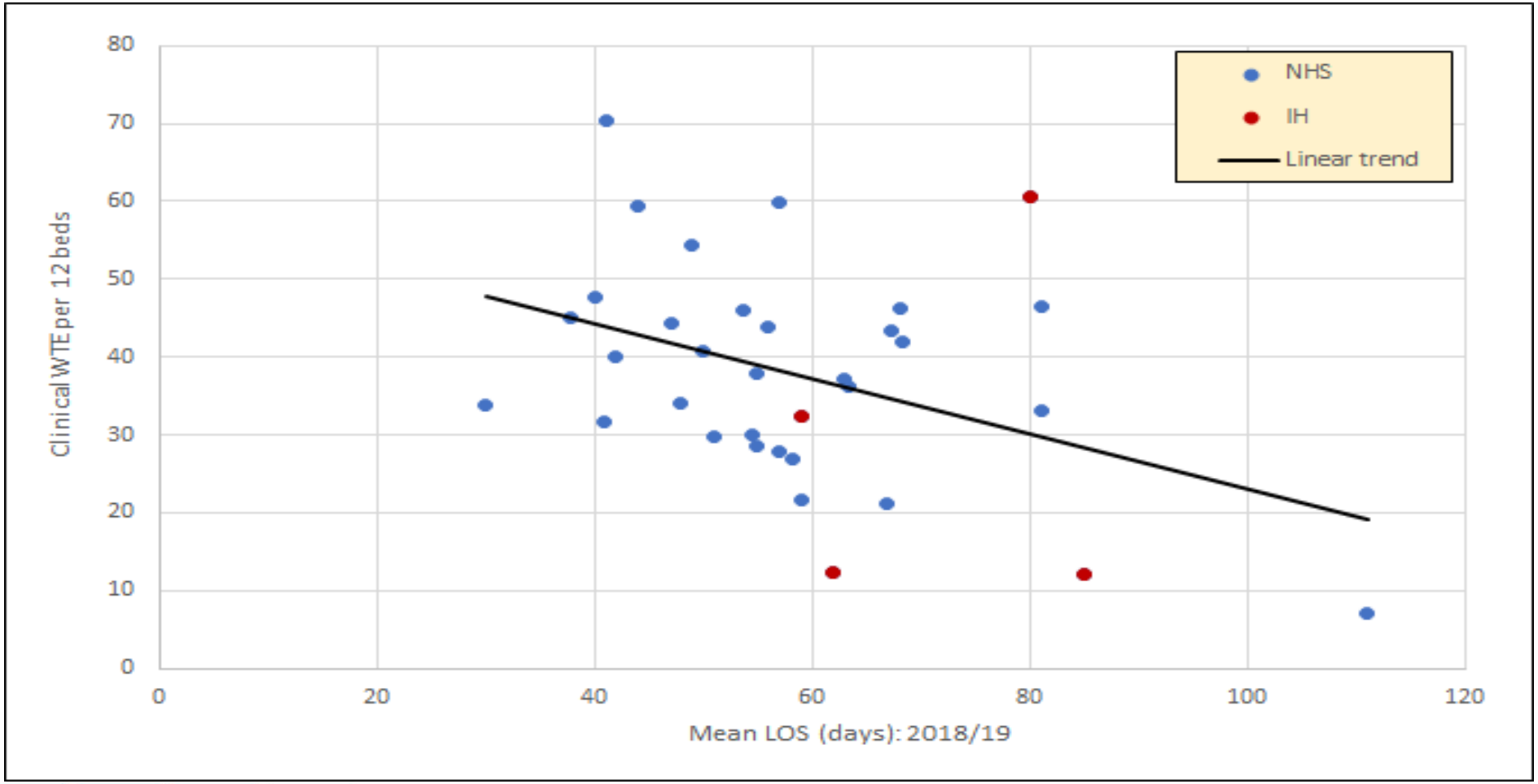
Trusts with Eating Disorder inpatient services

4.13 Maximum length of stay for discharges during 2018/19



Data source: NHS Benchmarking Network 2018/19

Impacting of staffing levels on mean LOS GAU only



Source: NHSBN 2018/19

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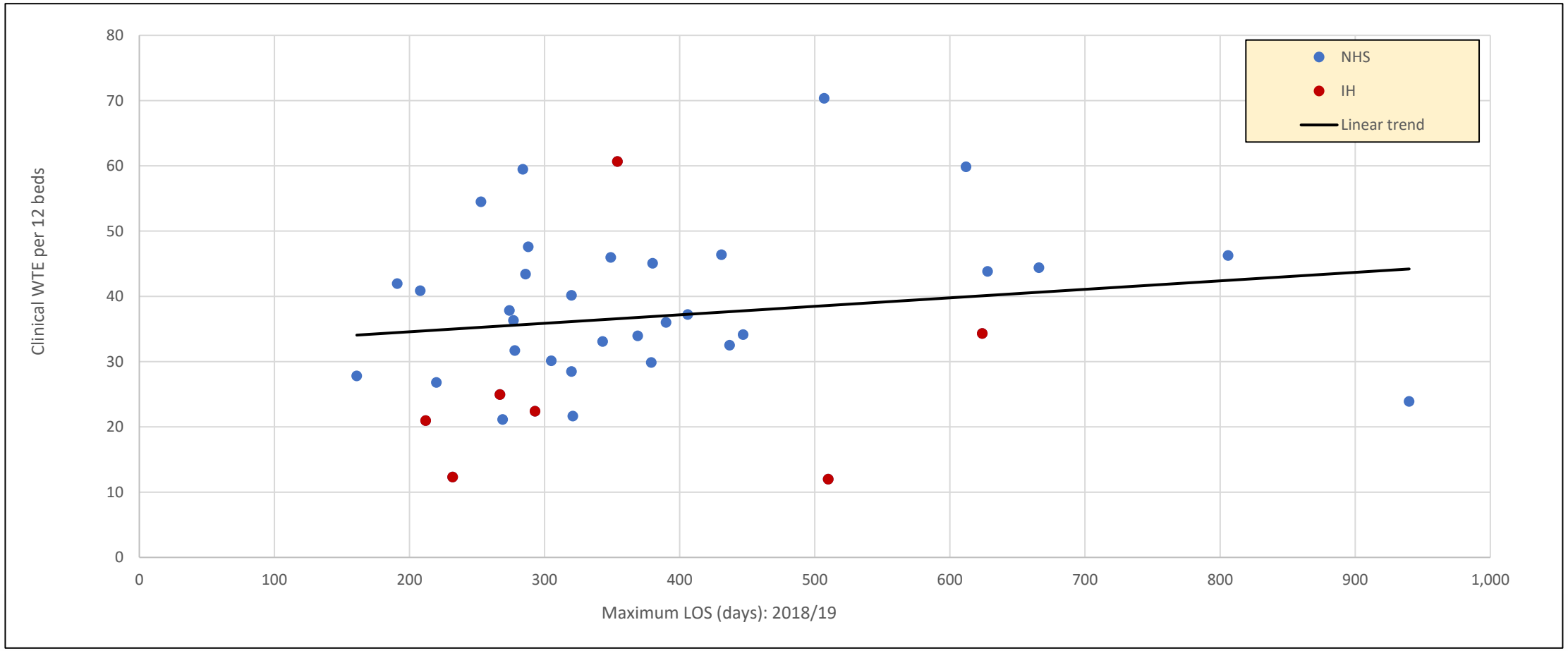
Impact of staffing on maximum LOS (GAU)



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Source: NHSBN 2018/19

Length of Stay

- **Whilst longer admissions are unavoidable and often the most effective and efficient for a young person, too many admissions are longer than required.**
- **Recommendation:** 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.

There must be a guiding principle of discharge being linked to agreed clinical outcomes rather than an arbitrary length of stay.

Note: 60 days used as this is just over the mean position combined with clinical judgement and feedback at deep dive visits.

A collaboration

- Work is a collaboration with all the other work being undertaken at NHSE/I CYP policy Team
  - In particular Steve Jones
- CAMHS SPECOM and clinical reference group
  - In Particular Prathiba Chitsabesan
- The importance of ongoing research/engagement with Royal College of Psychiatry.
  - In Particular Bernadka Dubicka and Kapil Sayal

Guy.northover@berkshire.nhs.uk

@GuyNorthover

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