Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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Open Report on behalf of Lincolnshire Partnership NHS Foundation Trust and NHS England and NHS Improvement (Midlands)

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 July 2021**
Subject:	**Lincolnshire Child and Adolescent Mental Health Services Crisis and Enhanced Treatment Team**

Summary:

This report sets out an end-of-pilot evaluation for the Intensive Home Treatment service within the Child and Adolescent Mental Health Service (CAMHS) Crisis and Enhanced Treatment Team (CCETT) following the temporary closure of Ash Villa in October 2019 and implementation of the new community-based service.

This item has previously been considered by this Committee on 22 January 2020, 22 July 2020, and 17 February 2021.

Actions Requested:

(1) To consider the information in the evaluation of the pilot CAMHS Crisis and Enhanced Treatment Team.

(2) To consider whether to support the view that the CAMHS Crisis and Enhanced Treatment Team would be the new model of care in Lincolnshire on a permanent basis.

1. New Model of Care

A new model of care, in line with the principles of NHS England and NHS Improvement provider collaboratives was designed as an alternative provision to Lincolnshire Partnership NHS Foundation Trust's CAMHS inpatient ward Ash Villa, as this closed at the end of September 2019. The objective of the new model was to prevent unnecessary admission to out of area hospital beds and ensure that children and young people were repatriated back into the community in a timely manner where admission occurs. Whilst this is not exclusively for children and young people at risk of admission or actually admitted to general adolescent units, this will be the main focus as non-general adolescent unit beds (specialist eating disorders, psychiatric intensive care, low secure, learning disability beds) are out of scope from a financial perspective at this stage of the pilot. This would ensure that Lincolnshire children and young people would receive a service to support their needs in the absence of an inpatient facility.

Ash Villa was closed at the end of September 2019 due to a combination of staffing, estates and strategic factors. This closure led to a rapid mobilisation of an interim intensive home treatment team and an operational policy was pulled together in October and commenced on the 4 November 2019. The intensive home treatment team merged with the CAMHS crisis team on the 1 April 2020 to become the CAMHS Crisis and Enhanced Treatment Team (CCETT) to ensure a seamless service and improved journey for young people in crisis.

The data for this report has been taken from local sources as national data is underrepresenting inpatient usage and would overestimate the impact of the pilot. The key for all graphs analysed by month is that red is with Ash Villa and blue is with CCETT.

Previous Committee Consideration

Reports on this pilot have previously been submitted to this Committee on:

- 22 January 2020, which is available at Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 22nd January, 2020, 10.00 am (moderngov.co.uk)
- 22 July 2020, which is available at: Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 22nd July, 2020, 10.00 am (moderngov.co.uk)
- 17 February 2021 Agenda for Health Scrutiny Committee for Lincolnshire on Wednesday, 17th February, 2021, 10.00 am (moderngov.co.uk)

2. Covid-19 Impact

When the pilot was established, Covid-19 and the associated impact on mental health were unknown. Lincolnshire Partnership NHS Foundation Trust (LPFT) continues to monitor and assess the impact of Covid-19 on mental health and the associated increases activity on services. The national expectations are to see an average of 30% increase in demand. Figure 1 shows the number of referrals received by LPFT crisis services since 2017/19. In the last year there has been a 7% increase and in the last two years a 13% increase.

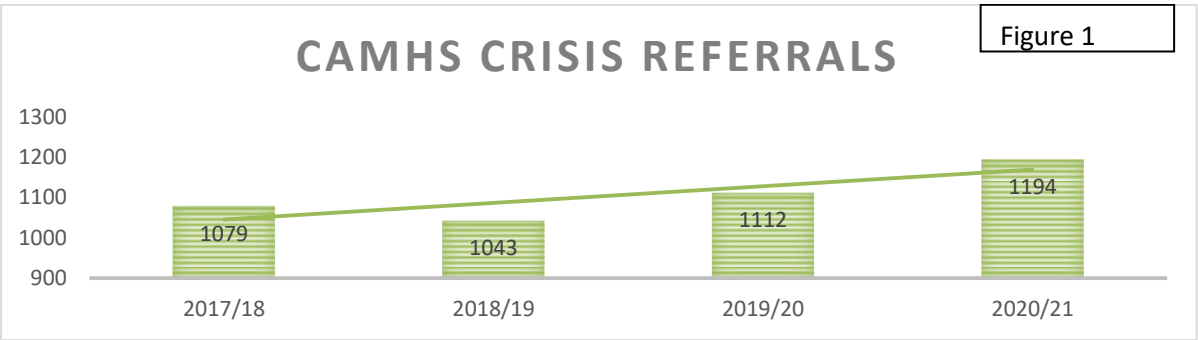
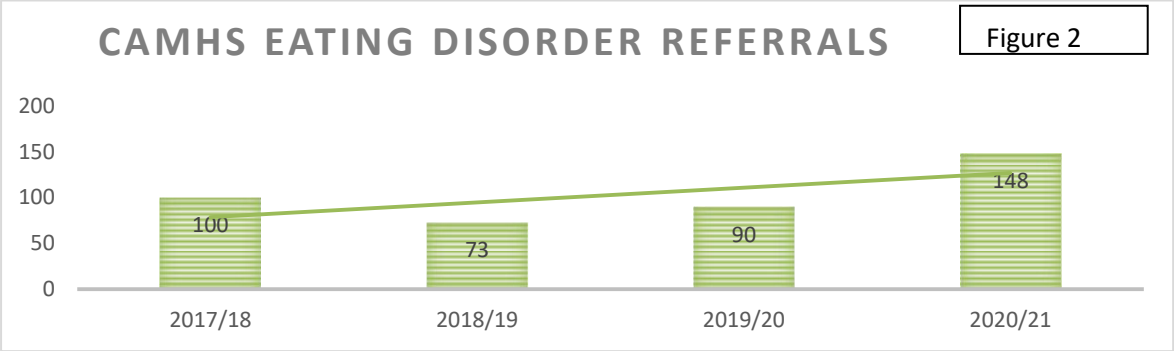


Figure 2 shows the eating disorder referrals into the CAMHS services since 2017/18. In the last year there has been a 39% increase in referrals and in the last two years a 51% increase. Presentations of eating disorder patients in this last year have been higher in acuity than normal resulting in an increase in crisis and home treatment interventions in this group of patients to avoid hospital admission.



3. Success Criteria for Lincolnshire CAMHS Crisis and Enhanced Treatment Team (CCETT)

The success criteria were agreed in advance by the provider and at the time commissioner, NHS England and NHS Improvement specialised commissioning team. They were designed to ensure that the pilot would improve experience, quality and be financially sustainable. The CCETT team successfully kept 97.7% of accepted referrals out of hospital during 2020/21.

Objective	Achieved?
Run at or below 61 occupied bed days per month on average for General Adolescent Units	☺
Have no increase in serious incidents	☺
To receive positive feedback from service users using the experience of service questionnaire and session rating scale	☺

4. Running a Community-based Service in Comparison to a General Adolescent Unit

Performance and Activity

Table 1	2018/19	2019/20	2020/21
Total Admissions General Adolescent Units	46	26	13

Table 2	2018/19	2019/20	2020/21
Mean Monthly Occupied Bed Days General Adolescent Units	168	146	61

The service has managed to avoid admission for 97% of children and young people who have been provided with home treatment in 2020/21.

Figure 3 shows the number of admissions each month into a general adolescent unit bed. This graph shows both Ash Villa Admissions and out of area admissions. Prior to Ash Villa's closure we averaged three general adolescent unit admissions a month. Since the enhanced community team (CCETT) commenced in November 2019, this has reduced to an average of 0.9 admissions a month from 3.4 a month which is a 74% reduction.

Figure 3

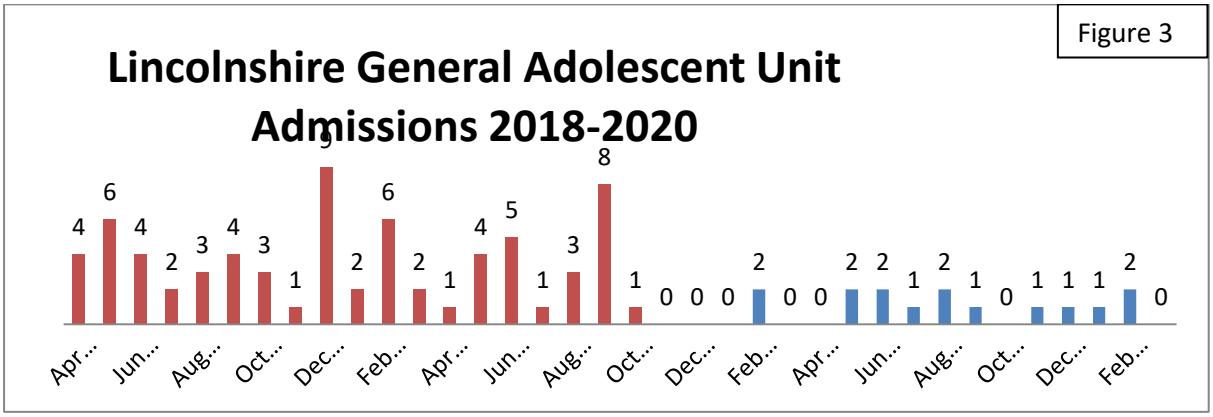


Figure 4 demonstrates that general adolescent unit occupied bed days have reduced by 53% from the 19 months prior to the closure of Ash Villa to the 17 months since the CCETT team has been in operation. In the 2020/21 financial year the service is just over its target of general adolescent unit occupied bed days a month, with 61 occupied bed days on average each month. It is clear from the trend line that general adolescent unit occupied bed days have reduced significantly over the last couple of years.

Figure 4

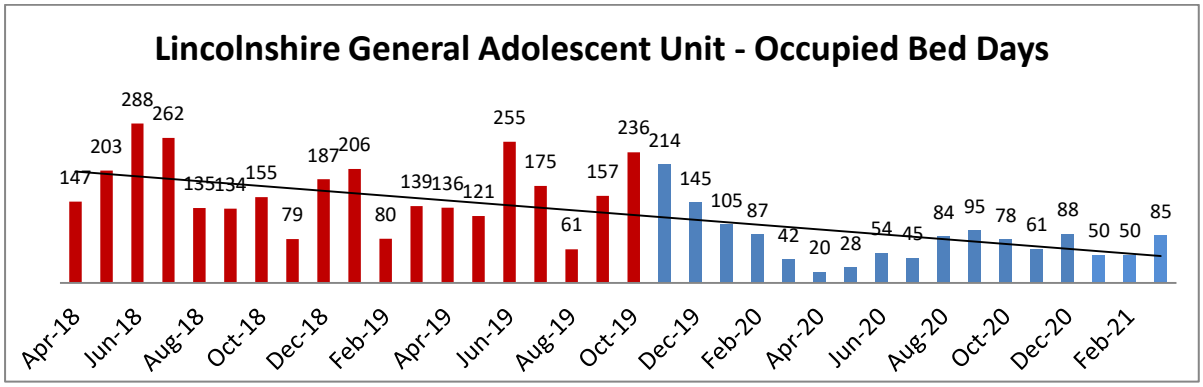


Figure 5 demonstrates that there has been a steady decline in the mean length of stay in GAU beds since Ash Villa closed. There were concerns that not having an inpatient unit may increase the median length of stay for young people as we would have less control in managing discharge. However, the teamwork with inpatient providers, children and young people and families to plan for discharge from the point of admission. The team have been successful at promoting the repatriation pathway and inpatient hospitals have felt confident in the intensive care packages that the team are able to offer. This in turn enables the hospital to discharge quickly and safely.

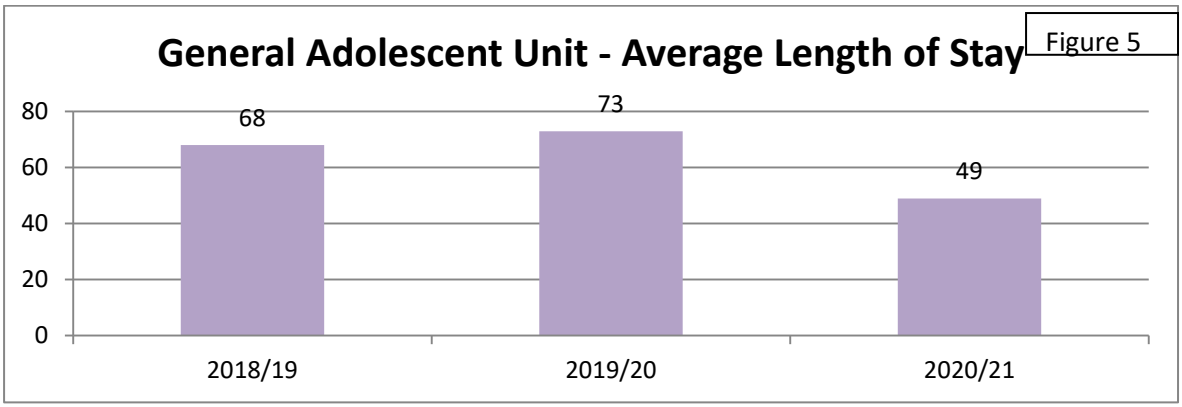


Figure 5

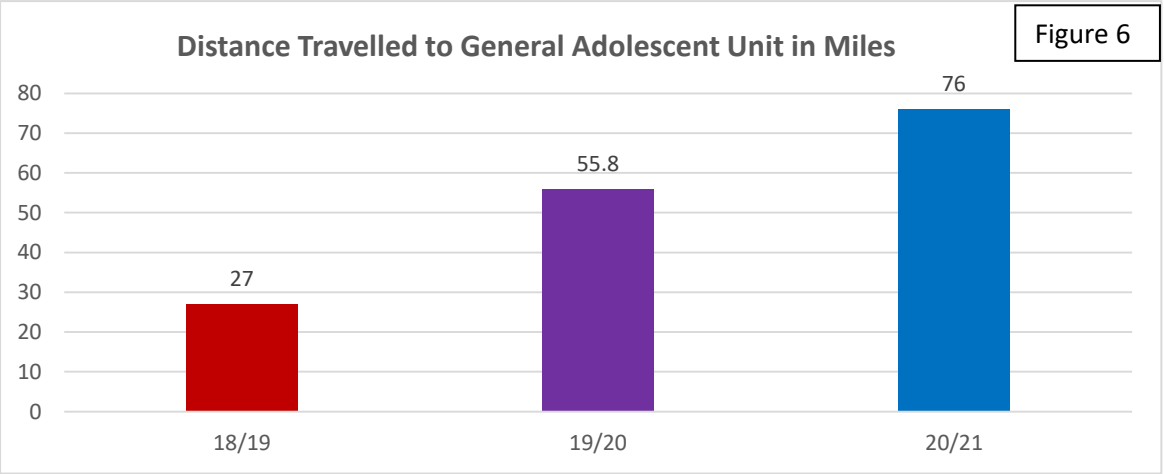
Data from figure 5 can also be compared to the national average length of stay for general adolescent units, which shows LPFT being very much comparable for both 2018/19 and 2019/20, whilst Ash Villa was open. However, a significant positive variance of 49 days for LPFT vs a national average of 71 days in 2020/21 shows the direct impact of CCETT which benefits the children and young people of Lincolnshire in not staying in inpatient care.

5. Equalities

Figure 6 shows the distance travelled in the period before Ash Villa closed was on average 55.8 miles. This was because most young people from Lincolnshire could be admitted to Ash Villa unless it was full and were allocated a bed out of area. This figure is, however, negatively distorted by six admissions, who lived fewer than three miles away from the unit, arguably showing an overuse of the service because it was locally convenient. Since the closure of Ash Villa, the distance children and young people have had to travel averages at 76 miles, which is an increase of 64% between 2018/19 and 20/21. Most young people are able to access beds in the East Midlands area. The significant point to note is that whilst this increase is not insignificant, from 2018/19 to 2020/21 the overall benefit to the population

of Lincolnshire by being able to avoid admissions by 71% and length of stay by 30%. This means that more people are benefiting from the closure of the service than are negatively impacted by increased travel.

Figure 6



There have been 0 admissions for children and young people diagnosed with learning disabilities and or autism since the start of the pilot, showing a success in line with the national Transforming Care programme, of which Lincolnshire was the top performing area in the country in 2019/20. Approximately 13% of referrals into the CCETT team in the last year have been for young people with a learning disability or autism or both. Figure 7 shows the monthly breakdown of referrals in 20/21 into CCETT.

Figure 7

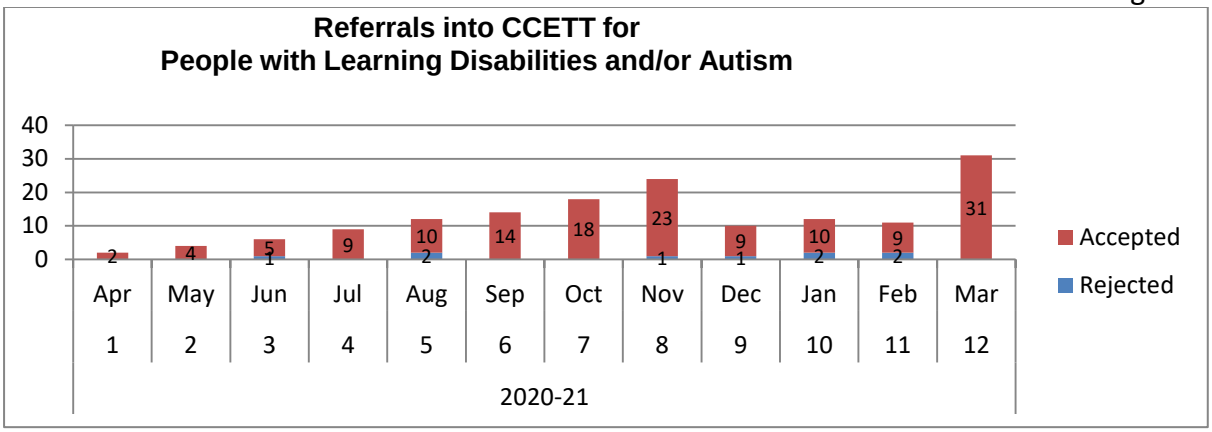
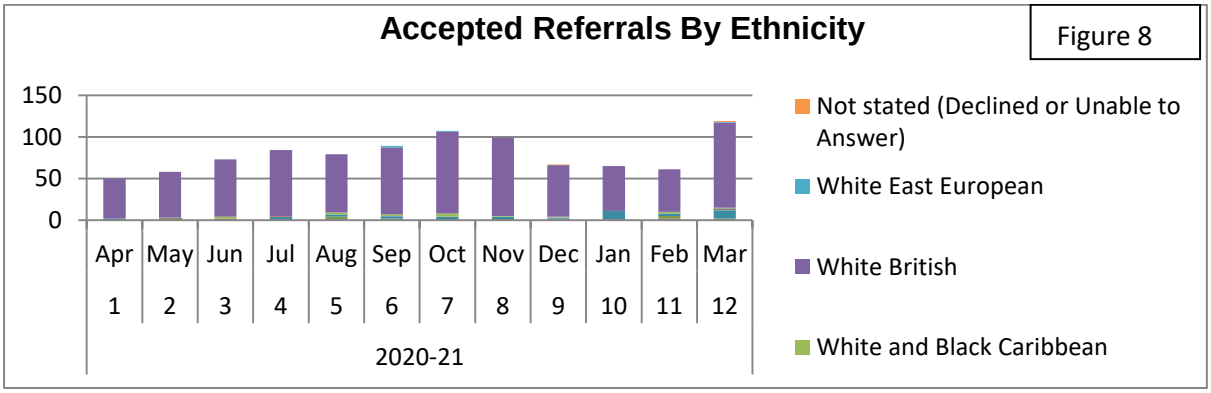


Figure 8, shows the ethnicity make up of referrals into the CCETT this is in line with Lincolnshire demographics.



6. Quality

Figure 9 represents serious incidents, usually categorised by unexpected or avoidable significant harm or death, have stayed at 0 during the whole of 20/21. This metric will be continuously monitored as the service would not be considered effective if there was an increase in serious incidents and the root causes analysis established that the closure of Ash Villa, or providing intensive support in the community were a factor in why incidents were occurring.

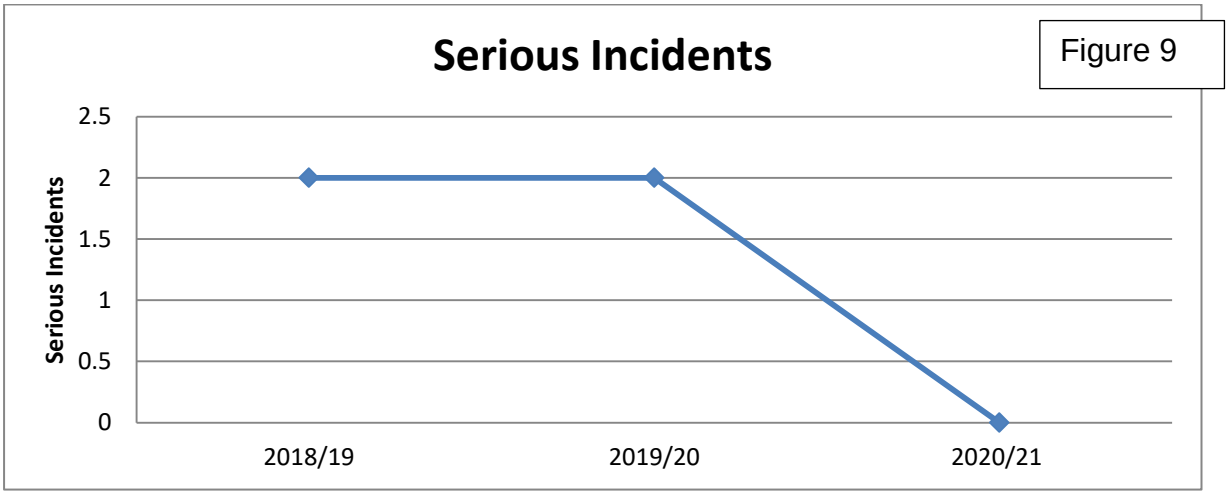
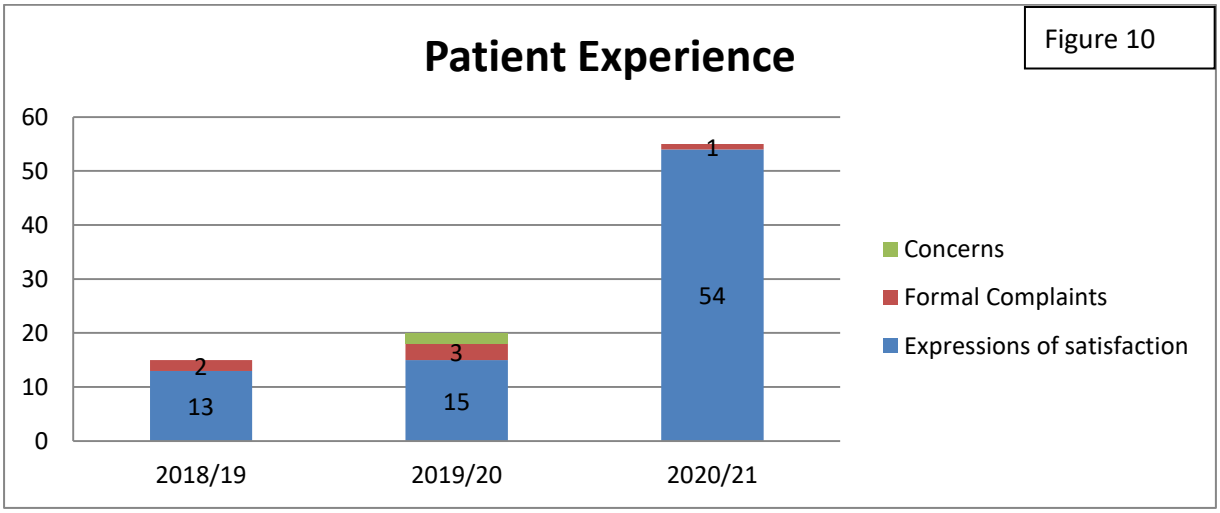


Figure 10 shows the new service has seen a reduction in complaints and concerns. The formal complaints across all 3 years relate to Ash Villa, with no complaints relating to the new service. Positive feedback has increased significantly as the service has developed and comes in greater volume than Ash Villa saw.



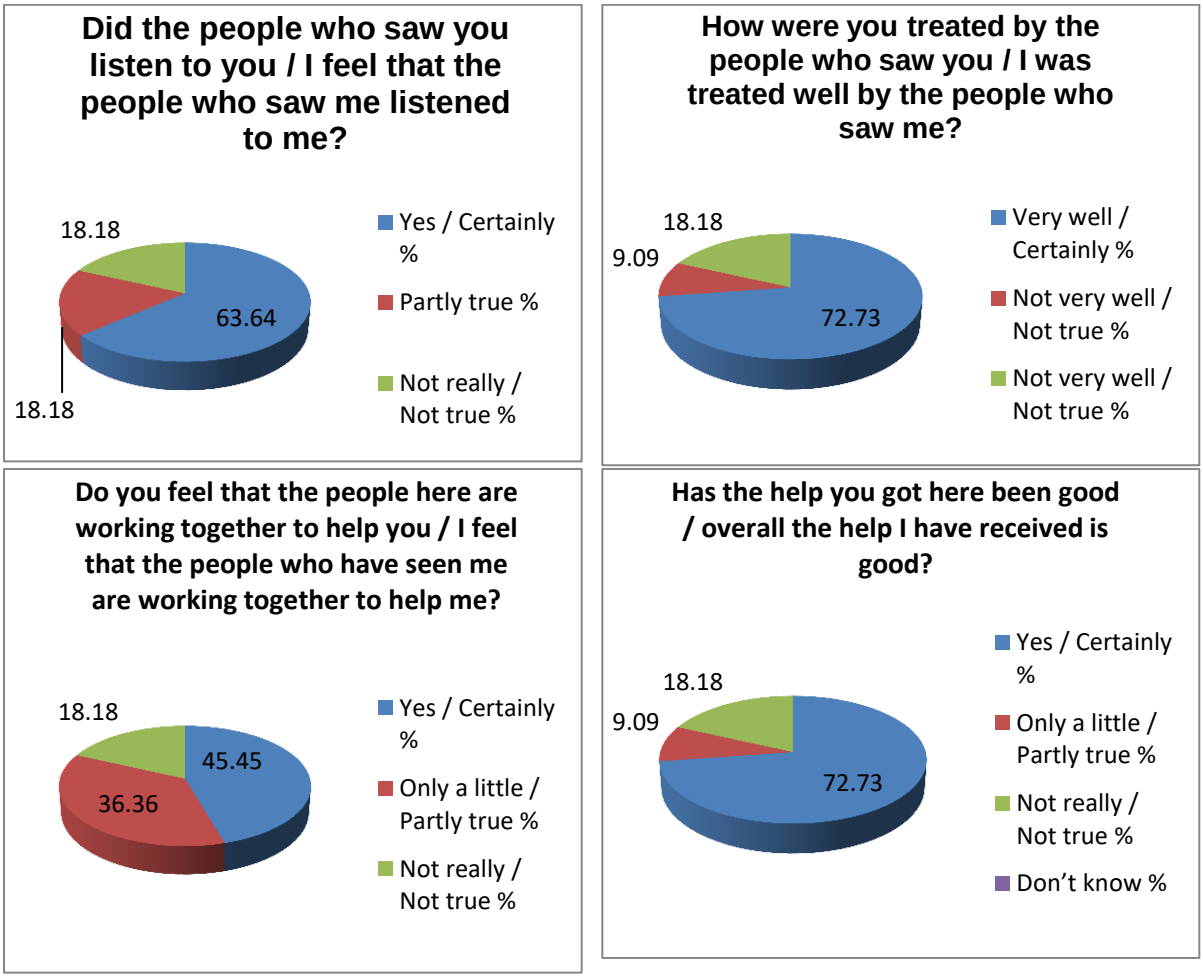
The following includes comments relating to LPFT services and has been unaltered from a consultation run by NHS England/Improvement in 2021 re the change of service from an inpatient to community service.

Questions	Comments
Community service – did you find the service helpful?	• Yes helpful (patient) • Patient experienced Ash Villa and community pilot – positive about both but extremely positive about the community option/not having to go anywhere (patient) • Flexible and responsive (professional) • Immediate response when needed (professional) • Sometimes helpful sometimes not. Not helpful that have to ring rather than text after 5pm but feels they were helped a lot (patient) • The team have been brilliant (carer)
Inpatient service – did you find the service helpful?	• Didn't find treatment helpful apart from art and activities (patient)
Anything that could have been better?	• More support for eating disorder/support around meals in particular (patient with reference to the community model) • Not having constant rotation of staff (patient re: community model) • Operating after 7pm as young people can struggle in the night (professional re: community service) • Improved transition to adult services (patient re: community services) • Earlier intervention (carer)

Questions	Comments
Preference for model – inpatient or community	• Strong preference for the community model (patient) • Prefer community but dependent on needs (patient) • Strong preference for the community model (professional) • No preference but thinks the distance to travel to an inpatient unit is too far (professional) • Depends on the patient (carer)

Feedback and pie charts from the experience of service questionnaire feedback forms. This shows more detail as to some of the feedback from service users and external professionals.

Stakeholder	Comments
Young Person	"They explained everything really well and it was very helpful" "the people were lovely and caring" "the staff listened to me and it felt like they actually wanted to help" "the people I worked with are nice and easy to get along with. One of the most helpful things was the reassurance I was given when I didn't know what to say and I wasn't forced to answer questions"
Parent/Carer	"G**** was absolutely amazing with him" "I would have liked a little more interaction so that I knew what was being discussed whist recognising the need for confidentiality. Not all teenagers will discuss what the sessions cover."
Professional	"I just wanted to say how amazing the work you're doing keeping children and young people out of hospital is. Thank you and keep it up."



7. Case Studies

Case Study 1

Following the national enforced lockdown in April 2020, the young person who is central to this case study (and will be referred to as 'Ben') presented with a significant increase in anxiety levels, negative perception of self and subsequent restricted eating which resulted in a significant weight loss and physical impairment which required admission to acute paediatrics in late April.

The initial assessment and subsequent intervention was provided by the CCETTs team at this time for the duration of circa twenty weeks. Intensive CCETT intervention initially entailed attending the paediatric ward twice daily in order to support the paediatric nursing team and promote re-feeding. This episode of care entailed formally assuming the Care Co-ordinator role under the Care Programme Approach and the convening of multiple professionals meetings, requesting indicated CCG Care, Education and Treatment Review assessment and attempting to work towards Ben and his family's wish to achieve discharge home to work further with the service in the community.

Ben and his family's goal to return home was initially met after achieving pre-identified physical health and weight gain parameters after a six-week paediatric admission. Daily CCETTs input continued both during the inpatient admission and following discharge home and included occupational therapy, cognitive behavioural therapy and additionally accessed dietetic input. However, Ben's relationship with food would not significantly alter and they subsequently required two further paediatric hospital admissions for further weight restoration purposes. Throughout the CCETTs team worked intensively and collaboratively with Ben's parents, the medical team, social care and the CCG in an attempt to collaboratively promote engagement in treatment and prevent the necessity for admission to a specialist eating disorder unit.

Collaborative care planning required on-going daily CCETTs intervention (both whilst on the ward and at home) and entailed the development and subsequent amendment of multiple bespoke plans of care to support Ben's re-feeding and psychological well-being. The later versions of which requiring the deployment of a team of suitably trained individuals within the team to provide least restrictive physical interventions to support three meals a day whilst remaining on the paediatric ward whilst under the parameters of the Mental Health Act, Section 2.

On initial receipt of the referral, it was being explicitly requested that Ben be transferred from the paediatric environment to a specialist mental health eating disorder environment. However, after working collaboratively with the ward, Ben and his family, it became evident that the young person and their family's goal-based outcome was to avoid mental health inpatient admission, achieve weight restoration and be able to return home where they may subsequently access and engage with specialist eating disorder service community provision locally. This outcome was subsequently achieved after 20 weeks of intensive CCETTs input (both within the home and hospital setting), which subsequently avoided the need for specialist eating disorder unit admission. However this was not initially supported by the Care, Education and Treatment Review process and achieved Ben's goal-based outcome to return to the consistency and familiarity of their home environment whilst accessing indicated on-going health and social care provisions.

The episode of care is demonstrative that an enhanced level of crisis support and intervention (thrice daily input at some stages) can support in achieving mental health stability and respond to the risks associated to an episode of mental crisis without the requirement of mental health hospitalisation.

The episode of care required an immediate identification of an acting Care Co-ordinator (CCETTs Clinical Lead) who subsequently quickly identified the necessity for multi-disciplinary mental health team involvement and subsequently assembled the team, which consisted of the consultant psychiatrist, two clinical leads, an occupational therapist and multiple CCETTs practitioners based both within the North and South of the county.

The Clinical Lead subsequently organised and facilitated weekly meetings with the Paediatric Team, organised staffing to attend and support within the paediatric environment and continued to work therapeutically with both the Ben and the family. Additionally within the acting Care Co-ordinator role multiple further liaisons were had with social care, the CCG, Mental Health Act legal teams, the Trust's Prevention and Management of Violence and Aggression team and secondary CAMHS services (Eating Disorder and Core Services) in order to identify to promote safe practice and the achievement of positive recovery outcomes for Ben.

The episode of care is demonstrative that an enhanced level of crisis support and intervention can support in achieving mental health stability and respond to the risks associated to an episode of mental crisis, without the requirement of mental health hospitalisation. Imperative to this was the responsive acceptance of an acting Care Co-ordination role and the actioning of indicated clinical responses/actions. Furthermore, the Multi-disciplinary make-up and involvement within the CCETTs team (psychiatry and occupational therapy) aided the achievement of the positive patient outcome.

Ben and family regularly expressed difficulties engaging with multiple clinicians from the team and different agencies at this time. Therefore, best attempts were made to limit the involvement of multiple clinicians and provide supportive intervention responsive to the wishes of the family (particularly within the home setting).

Lessons learnt being the timely arrangement of a CETR (by the CCG) and then outcomes of said formal reviews not accurately capturing the discussions and information presented in the meetings. Furthermore, the clinical case highlighting some disparities between clinical and safeguarding needs and demonstrated a need for improved multi-agency working practices, communication and subsequent actions (Health, social care and CCG's).

From a CCETTs perspective the episode of care highlighted the need for an increased number of clinicians to be trained in prevention and management of violence and aggression within both the CCETTs and the wider community CAMHS teams, should individuals further require physical intervention/assistance for re-feeding purposes (under either the safeguards of the Mental Health Act or parental consent). Furthermore, it identified the need for on-going specialist community teams to be more responsive and efficient in commencing their assessment process in order to assist a timelier move towards recovery after the initial severity of crisis has subsided.

Case Study 2

This involved a young person (who shall be referred to as Sarah) with a long history (three years plus) of accessing Community CAMHS for therapeutic intervention in relation to difficulties of a complex multi-trauma nature, presented with an increase in significant self-injurious behaviours (incidents of self-induced poisoning and lacerating limbs) resulting in six A&E attendances within a seven day period.

Subsequent inpatient admission was discussed and sought by the Community Consultant Psychiatrist for risk management purposes. There was limited opportunity to provide enhanced home treatment model of care aimed at maintaining safety and preventing admission, as inpatient admission had been promoted as a treatment option to the patient and family prior to referral to CCETTS.

A subsequent brief 4 inpatient admission ensued for risk management purposes. During the admission the CCETT's Clinical Lead provided regular in reach and communication to the ward as per the Repatriation Pathway and associated agreed timescales. The Clinical Lead subsequently assumed the role of Acting Care Co-ordinator, which promoted and subsequently appropriately planned for a safe and supportive discharge eleven days following admission in order to allow the provision of a collaboratively agreed episode of indicated home treatment as per a trauma pathway.

Early discharge supported and facilitated from the inpatient environment after a period of 11 days duration. Following discharge from the inpatient environment and implementation of the Repatriation Pathway and subsequent trauma pathway interventions, Sarah, has maintained their safety and not engaged in any further significant risk behaviours of concern.

The episode of care required an immediate identification of an acting Care Co-ordinator (CCETT's Clinical Lead) who subsequently quickly identified the necessity for collaborative working with both the patient, their family, the inpatient unit and the Community CAMHS teams within Lincolnshire.

The Clinical Lead subsequently organised and facilitated daily communications with the inpatient team in order to identify and to share previous clinical knowledge and safely plan for a timely supported discharge with on-going indicated crisis care, whilst also making subsequent CPA planning arrangements for post-discharge.

Sarah could possibly have been internally referred to CCETTS approximately two weeks earlier when initially voicing and presenting with risk ideation/intent of concern. It was apparent that referring to CCETTS (enhanced home treatment team) following previously promoting inpatient admission as a treatment option, that likelihood for successful home treatment which would reduce the need for inpatient admission was significantly impaired.

Therefore, considered that this case has highlighted the need for timely referrals to CCETTS and that potential inpatient admission may be best discussed and explored with patients and their families by the team who access assesses for inpatient admission (CCETTS).

The patient has reported that they would not wish to access a further inpatient admission and thus states a desire and consideration that they can maintain their safety in order to avoid such. Furthermore, said experience has resulted in greater co-ordination of said patients community mental health care and the safety/containment to engage in the indicated and required trauma pathway intervention, which is reflected by a significant reduction in the severity (and reported intent) of self-injurious behaviours.

8. Staff Experience

Feedback from clinical staff working within the CCETT team has indicated that they believe a community approach is more beneficial than an inpatient one, with the main theme being it gives greater opportunity to maximise independence and allow people to live their life in a way meaningful for them away from institutional settings, in line with the core principles of a recovery philosophy. They value having a multidisciplinary model that increases the access to specific therapies and treatments and being able to do this in a residential environment amongst family and still having access to their school and community adds value.

It is also a belief of team members that relationships with families and professionals are more consistent and supportive for families, who develop relationships with core staff members. This allows our staff to help and guide them through the challenges they are experiencing, rather than handing over the care of their child to a hospital setting, sometimes a long way from home. Staff are all aware that although sometimes admission is a necessary and where this will add to a person's quality of life is considered as part of a discussion around treatment options with children and young people and families.

Similarly when young people have been admitted, staff are of the belief that this model can give enhanced support on discharge in their transition home and this is able to be done in a more timely way due to the CCETT teams presence at ward rounds and Care Programme Approach reviews as they are able to be fully involved in discharge planning. Therefore, young people and families are less likely to feel abandoned by the local services, as their contact is consistent throughout the admission.

Staff are conscious that parents and carers may find treatment at home more challenging than hospital admission, as it can have a large impact on other areas of their lives, such as employment, family relationships and from a social perspective and always consider this with the families when discussing treatment options and supporting families in balancing the risks.

9. Finance

	2018/19	2019/20	2020/21
General Adolescent Unit Activity Costs (mean monthly total)	£92,354	£80,162	£33,825

Whilst the primary purpose of this pilot was a quality initiative to establish whether it was possible to provide an alternative to hospital in the community, it must be affordable. Fortunately, the cost of running the service, even with the requirement to fund a relatively low amount of general adolescent unit inpatient activity, makes it cost saving.

10. Assessment

The service has met the success criteria defined with NHSE/I prior to the implementation of the model. It is keeping the vast majority of children and young people in their usual place of residence in affordable way, and improving patient experience.

Added Value for non General Adolescent Unit Beds

Table 1 - Total Admissions	2018/19	2019/20	2020/21
Specialist Eating Disorder Units	7	14	5
Learning Disabilities Units	2	1	0
Low Secure Units	3	1	2
Psychiatric Intensive Care Units	2	2	2

Table 2 – Mean Monthly Occupied Bed Days	2018/19	2019/20	2020/21
Specialist Eating Disorder Units	56	130	80
Learning Disabilities Units	40	40	0
Low Secure Units	22	27	28
Psychiatric Intensive Care Units	44	27	54

Figure 11 shows that the number of specialist eating disorder admissions (SEDU) have also reduced. There were seven admissions in 18/19, 14 admissions in 19/20 and 20/21 there were five admissions. Eating disorder admissions from Lincolnshire had doubled between 2018/19 and 19/20 and eating disorder admissions across the country have continued to increase with bed placements becoming increasingly difficult to secure. It has been a great success therefore that in quarters 1 and 2 of 2020/21 there were no eating disorder admissions; and in quarters 3 and 4, there was a marked increase in the number of complex eating disorder presentations both locally and nationally. These often did not become known to services until they were in a very poor physical condition requiring immediate hospitalisation. The team has been working closely with the local general hospital to support patients to provide the appropriate care needs. This success in reducing eating disorder admissions has not been at the expense of increased admissions into general adolescent unit beds.

It is worth noting that psychiatric intensive care unit admissions have remained very similar between 2019/20 and 2020/21, with no learning disabilities general adolescent unit admissions and two low secure unit admissions since the CCETT service became operational.

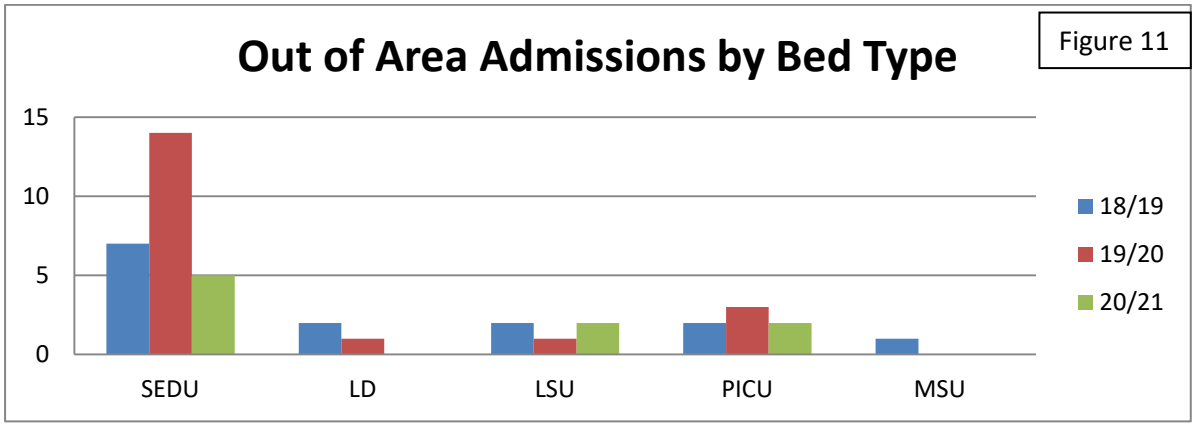


Figure 12 shows the total monthly admissions of young people into all bed types. In the 15 months prior to the introduction of the CCETT team there averaged 5 admissions per month. In the 14 months since the CCETT team commenced this has reduced to an average of 1.7 admissions of any bed type a month which is an 64% reduction in all admissions since the CCETT team commenced.

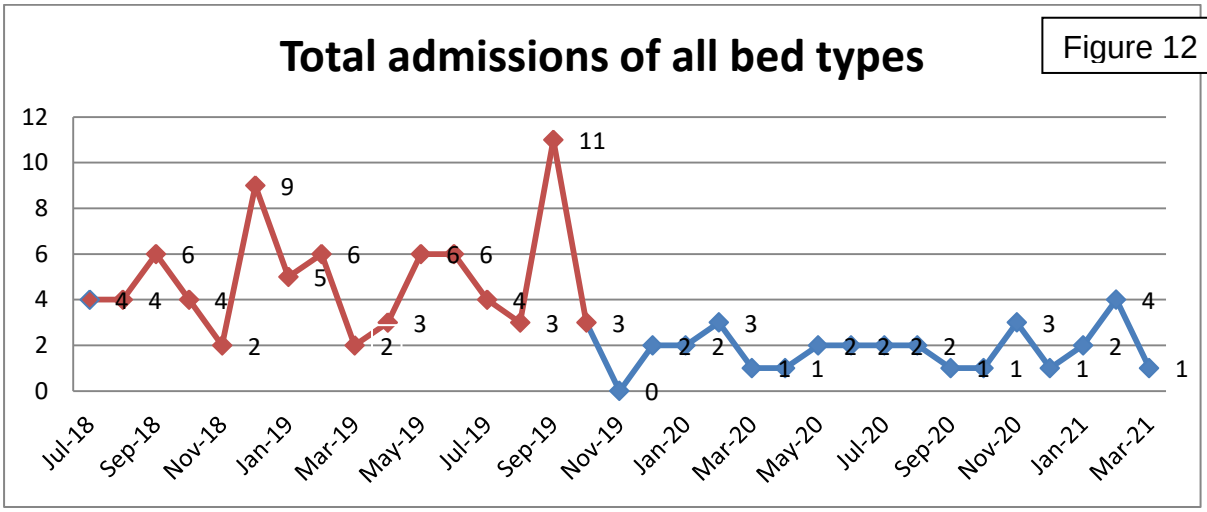
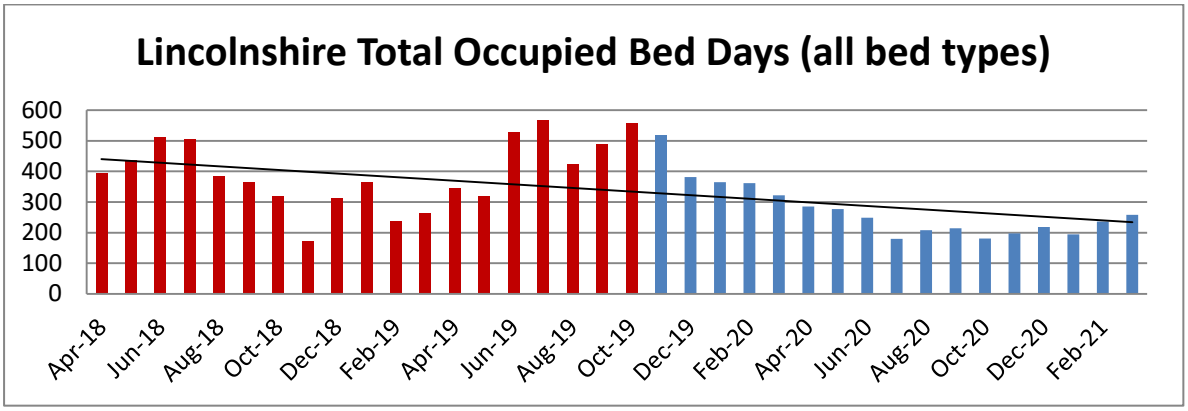
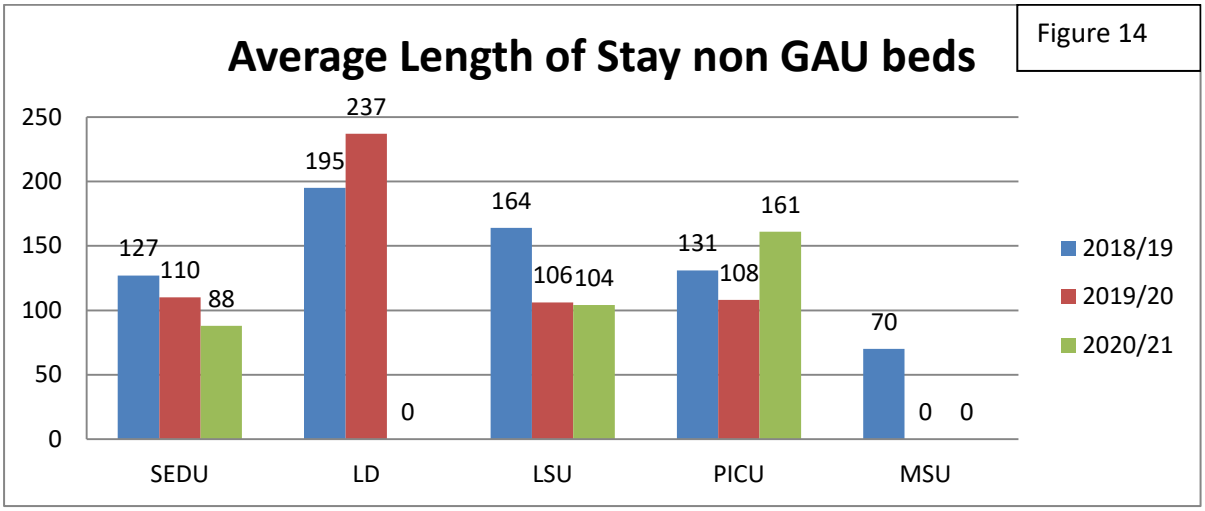


Figure 13 examines occupied bed days for all bed types. All occupied bed days have reduced significantly since the closure of Ash Villa with a 30.5% reduction when comparing the 19 months prior to closure (red line on graph) to the 17 months since closure (blue line on graph). Specialist eating disorder occupied bed days have also reduced due to the reduction in admissions. Psychiatric intensive care unit occupied bed days have increased slightly due to two long term patients with social needs that have been difficult to discharge.



With the increase in acuity now admitted to PICU due to the ability to keep most children and young people out of hospital that would have previously been admitted, Figure 14 is showing an increase in PICU length of stay by 23% between 2018/19 and 2020/21. However, over the same time period:

- Specialist Eating Disorder Units have seen a 30% reduction in length of stay
- Learning Disabilities units admissions have been reduced by 100% as has length of stay
- Low Secure Units have seen a 37% reduction in length of stay
- Medium Secure Unit admissions have been reduced by 100% as has length of stay



11. Conclusion

There is additional value above that was expected of the pilot due to the impact in reduction of bed use on GAU beds. This should be considered as part of the collaboratives over all commissioning strategy across the East Midlands, not just in relation to the establishment of community alternative to inpatient services but in the modelling of the total bed stock required.

Areas for Development

1. Workforce - enhancing the multi-disciplinary team through psychology and speech and language therapy and continuing to train all new starters in evidence-based home treatment approaches
2. Maintenance of the positive relationship with acute paediatric colleagues, whilst developing relationships with Emergency Department and Medical Admission Unit colleagues in relation to 16/17-year olds as the pathways are not currently similar and this puts a strain on staff from all organisations. This will include cross divisional work within LPFT with our acute hospital mental health liaison service and adult inpatient services, as well as the necessity to consider a system wide approach to supporting children and young people that require restraint to support with nutrition.
3. Review of the requirements for staffed 24/7 service rather than on call
4. Embedding CCETT staff within a children and young people specific single point of access for Lincolnshire as and when this is established
5. Ensuring access is equal through coproduction with populations of specific cohorts of children and young people, for example, autistic people, the eastern European community, children and young people with learning disabilities, and BAME children and young people and families
6. Developing a robust approach with Approved Mental Health Practitioners, on call CAMHS consultants and Section 12 approved doctors so that no child can be detained under the mental health act without CCETT involvement in the decision to treat at home. Without this application of the mental health act can be used without the full knowledge of therapeutic provision available, and the intensive nature of the service that can be provided in the community.

7. Constantly monitoring and reviewing the impact of the pandemic on demand for children and young people's services to ensure that we respond to the increase in the number of people needing a service. This requires close working with all of our partners in the wider system of health and care, including our primary care and social care colleagues.

12. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Community Engagement Pilot

13. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Jane Marshall, Director of Jane Marshall, Director of Strategy, People and Partnerships, Lincolnshire Partnership NHS Foundation Trust, who can be contacted via Jane.Marshall3@nhs.net

APPENDIX A

Lincolnshire Community Pilot Engagement

The Health Scrutiny Committee for Lincolnshire considered a previous report on 22 July 2020 on the impact of the new model of care in place for Lincolnshire. The Health Scrutiny Committee asked that targeted engagement with the Lincolnshire public commence to consider whether to make the new model of care a permanent change. An update report was presented to the Health Scrutiny Committee in February 2021 which resulted in a request for a further report on completion of the engagement exercise which was ongoing at that time.

Engagement was carried out from 18 January 2021. An initial four-week period was allowed for responses, and the time was extended to encourage more responses. The survey sought to gather feedback from patients who might have experienced care in an inpatient setting or from the new community model and their parents/carers. The questionnaire was circulated to former patients, staff, charities that care for children and young people locally as well as patient groups. It was also circulated to other healthcare organisations.

Details of those providing feedback are detailed below with a summary of their responses.

Summary of Responses

There were nine individual responses in total.

Q1 Are you (please tick, more than one option can be selected if necessary):

Option	Total	Percent
Someone who has received care as an inpatient within a child and adolescent in-patient unit?	3	33.33%
A carer of someone who has received care as an inpatient within a child and adolescent in-patient unit?	1	11.11%
A professional who cares for people admitted to in-patient child and adolescent inpatient units?	0	0.00%
Someone who has received care from the new community model?	3	33.33%
A carer of someone who has received care from the new community model?	1	11.11%
A professional who has cared for someone in receipt of the new community model?	3	33.33%
Not Answered	0	0.00%

Overall summary of responses to other questions

Questions	Comments
Community service – did you find the service helpful?	• Yes helpful (patient) • Patient experienced AV and community pilot – positive about both but extremely positive about the community option/not having to go anywhere (patient) • flexible and responsive (professional) • Immediate response when needed (professional) • Helpful input from inpatient unit in Nottingham (carer) • Sometimes helpful sometimes not. Not helpful that have to ring rather than text after 5pm but feels they were helped a lot (patient) • The team have been brilliant (carer)
Inpatient service – did you find the service helpful?	• Didn't find treatment helpful apart from art and activities (patient) • Comment that was helpful although it was Hopewood rather than AV. Not needed to use pilot (carer)
Anything that could have been better?	• More support for ED/support around meals in particular (patient with reference to the community model) • Not having constant rotation of staff (patient re: community model) • A list of things in relation to the inpatient unit relating to need for more awareness of disability/LGBTQ issues, discharge planning and communication, use of restraint (patient) • Operating after 7pm as young people can struggle in the night (professional re: community service) • Comments about the need to be admitted a long way from home which restricted attendance at meetings (these were however secure units rather than GAU although also used AV briefly) (carer re: inpatient access) • Improved transition to adult services (patient re: community services) • Earlier intervention (carer)
Preference for model – inpatient or community	• Strong preference for the community model (patient) • Prefer community but dependent on needs (patient) • Community definitely (professional) • No preference but thinks the distance to travel to an inpatient unit is too far (professional). • Depends on the patient (carer) • No preference (patient) • No preference (carer)

Questions	Comments
Top 5 things	• Accessibility and responsiveness (patient) • Diagnosis. Getting help in time. (patient) • Staff awareness of different needs. Communication between teams (patient) • Empathy, time, skills, accessibility (timeliness), consistency (professional) • Being seen quickly, being admitted within an hour of home, experienced staff, flexibility of treatment, being able to attend MDTs each week (carer) • Caring, supportive, listening, understanding and flexibility of approach (patient) • Early intervention (carer)
Experience of inpatient unit	• Not positive – frequent admissions for issues that are not MH related which removes responsibility from the people around the child (professional) • Very dedicated and skilled staff (professional)
Experience of community offer	• Much better than the previous offer – really important to keep CYP in their community. Admission can make problems worse (professional) • Teams have been merged poorly creating a lack of consistency and support. Due to Covid difficult to shadow and learn the role. Staff trying their best in difficult circumstances (professional)
Preferred Model	• Community Model (professional) • Inpatient model (professional)
Further comments	• Keep the current model. Don't go back to inpatient care as the default. And more areas should be doing this based on the evidence and outcomes of the pilot (professional)

Questionnaire Questions

Q1 Are you (please tick, more than one option can be selected if necessary):

- Someone who has received care as an inpatient within a child and adolescent in-patient unit?
- A carer of someone who has received care as an inpatient within a child and adolescent in-patient unit?
- A professional who cares for people admitted to in-patient child and adolescent inpatient units?
- Someone who has received care from the new community model?
- A carer of someone who has received care from the new community model?
- A professional who has cared for someone in receipt of the newcommunity model?

If you have used services or are the carer of someone who has used services, please answer questions 2 – 5

Q2 Did you find the treatment helpful? If so, what was good about it?

Q3 Was there anything you think could have been better? If so, what do you think could have been better?

Q4 Do you have a preference for a community or in-patient model of treatment?

Q5 What are the top 5 things that are important to you in relation to your experience of children and adolescent mental health services?

If you are a professional or organisation involved in delivering services or representing the views of young people, please answer questions 6-9

Q6 What is your experience of the inpatient model of care in Lincolnshire?

Q7 What is your experience of the community model of care in Lincolnshire?

Q8 Do you have a preference for either model? If so, can you explain the reasons for your preference?

Q9 Do you have any further comments on the model of care in Lincolnshire?