Briefing – Supporting document

November 2019

Children and young people's mental health care

Quality indicators

The Health Foundation

A number of resources were compiled in relation to quality indicators for children and young people's mental health (CYPMH) care as part of *The measurement maze* research. Through the qualitative aspect of the research it was ascertained that front-line clinicians and managers would find it useful to see a list of all the identified quality improvement indicators in one place. The lists of local quality indicators and missing indicators together give a richer picture of what is meaningful to clinical teams beyond the national-level indicators.

This document includes three indicator lists: national-level quality indicators, local quality indicators and missing indicators.

National-level quality indicators

The following list brings together 56 national-level quality indicators, or measures that are relevant to the work of a community-based CYPMH care team. The indicators have been grouped into themes and/or stages of the care pathway to enable easier reading and navigation. Not all the indicators listed are specific to CYPMH care; for example, some are relevant to mental health or hospital care more generally. The lowest level of specificity available (children and young people, mental health inpatients, and so on) for each indicator is included in the list.

The list is up to date as at November 2017, to the best of our knowledge and efforts. Though comprehensive, this list is not exhaustive; it includes indicators that reflect the services delivered by the clinical teams interviewed. For example, indicators relating to transformation milestones and spend have been excluded. Further, the research focused on children and young people aged 14 to 18 years, excluding those with learning disabilities or looked after children.

Links to the summary data are provided where available. Where published data is unavailable, further information about the measure or collection of the dataset has been linked. Some of the listed datasets and dashboards are no longer updated.

Patient feedback

1. How likely they would be to recommend the service to their friends and family, if they needed similar care or treatment – reported through the Friends and Family Test. (Reported by ward for inpatient and outpatient care, and for a specific service within a trust for community care.)
2. Patient experience of hospital care (for people aged 16+) – calculated based on a number of questions from the Care Quality Commission (CQC) survey. (Reported by trust.)

Depression

3. Children and young people with suspected depression have a diagnosis confirmed and recorded in their medical records. (Not mandated or routinely reported.)

4. Children and young people with depression are given information appropriate to their age about their diagnosis and treatment options. (Not mandated or routinely reported.)
5. Children and young people with suspected severe depression, but who are not at high risk of suicide, are assessed by child and adolescent mental health services (CAMHS) professionals within a maximum of 2 weeks of referral. (Not mandated or routinely reported.)
6. Children and young people receiving treatment for depression have their health outcomes recorded at the beginning and end of each step in treatment. (Not mandated or routinely reported.)

Suicide and self-harm

7. Children and young people with suspected severe depression and at high risk of suicide are assessed by CAMHS professionals within a maximum of 24 hours of referral. If necessary, children and young people are provided with a safe place while waiting for assessment. (Not mandated or routinely reported.)
8. Proportion of patients that have self-harmed in the last 72 hours for community and/or inpatient settings. (Reported by trust.)
9. Age-standardised death rate for suicide per 100,000 population (aged 10+ years).
10. Hospital admissions for self-harm per 100,000 population (aged 10-24 years).

Eating disorders

11. Waiting time for urgent cases of children and young people with an eating disorder: the number of patients who have started treatment or are waiting to start treatment by week since referral (% within 1 week; 0-1 weeks; 1-4 weeks; 4-12 weeks; 12+ weeks).
12. Waiting time for routine cases of children and young people with an eating disorder: the number of patients who have started treatment or are waiting to start treatment by week since referral (% within 4 weeks; 0-1 weeks; 1-4 weeks; 4-12 weeks; 12+ weeks).

Psychosis and serious mental illness

13. People with a first episode of psychosis begin treatment with a National Institute for Health and Care Excellence (NICE) recommended package of care within two weeks of referral. (This is a 'placeholder' indicator: data is only available for the proportion of people who started treatment within 2 weeks, but not specifically on a NICE-recommended package of care.)
14. Children and young people who are referred to a specialist mental health service with a first episode of psychosis start assessment within 2 weeks. (Not mandated or routinely reported.)

15. Waiting time for early intervention in psychosis (EIP): the number of patients who have started treatment or are waiting to start treatment by week since referral (% within 2 weeks; 0-2 weeks; 2-6 weeks; 6-12 weeks; 12+ weeks).

16. Proportion of people who started early intervention in psychosis (EIP) treatment within 2 weeks of referral.

17. Proportion of people waiting more than 2 weeks following referral for early intervention in psychosis (EIP) treatment.

18. Children and young people with a first episode of psychosis and their family members are offered a family intervention. (Not mandated or routinely collected.)

19. To demonstrate positive outcomes in relation to body mass index (BMI) and smoking cessation for patients in early intervention in psychosis services. (Nationally mandated but locally collected as part of Commissioning for Quality and Innovation (CQUIN).)

20. Parents and carers of children and young people newly diagnosed with bipolar disorder, psychosis or schizophrenia are given information about carer-focused education and support. (Not mandated or routinely collected.)

21. Children and young people with bipolar disorder, psychosis and schizophrenia have arrangements for accessing education- or employment-related training included in their care plan. (Not mandated or routinely collected.)

Co-morbidities, and physical health in mental health

22. Children and young people with bipolar disorder, psychosis or schizophrenia prescribed antipsychotic medication have their treatment monitored for side effects. (Not mandated or routinely collected.)

23. Children and young people with bipolar disorder, psychosis or schizophrenia are given healthy lifestyle advice at diagnosis and at annual review. (Not mandated or routinely collected.)

24. Proportion of people with a diagnosis of severe mental illness (SMI) who have received a full physical health check in a primary care setting.

25. Proportion of people with a diagnosis of severe mental illness (SMI) who have received a cardio-metabolic assessment and treatment in inpatient wards, early intervention in psychosis (EIP) services and community mental health services (people on Care Programme Approach (CPA)).

26. Level of compliance with physical health sever mental illness (SMI) Commissioning for Quality and Innovation (CQUIN) within inpatient settings: proportion of patients who have a diagnosis of psychosis (including schizophrenia and bipolar affective disorder) that were screened for all six CQUIN parameters and received an intervention for each measure where needed.

Psychological therapies

27. Improving Access to Psychological Therapies (IAPT) and talking therapies: the proportion of patients who waited (within 6 weeks/within 18 weeks) to begin treatment.
28. Proportion of people who had their first Improving Access to Psychological Therapies (IAPT) treatment appointment within 6 weeks of referral.
29. Proportion of people who have depression and/or anxiety disorders who receive psychological therapies.
30. Children and young people newly diagnosed with bipolar depression or a first episode of psychosis are offered a psychological intervention. (Not mandated or routinely reported.)
31. Proportion of people who finished treatment within the reporting period who were initially assessed as 'at caseness', have attended at least two treatment contacts and are coded as discharged, who are assessed as moving to recovery.

Community, crisis resolution and home treatment teams

32. Proportion of children and young people with a mental health condition receiving at least two contacts with NHS-funded community services.
33. Number and proportion of admissions to acute wards that were gate-kept by the crisis resolution and home treatment (CRHT) teams.
34. Children and young people with bipolar disorder, psychosis or schizophrenia who are in crisis are offered home treatment if it is suitable. (Not mandated or routinely reported.)
35. Proportion of crisis resolution and home treatment (CRHT) services in the Sustainability and Transformation Partnership (STP) area able to meet these selected core functions:
    a. offer 24/7 crisis assessments and home visits
    b. response time standards for assessment and treatment within 4 hours
    c. 24/7 crisis assessment
    d. 24/7 home visits
    e. open access/referral
    f. 4-hour response

Liaison teams

36. Proportion of acute hospitals meeting the 'core 24' service standard.
37. Proportion of population with access to liaison and diversion services.

Mental Health Act

38. Number of detentions under the Mental Health Act (MHA).
39. Proportion of people detained under the Mental health Act (MHA) who are black and minority ethic (BAME).
40. Total number of section 136 detentions taken to police cells as a place of safety that are under 18.

Inpatient stay

41. Admissions to adult mental health facilities of patients who are under 16 years old.
42. Number of admissions of children and young people aged under 18 in child and adolescent mental health services tier 4 wards.
43. Number of bed days for children and young people aged under 18 in child and adolescent mental health services tier 4 wards.
44. Number of children and young people aged under 18 in adult inpatient mental health wards.
45. Number of bed days of children and young people aged under 18 in adult inpatient mental health wards.
46. In-hospital mortality for conditions associated with mental health. (Previously reported as part of the CQC's Intelligent Monitoring report.)
47. Emergency readmissions with an overnight stay within 30 days of discharge, following an elective mental health spell at the trust. (Previously reported as part of the CQC's Intelligent Monitoring report.)
48. Potential under-reporting of patient safety incidents.
49. Never event incidence. (Reported as type of incident, with additional detail.)
50. Proportion of reported patient safety incidents that are harmful. (Reported as a proportion of overall incidents at each trust and by organisation cluster.)

Safety – across all settings

51. Proportion of mental health patients that have been the victim of violence or aggression in the last 72 hours.
52. Proportion of mental health patients that feel safe at the point of survey.
53. Proportion of mental health patients that have had an omission of medication in the last 24 hours.

Follow up after inpatient stay

54. Proportion of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care.

Transition and communication between teams and sectors

55. Proportion of mental health patients who have either an up-to-date Care Programme Approach (CPA), care plan or comprehensive discharge summary shared with their GP. (Nationally mandated, but locally collected as part of CQUIN.)

56. Experience and outcomes for young people as they transition out of CYPMH services. This covers the following three components:

    a. a case note audit to assess the extent of joint agency transition planning
    b. a survey of young people's transition experiences ahead of the point of transition (pre-transition/discharge readiness)
    c. a survey of young people's transition experiences after the point of transition (post-transition experience).

Local quality indicators

The following list identifies quality indicators being measured at a local level by either of the two CYPMH care teams interviewed. Whether these local indicators are included in any national-level indicator or measurement framework is unconfirmed.

1. Patient outcome measurement tools such as the Child Outcomes Rating Scale (CORS and ORS), Strengths and Difficulties Questionnaire (SDQ) and the Rosenberg Self-Esteem Scale.
2. Number of children and young people in out-of-area placements for mental health service admissions.
3. Number of children and young people who present at hospital with mental health conditions.
4. Number of children and young people who are admitted to hospital in order to await an assessment from a mental health professional.
5. Number of children and young people admitted to hospital for physical health problems that also have mental health or behavioural problems.
6. Number of patient complaints, including the proportion upheld.

Missing quality indicators

The following list identifies indicators that either of the two CYPMH care teams interviewed identified as being useful, but that were not available to them as either a national or local indicator.

1. Staff workload, wellbeing, recruitment and retention.
2. Patient feedback/experience that is more in-depth than the Friends and Family Test.
3. Prevalence of children and young people with mental health problems – for example, eating disorders.
4. Length of time a patient remains within the service, from referral to discharge.
5. Rates of patient contact/how often the patient is seen.
6. Broader measures to understand the performance and effectiveness of the wider CYPMH system, encompassing health, social care and education.
7. Volume of lower-level cases of overdose and self-harm.