

**Outline Planning Application for a Hospital for
the Provision of Children and Adolescent
Mental Health Services**

**BACKGROUND REPORT
Provided by New Dawn Health Group**

**SHORTWOOD BUSINESS PARK, BARNSELEY,
SOUTH YORKSHIRE**

June 2016

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1. THE PROPOSED SERVICE

The proposal is to provide generic acute mental health units for young people with conditions such as Depression, Bipolar Disorder, Psychosis, Eating Disorders, Complex PTSD / Severe Self-harm and complex neurodevelopmental presentations including ADHD (Attention Deficit Hyperactivity Disorder) and ASC (Autism Spectrum Conditions). Very limited specialist Eating Disorder provision or secure mental health units for young people exists at present in either the East Midlands or Yorkshire and Humber. The specific and specialist ASC service would be the first in the north of the country, to our knowledge. It is also planned to provide specialist services for young people with significant Learning Disabilities (LD) and Mental Illness, as these services are currently predominantly but limited, provided nationally in Newcastle and Birmingham.

No existing service nationally, either in the NHS or independent sector, offers the range of inpatient child mental health facilities proposed in this development within one campus. Research and innovation will form a key role within the centre. Academic and university links already exist and will be developed to ensure that the centre develops a reputation for ground-breaking research and innovation as well as excellent practice. As such, the range of expertise within this one site will be unparalleled in the UK and this will be a truly national centre of expertise in developmental mental health for children and young people.

2. POLITICAL CONTEXT AND MARKET BACKGROUND

In setting the context for this proposal, it is important to consider the current political environment in regard to future mental health provision. The current government, through the Health and Social Care Bill, is expressing greater enthusiasm than ever before for the involvement of the Independent and Voluntary sectors in NHS provision under the banner of 'Any Willing / Qualified Provider'. Our understanding is that in the future, commissioning will be driven by cost-effective, quality-focused and outcome-based care.

In the past, NHS services have somewhat 'rested on their laurels' in regard to outcome measurement and quality improvement as they took their continuing existence for granted. Conversely, some independent sector providers (ISPs) have recognised the importance of providing the 'customer' with the best quality at the best price – and providing evidence of good outcomes.

This places such ISPs in a strong position to engage in the new commissioning processes and to win business from existing providers.

The Company takes the measurement, analysis and reporting of outcomes seriously and will have developed systems to support this process.

The Clinical team has an ongoing research interest in outcome measurement in inpatient CAMHS and using outcome data in clinical practice. Such research is appealing to commissioners as they are drawn to supporting services that take outcomes seriously.

3. THE ORGANISATION AND ONTEXT OF CAMHS

Background to this Application

Every Child Matters (2003), and the National Service Framework for Children, Young People and Maternity services (2004), using the four tier strategic framework for child and adolescent mental health services (CAMHS), defines what is required to ensure children and young people receive comprehensive care. This includes the provision of effective early help services which may prevent problems escalating to the point where admission to hospital becomes necessary.

Since April 2013 NHS England has been responsible for commissioning CAMHS Tier 4 services and clinical commissioning groups (CCGs) are responsible for ensuring a robust infrastructure is in place at tiers 2 and 3, including the provision of effective early help services which can prevent problems escalating to the point where admission to hospital becomes necessary.

During the first six months of the new arrangements, a number of concerns around CAMHS Tier 4 inpatient services emerged, which included but not exclusively:

- ☐ Quality concerns about a small number of services;
- ☐ Closure to admissions impacting upon capacity (closure sometimes due to staff, case mix or quality issues);
- ☐ Problems with accessing beds when needed;
- ☐ Children and young people having to travel long distances to access a bed;
- ☐ Poor environmental standards in some services;
- ☐ Disparity in education input to CAMHS Tier 4 inpatient settings; and
- ☐ Continuing inequity in provision across the country.

The Organisation and Context of CAMHS

The 'commissioning footprint' (i.e. the size of the population over which a service is most effectively and efficiently provided) varies according to the type of service, but also increases with progression through the tiers.

The structure and operation of CAMHS can appear complex at first as the organisation differs from both traditional secondary care mental health services for adults and the majority of general physical health services for children and young people (specifically in regard to multi-agency relationships and interdependencies). The structure of CAMHS is often best explained in terms of how a child or young person accesses the service, with four 'tiers' of service provision. There are differences in the levels of support and types of intervention offered in the different tiers and also in how each of the tiers is commissioned.

Tier 1 (Universal services)

These are services whose primary remit is not that of providing a mental health service, but as part of their duties they are involved in both assessing and/or supporting children and young people who have mental health problems. Universal services are commissioned by CCGs and Local Authorities and schools themselves, and may be provided with a range of agencies.

Tier 2 (Targeted services)

These include services for children and young people with milder problems which may be delivered by professionals who are based in schools or in children's centres. Targeted services also include those provided to specific groups of children and young people who are at increased risk of developing mental health problems (e.g. youth offending teams and looked after children's teams, paediatric psychologists based in acute care settings). Targeted services are commissioned by CCGs and Local Authorities and schools, and are provided by a range of agencies. Arrangements vary across the country and according to the nature of the service.

Tier 3 (Specialist services)

These are multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions. Access to the team is often via referral from a GP, but referrals may also be accepted from schools and other agencies, and in some cases self-referral. These services are commissioned by CCGs although there may be a contribution from Local Authorities. The latter varies across the country.

Tier 4 (Specialised CAMHS)

These include day and inpatient services and some highly specialist outpatient services including services for children/young people with gender dysphoria; eating disorders; emergent personality disorders and severe self-harm; CAMHS for children and young people who are deaf; highly specialised autism spectrum disorder (ASD) services; and highly specialised obsessive compulsive disorder services. These services have, since April 2013, been commissioned directly by NHS England.

Within the inpatient element of CAMHS Tier 4 there are several different types of service. Service specifications were developed for these services as part of the 2013/14 NHS standard contract. The general adolescent services specification is an overarching core specification which includes additional requirements for adolescent psychiatric intensive care units, low secure inpatient units, eating disorder services, and inpatient learning disability services. There are separate specifications covering children's inpatient units, specialist ASD services and secure forensic mental health services for young people.

The majority of units are those termed Tier 4 CAMHS General Adolescent Units; these units admit young people aged 13-18 years with a range of problems. In some areas Tier 4 General Adolescent Units have a further sub-specialisation into services which aim to offer short-term crisis admissions; a few Tier 4 General Purpose Adolescent Units have an attached or integral high dependency area.

Although the majority of young people with anorexia nervosa requiring admission are treated in CAMHS Tier 4 General Adolescent Units, there are a small number of specialist CAMHS Tier 4 Eating Disorder Units – these may be linked to a CAMHS Tier 4 General Adolescent Unit or function as a stand-alone service.

There are a small number of CAMHS Tier 4 Children's Units admitting under 13s.

There also a small number of CAMHS Tier 4 Learning Disability Units catering for varying ages and degrees of disability, although these services tend to focus on young people with moderate to severe learning disabilities.

There are a small number of units which are categorised as Low Secure or Psychiatric Intensive Care Units. To date, the separation and functioning of these units has been poorly defined. The CAMHS Tier 4 CRG produced initial specifications for use in 2013/14 and recommended further work by a

dedicated CRG focusing on secure CAMHS provision. This work is currently being undertaken by the Secure CAMHS CRG.

All of the aforementioned service types were largely commissioned by Primary Care Trusts (PCTs) prior to 2013. There is a national network of Medium Secure Adolescent Units. These were nationally planned and commissioned prior to April 2013. There is also one inpatient unit in London for young people who are deaf which, prior to April 2013, was also nationally commissioned and which now comes under the remit of the CRG for Services for the Deaf, as do the community CAMHS services for the deaf.

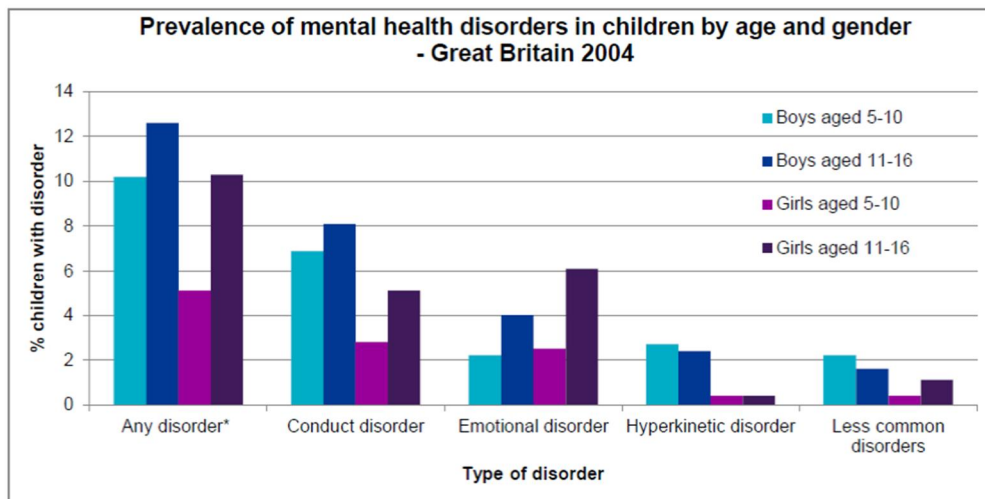
The combined bed total of these different services is circa. 1264 beds.

CCGS and Local Authorities decide what they wish to spend on individual services. The charity Young Minds (Young Minds, 2011/12) reported on the basis of the Freedom of Information requests that there has been disinvestment in CAMHS, particularly in Local Authority Expenditure. Evidence of disinvestment in recent years is also borne out in the NHS Benchmarking Review of CAMHS 2013 (NHS Benchmarking Network, 2013).

The best available estimate of the prevalence of mental disorders amongst children and young people are those from the Office of National Statistics surveys in 1999 and 2004 (Office for National Statistics, published 2000 and 2005 respectively). These found that one in ten children aged between 5 and 16 years has a mental disorder. About half of these (5.8%) have a conduct disorder, 3.7% an emotional disorder (anxiety, depression), 1-2% have severe Attention Deficit Hyperactivity Disorder (ADHD) and 1% have neurodevelopment disorders. The rates of disorder rise steeply in the middle to late adolescence and the profile of disorder changes with increased presentation on the types of mental health illness seen in adults. Although as noted in the Chief Medical Officer's report (Dept. of Health 2013) there is reason to believe these estimates of prevalence may be out of date.

4. SERVING LOCAL AND NATIONAL NEED

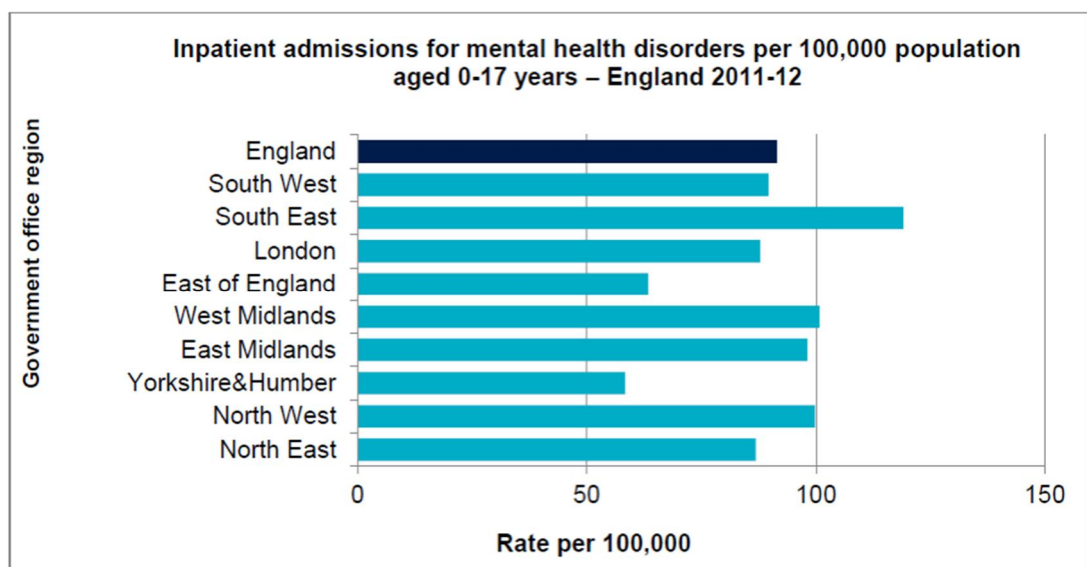
The Royal College of Psychiatrists (RCP), based on Kurtz et al. (1996) have recommended that there should be between 24 to 40 CAMHS beds per million of the population. In his 2006 report, *'Pushed into the Shadows'*, the Children's Commissioner Prof Sir Al Aynsley Green recommended that "action must be taken by the Department of Health, mental health trusts and Primary Care Trusts (PCTs) to ensure that the Royal College of Psychiatrist's recommendations (that around 24 to 40 beds are required per one million total population at a bed occupancy rate of 85%) are met consistently and geographical inequalities addressed. Tier 4 units include both acute care provision (to be able to respond to the need for emergency admissions of young people who are acutely disturbed or high risk) and medium to long term planned patient care".



Data source/s: Office for National statistics licensed under the Open Government Licence v.2.0 - Mental health of children and young people in Great Britain, 2004 Crown Copyright

The above chart relates to prevalence of mental health disorders in the general population of children. Given below are rates of admission for those children who access inpatient services by government office region.

There are no recent data on estimated levels of need for the different elements of CAMHS including Tier 4 services. This depends not only both on prevalence but also other factors including the range of alternative services. The only available data is that detailing actual admissions by Government Office region.



Information on access times for treatment in community CAMHS is not currently systematically available at a national level though it is understood that there is considerable geographical variation. Data from the NHS Benchmarking Report 0 2 4 6 8 10 12 14 Any disorder* Conduct disorder Emotional disorder Hyperkinetic disorder Less common disorders % children with disorder Type of disorder Prevalence of mental health disorders in children by age and gender - Great Britain 2004 Boys aged 5-10 Boys aged 11-16 Girls aged 5-10 Girls aged 11-16 0 50 100 150 North East North West Yorkshire and Humber East Midlands West Midlands East of England London South East South West England Rate per 100,000 Government office region Inpatient admissions for mental health disorders per 100,000 population aged 0-17 years – England 2011-12 16 CAMHS (NHS Benchmarking Network, 2013) found that in 2012/13 amongst its members the maximum waiting times for specialist CAMHS Tier 3

average 15 weeks across the participating providers. This has increased from 14 weeks recorded in 2011/12. Waiting times for accessing urgent CAMHS Tier 3 had a 3-week median wait. This should also be seen in the context of the lack of crisis response services in CAMHS, with less than 40% of CAMHS in the benchmarking offering rapid access through crisis pathways.

There are concerns from CAMHS Tier 4 commissioners and CAMHS Tier 4 providers that due to the lack of ability by CAMHS Tier 3 and other related community services in some areas to respond early to problems, there may be deterioration in a child/young person's problems which can lead to crisis. This may be further compounded by a lack of services offering alternatives to admission to hospital (which, in itself, for some individuals can be more harmful) thereby increasing demand for inpatient services. By this stage, admission is often not inappropriate, as it is the only safe alternative, though it could have been avoided with earlier intervention.

Using these figures and the Department of Health statistics on current population per region, the total current and required number of beds per area is calculated in Figure 1 below.

Referring to the O'Herlihy review, the CSIP report stated:

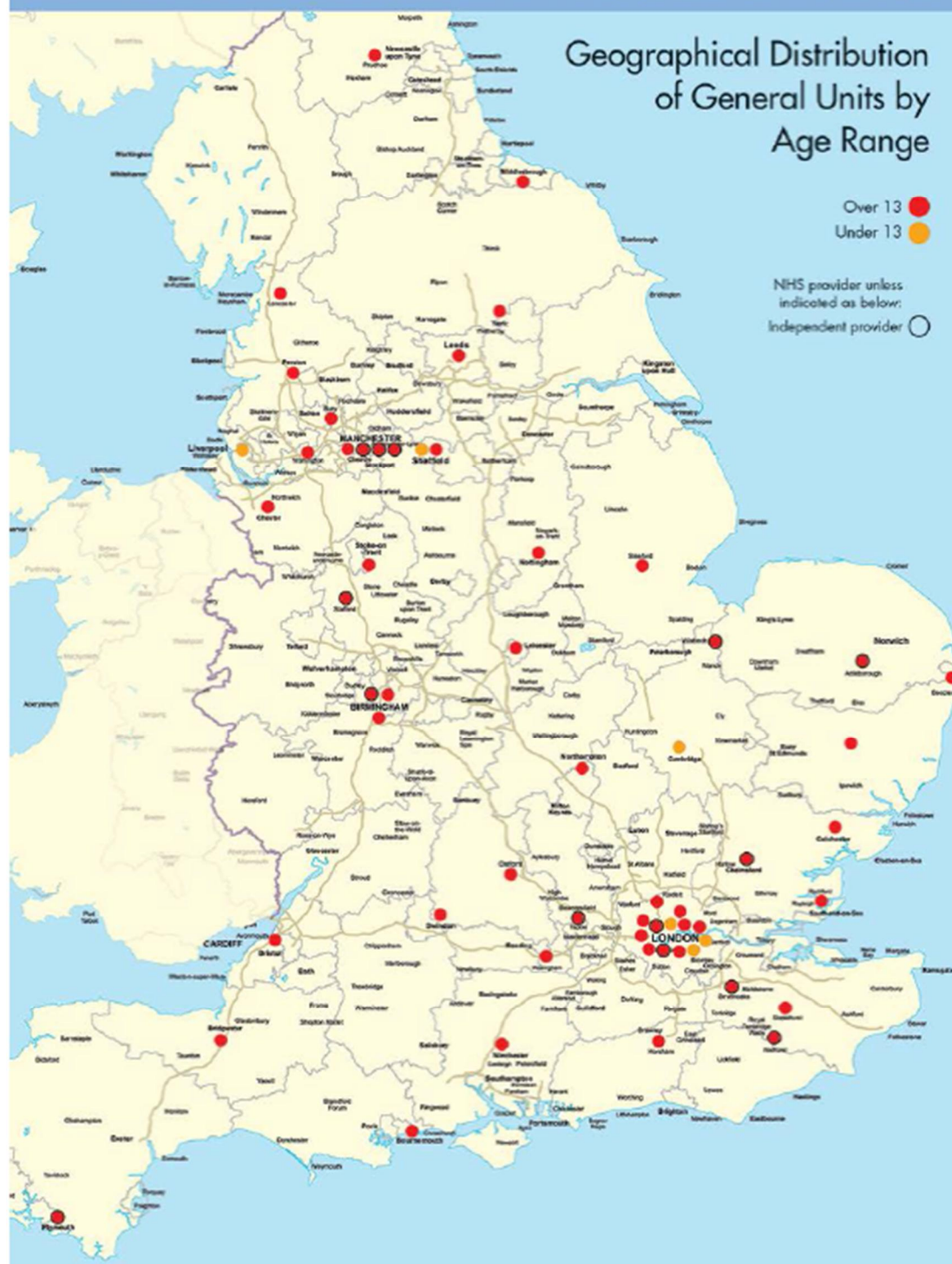
This study shows that four regions of England, [including East Midlands and South Yorkshire, Bassetlaw] are still well below the minimum of 20 beds per million population, while the total bed numbers in England have increased by 284.

CAMHS TIER 4 INPATIENT UNITS IN ENGLAND AS AT JANUARY 2014

Geographical Distribution of General Units by Age Range

Over 13 ●
Under 13 ●

NHS provider unless indicated as below:
Independent provider ○



CAMHS TIER 4 INPATIENT UNITS IN ENGLAND AS AT JANUARY 2014

Geographical Distribution of Designated Specialised Units

- Eating Disorder ●
 - HDU ●
 - Learning Disability ●
 - PICU ●
 - Low Secure ●
 - Medium Secure ●
 - Deaf CAMHS ●
- NHS provider unless indicated as below:
Independent provider ○

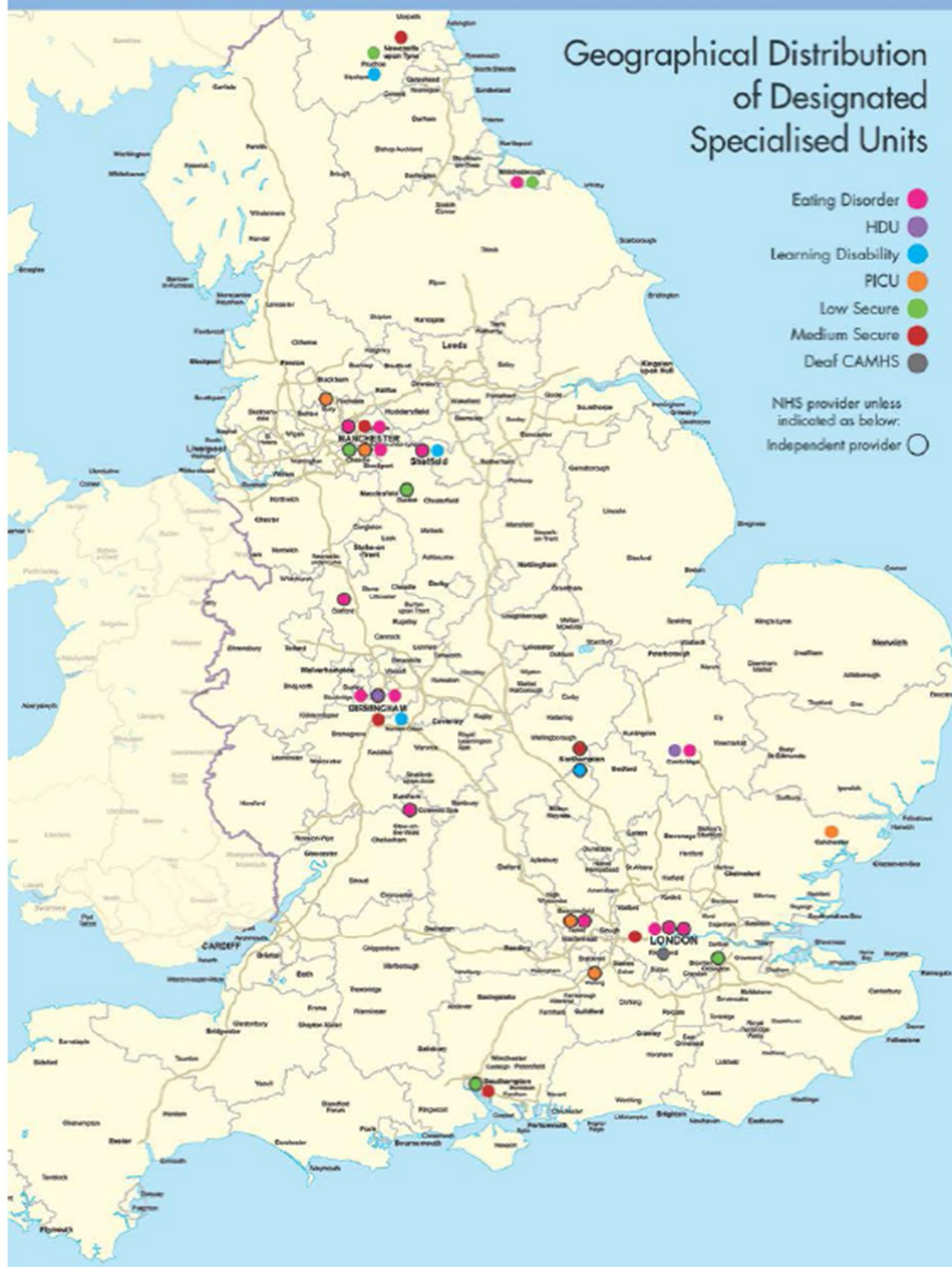


Figure 1 – Stipulated Inpatient CAMHS Provision compared with Actual Provision

Region	No. Beds Based on 24-40 per Million	Actual Current Bed Numbers
East Midlands	82 to 136	36
North East	58 to 97	76
North Wales	16 to 27	15
North West	164 to 273	160
West Midlands	128 to 212	105
Yorkshire and The Humber	153 to 214	39

This starkly demonstrates that the East Midlands and Yorkshire/Humber regions are the two regions where bed numbers remain significantly below the required level. As a result, many young people have to travel out of region to access services in other areas causing additional stress and hardship. Moreover, existing NHS facilities within these regions are often unfit for purpose and will require significant capital spends if they are to be appropriately replaced. There are currently no independent sector providers offering inpatient CAMHS in these regions, therefore overspill from NHS general units or patients with needs for higher levels of security or specialism require to be treated in neighbouring regions – often the West Midlands or the North West. The actual number and location of existing beds in the Yorkshire and Humber and East Midlands regions is shown in Figures 2 and 3 below.

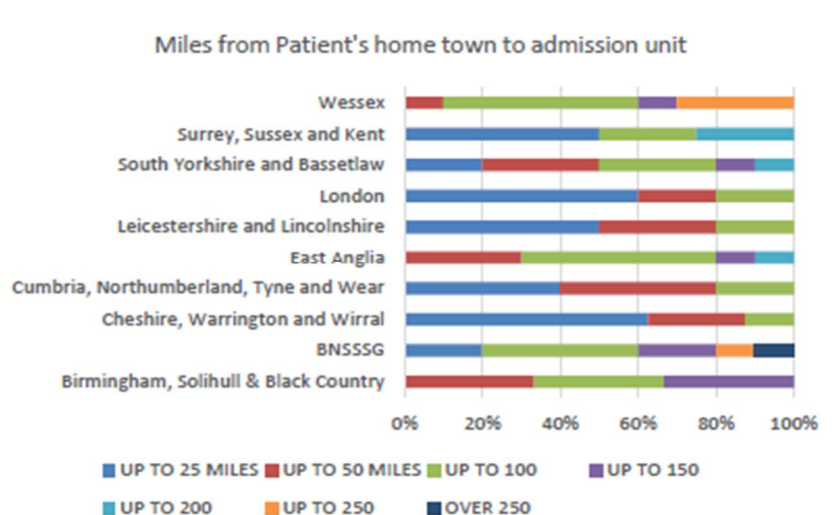
There is no specified distance beyond which an admission is regarded to be “long distance”. Indeed, the aim for all admissions is to find a clinically appropriate bed as close as possible to the child/young person’s home. CAMHS Tier 4 services are, by definition specialised, and will not be available in every local geographical area, as they are low-volume specialties. As can be seen from the maps, the distribution of sub-specialty beds is particularly uneven across the country.

Commissioner responses on beds not available within 50 miles

The area covered by the 10 lead commissioners is frequently geographically very large. This could still mean patients travel a significant distance and are not technically “out of area”. Commissioners responded to this question by indicating services not provided within their geographical area (see table below).

Area team	Services not provided within 50 miles
NORTH	
Cheshire, Warrington and Wirral	Learning disability, autistic spectrum disorder is not within the area, though is within 50 miles for Lancashire patients Eating disorder- localised in greater Manchester, no services in Lancashire and limited in Cheshire and Mersey.
Cumbria, Northumberland, Tyne & Wear	Two regional centres provide all services (North and South) within the area, though still greater than 50 miles for some patients
South Yorkshire and Bassetlaw	Adolescent psychiatric intensive care (PICU) low secure adolescent low secure learning disability medium secure adolescent under 12s some areas do not have general adolescent beds within 50 miles
MIDLANDS AND EAST	
Birmingham, Solihull and the Black Country	All services available within 50 miles Low secure and under 12 children's ward not within area

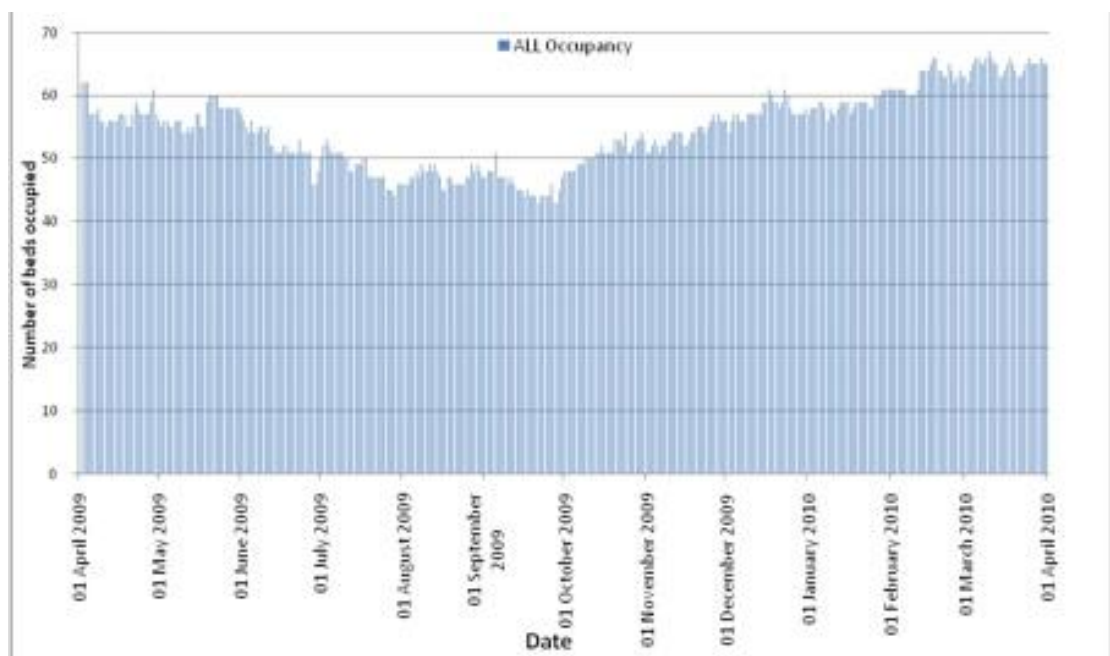
Leicestershire and Lincolnshire	PICU eating disorder learning disability
East Anglia	Low secure in Norwich, but greater than 50 miles depending on patient home; eating disorder within 50 miles of area team HQ
LONDON	
London	Specialised learning disability/ASD (non-secure)
SOUTH	
Bristol, North Somerset, Somerset and South Gloucestershire	Eating disorder learning disability secure
Surrey and Sussex	Learning disability (Kent and Surrey)
Wessex	Learning Disability ASD Low Secure PICU -Wessex – not available within patch, for some bordering North Hampshire, available in adjacent Area Team and within 50 miles. Thames Valley – available in Area Team patch Under 12s Specialist Eating disorder



5. CURRENT MARKET DYNAMICS

At the current time and to the best of our knowledge using reliable and accessible data sources, Yorkshire and Humber are using an average of 55 inpatient beds at any one time for inpatient CAMHS admissions as shown in Figure 4 below. For considerable periods they are using over 60 beds (maximum 67 in 10/11).

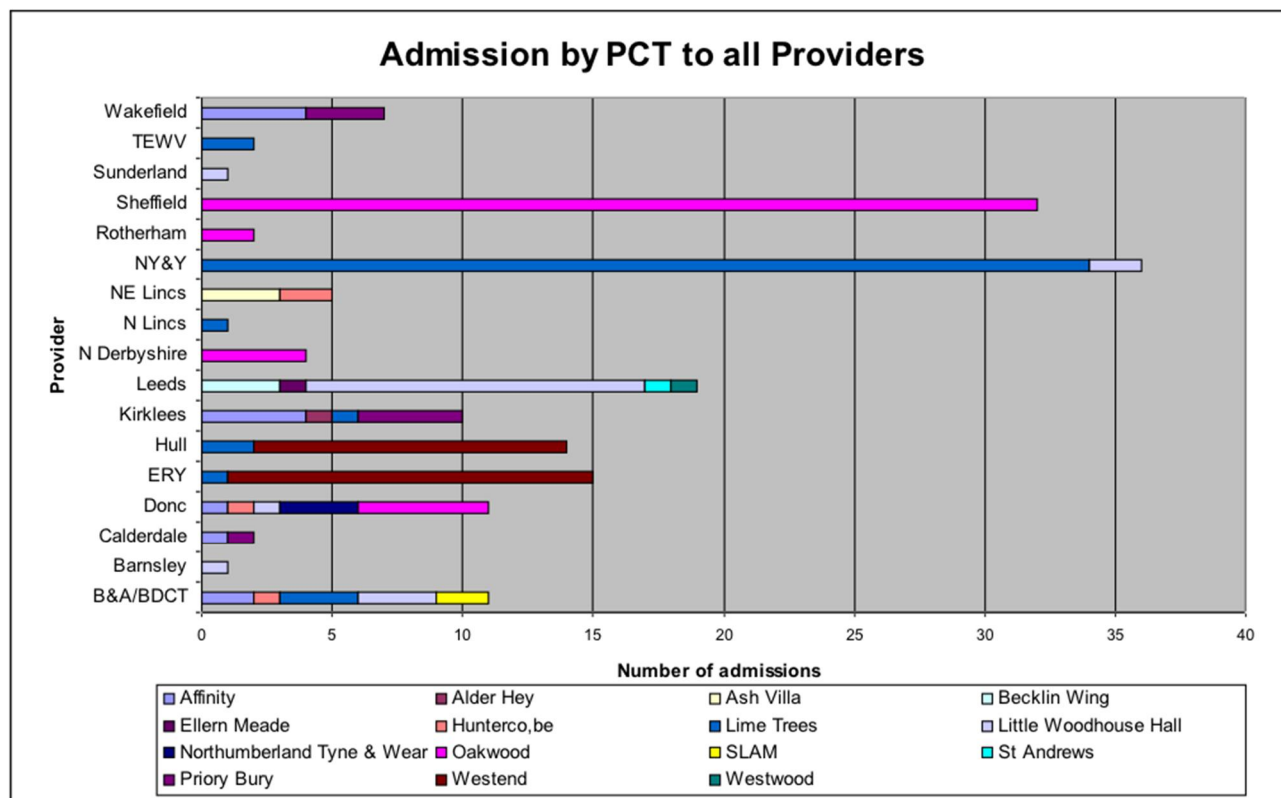
Figure 4 – CAMHS Bed Occupancy for Yorkshire & Humber 2009-10



Given that they only have 39 beds available to them at any one time within the region, they are using between 16 and 28 adolescent inpatient beds outside of the region at any one time, predominantly provided by the Independent sector. Most of these admissions have been to Cheadle Royal Hospital (Affinity), but in 2010-11 several other ISPs were used including Ellern Mede (a specialist

Eating Disorder unit in West Midlands), Huntercombe (an ISP providing secure CAMHS in Stafford and Maidenhead) and Priory Hospital in Bury. The profile of inpatient units providing for Yorkshire and Humber inpatient admissions in 2009-10 is shown in Figure 5 below.

Figure 5 – Profile of Inpatient CAMHS admissions in Yorkshire and Humber 2009/10



A Strategy Group based out of the Specialist Commissioning Team for Yorkshire and Humber has developed a Tier 4 CAMHS strategy for the region. In concluding their strategy document, which was dated September 2010, they identified several key gaps within their regional provision that they would wish to see filled. Across the piece, they emphasise that their key driver is to bring inpatients back within the region, whilst openly expressing a willingness to work with a diversity of providers including within the independent sector. In Figure 6 below, an extract of this document is shown, which clearly identifies Eating Disorder services, secure PICU services and Learning Disability services as the three areas which they would wish to see expanding within the region.

Following publication of the NHS England 'Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report' July 2014 more statistical data is available for scrutiny.

**Figure 6 – Extract from Yorkshire and Humber CAMHS Tier 4
Service Strategy 2011-14**

The Strategy Group together with the Clinical and Provider Management Reference Groups have acknowledged that there is a need to address all the issues identified above to ensure the provision of service is cohesive, equitable and delivered as closely to home wherever possible. In achieving this, the following gaps have been identified from discussions with the providers and clinicians in the current services, the data findings above, and the patient and service user feedback.

1. There is nowhere in the region that deals with the very intensive, acute needs of patients with **eating disorders**. Parents and carers frequently express dissatisfaction that there is no dedicated, expert unit for eating disorders, as the needs of these patients are very distinct from other mental health conditions. Local T4 units struggle to cater for the physical needs of patients with this condition.
2. The most common presenting condition for out of area admission is **psychotic behaviour** (23%). This is linked to the fact that there is no Psychiatric Intensive Care Unit (PICU) commissioned within Yorkshire and Humber, which provides specific mental health care within a secure, safe environment. Local units receiving psychosis patients often have to reduce overall bed capacity in order to cater for their needs.
3. Patients with mental health conditions who also have **learning difficulties** are not served well in the region. These patients are difficult to quantify as they are frequently cared for in residential homes or respite care. However their needs are particularly distinct and acute, and there is a lack of dedicated CAMHS provision in Yorkshire and Humber. This needs to be addressed in future commissioning of service models.
4. Tier 4 services across the localities within Yorkshire and Humber are the product of varying **Tier 3** services locally, making it difficult to really compare and understand the true demand for Tier 4 services across the region. Any future commissioning of Tier 4 services must take this into account, and investment in Tier 3 services must not be overlooked.
5. CAMHS Tier 4 **workforce** should be reviewed in relation to age/knowledge and competency to deliver a modern Tier 4 service.

In conclusion, the ground breaking and highly illuminating 'Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report' July 2014 has provided a comprehensive factual understanding of current CAMHS Tier 4 services from the perspective of commissioners and providers of services. The mapping of services has enabled identification of a number of issues that require addressing now.

There are twenty recommendations made in the report. Of these, three require immediate implementation:

- ☐ To procure additional Tier 4 beds in parts of the country where there is insufficient capacity
- ☐ To ensure that all admissions to inpatient services are appropriate for the individual child
- ☐ To increase the number of case managers to enable timely and effective discharge planning and support back to local services

New Dawn proposes to work with all strategic partners and stakeholders to address these urgent requirements within the East Midlands, Yorkshire and Humber.

6. NEW DAWN AND SERVICE PROVISION

New Dawn Executive and Clinical teams have a track record in the provision of excellent services for children and adolescents with mental illness and or autism and has pioneered a Pathway approach known as a Lifelong Support Programme providing continuity of approach as individuals develop their capacity for independence.

The executive and clinical teams within the Company has unrivalled experience in the public, private and not-for-profit sectors across the wide spectrum of services to be provided within the Hospital.

The company is committed to training and best practice policies and will be immediately looking to attain the highest standards for supporting staff and new recruits, including the attainment of best practice policies relating to Investors in People etc.

7. BRINGING BENEFIT TO THE LOCAL AREA

A key consideration in selecting Shortwood Business Park for this specialist service was also the immediate availability of:

- ☐ Local amenities for visitors to the site (e.g. accommodation, shops, restaurants, etc.)
- ☐ Good transport links, enabling local, national and international access to the site.
- ☐ Accessibility for local employed staff.
- ☐ Availability of local services to support the site once operational, e.g. locally sourced produce for catering, local trades' people to support ongoing maintenance and so on.

8. LOCAL EMPLOYMENT OPPORTUNITIES

The site will employ over 350 staff, and it is anticipated that over 100 of these will be new roles for non-specialist healthcare staff.

The Company will be seen to be a good employer. In addition to offering a living wage in line with our CSR policy and staff benefits, it will offer an exceptional programme of professional and personal development which supports staff as they develop and progress through the organisation. We will actively engage with appropriate stakeholders to support those returning to work after long term unemployment and to provide appropriate and sustainable apprenticeships.