

# Darwin Centre for Young People



Annual Report April 2022 - May 2023

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*Pride in our children's, young people's and families' services*

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## Acronyms

This report will use a lot of different acronyms, some of which may be familiar to the reader, and others which may not be. The list below is intended to be used as a reference point throughout the text.

Commonly used acronyms in this report, and what they stand for:

CAMHS – Child and Adolescent Mental Health Services  
CBT – Cognitive Behavioural Therapy  
CPA – Care Programme Approach  
CQC – Care Quality Commission  
DBT – Dialectical Behaviour Therapy  
DCfYP – Darwin Centre for Young People  
GAU – General Adolescent Unit  
HTT – Home Treatment Team  
MDT – Multi-Disciplinary Team  
MHA – Mental Health Act  
NHSE – National Health Service England  
NICE – National Institute for Health and Care Excellence  
QNIC – Quality Network for Inpatient CAMHS  
ROM – Routine Outcome Measure  
RP – Restrictive Practice  
SD - Standard Deviation

## About this Report

This report is written for all those with an interest in the Darwin Centre, including young people, their families, commissioners, external agencies, clinicians, and Darwin Centre staff. It aims to openly report and feedback on the work being completed at the unit, our outcomes, and developments during the activity period.

This report describes activity during the financial year, from 1<sup>st</sup> April 2022 to 31<sup>st</sup> March 2023. The information presented in this reported was collected from a variety of sources.

We would like to highlight that the Darwin Centre did not have a Research Assistant or Head of Patient and Parent Involvement in post for part of the financial period that the current report covers. This caused challenges to information gathering and collation.

## About us

### Introduction

The Darwin Centre for Young People is an NHS Tier 4 CAMHS General Adolescent Unit (GAU) located in Fulbourn, Cambridge.

We provide inpatient and day-patient admission and treatment for children aged 12-18 years with severe and complex disorders. These include children with neuropsychiatric disorders (such as hyperkinetic disorder and autism spectrum conditions), children with mood disorders, early onset psychosis, obsessive-compulsive disorder, eating disorders, self-harm, emotionally unstable personality disorder, and complex diagnostic conditions.

The Darwin Centre has provision for 14 beds. It is open 7 days a week when a child has psychiatric needs that are unable to be managed safely in the community. The service offers emergency admissions in selected cases, within 24 hours if a bed is available. The service occasionally admits patients out of hours. We admit children on an informal basis, and under the mental health act (MHA).

The Care Programme Approach (CPA) forms an integral part of the unit's work. There is an emphasis on liaison with Tier 3 CAMH services whose staff remain a fundamental component of the young person's care and management plan during their admission and discharge. There is also emphasis on working closely with the home treatment team (HTT) and the Crisis Team. The unit works closely with Children's Social Care and admits children who are looked after by the local authority under sections of the Children's Act (namely S20 and S31).

### Our Aims

We aim to provide a high quality, multi-disciplinary mental health service for young people experiencing severe, acute, emotional and/or mental health difficulties. Our treatment is based on a systemic approach to the young person and their family's needs. This approach ensures we work closely with the young person and their families to understand the wider context to the young person's presenting challenges.

We pride ourselves on our ability to work closely and effectively with external children's agencies and education to ensure that the needs of the young person are met during their admission, and after discharge.

We are committed to practice in the least restrictive manner and adopt a positive risk-taking approach, which are evidenced to improve the mental health of people with mental illness in the long term (Felton, Wright, & Stacey, 2018). We are committed to creating and building a culture of safety and transparency, and we are open to feedback from all involved with the Darwin Centre.

## Our Treatments and Programmes

The ward runs a therapeutic model, supplemented by other treatment modalities, including CBT, CBT parenting work, occupational therapy, and pharmacotherapy, in concordance with the NICE guidelines. The unit is supported by the Darwin Learning Centre educational provision where the children are offered remedial education when appropriate. The school liaises closely with the child's school of origin and with the relevant Educational Authority to help plan appropriate resources for the child's future educational needs.

Our multi-disciplinary team (MDT) consists of a consultant psychiatrist, nurses, clinical nurse specialist, ward manager, clinical psychologists, youth intensive psychological practitioners, occupational therapist, specialist doctors, family therapists, healthcare assistants, research assistant, dietician, teachers, teaching assistants, social worker, peer support workers, and head of parent and patient involvement.

We provide a holistic approach to treatment, which includes trauma-informed care. The MDT enables us to offer a variety of treatments individualised to each young person's needs, which typically includes:

- 1:1 weekly medical review
- 1:1 weekly ward round feedback conversation, for young person and parent/carer
- 1:1 key worker sessions with a nurse and/or a healthcare assistant
- Individual psychological therapy and assessment such as Cognitive Behavioural Therapy (CBT), Cognitive Analytic Therapy (CAT), Dialectical Behavioural Therapy (DBT), assessment for Autism Spectrum Condition, learning difficulties or other neurodevelopmental conditions etc.
- Family therapy
- Group therapy, such as DBT skills
- 1:1 sessions with a peer support worker
- 1:1 occupational therapy sessions
- Weekly occupational therapy led sensory group and cooking group
- Individual music therapy / group art therapy
- Care Programme Approach (CPA) review meetings, every 4-6 weeks, with members of the Darwin Team, the young person, their family, and members of the professional network working with the family.
- Education at the Darwin Learning Centre
- Staff outreaching to young people's homes and community during admission and in the initial period following discharge, to support transition.

There is also a weekly 'have your say' group, which is run by the advocate and peer support workers where young people can give feedback about their experiences on the ward. On Friday afternoons there is a recreational 'out and about' group to promote activity and fun outside of the unit.

An advocate comes weekly so that the young people can address any issues they may have where they don't want to approach a Darwin team member. The advocate is also available to visit as per request during the rest of the week if an advocacy issue occurs.

## The Darwin Learning Centre

Young people at the unit attend the Darwin Learning Centre, which is part of Pilgrim Pathways School. The Learning Centre aims to enable students to continue their learning as much as possible, with staff liaising closely with students' home schools. Each student has their own Individual Education Plan. The school provides specialist subject teaching of the core curriculum, as well as a flexible learning environment where students can carry out their own individual studies in a small class environment. The Learning Centre also offers a wealth of additional qualifications including Functional Skills at all levels, Trinity College Arts Award, Unit Award AQA Scheme and AQA PSE. As the Darwin Learning Centre is a registered exam centre, it is possible for students to take their exams here and students are supported to pursue their future and further education options. The Learning Centre also supports students who are seeking training or employment.

The Darwin Learning Centre was rated 'outstanding' by OFSTED in their latest inspection, in November 2023.

## CQC

The Darwin Centre is regulated by the Care Quality Commission (CQC). Our last inspection took place in 2021/2022, which rated the service as 'good' overall, with some improvements required in the area of safety. The full report can be found here: [Cambridgeshire and Peterborough NHS Foundation Trust - Care Quality Commission \(cqc.org.uk\)](#).

[Cambridgeshire and Peterborough NHS Foundation Trust - Overview - Care Quality Commission \(cqc.org.uk\)](#)

## Our Service: Safe

Unless otherwise stated, the information below is accurate between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023.

### Referrals

During this period, the Darwin Centre received 336 referrals. Table 1 shows the referrals received this year, compared to the previous two years, by referral type.

Referral Type	Year		
	2020-2021	2021-2022	2022-2023
Emergency	128	157	66
Urgent	200	275	220
Planned / Routine	13	15	34
Not noted	3	7	16
Total	344	454	336

Table 1. Note: 'not noted' refers to referrals received in which the referral type hasn't been stated on the referral form.

### Admissions and Discharges

Between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023, 38 young people received treatment at the Darwin Centre.

#### Admissions:

##### *Number*

There were 31 admissions during this period; two of the admissions were for the same young person. All patients were initially admitted as an inpatient, with four young people being transferred to day-patient status during their stay. Two of the young people admitted had previously been admitted to the Darwin Centre in the preceding financial years.

Of the admissions that took place during this period, 4 were emergency referrals, 19 were urgent referrals, 4 were planned/routine referrals, and 4 were admitted where the referral type wasn't noted.

##### *Age*

The average age on admission was 15 years 9 months, with a range from 13 years to 17 years 9 months.

### Gender

Of the 30 different young people admitted during this period, 77% (23) identified as female, 10% (3) identified as male, 10% (3) identified as transgender male, and 3% (1) identified as non-binary.

### County of Origin

Of the 31 admissions, most referrals (13; 42%) came from Cambridgeshire. Figure 1 below shows the spread of different counties from which we received and accepted referrals.

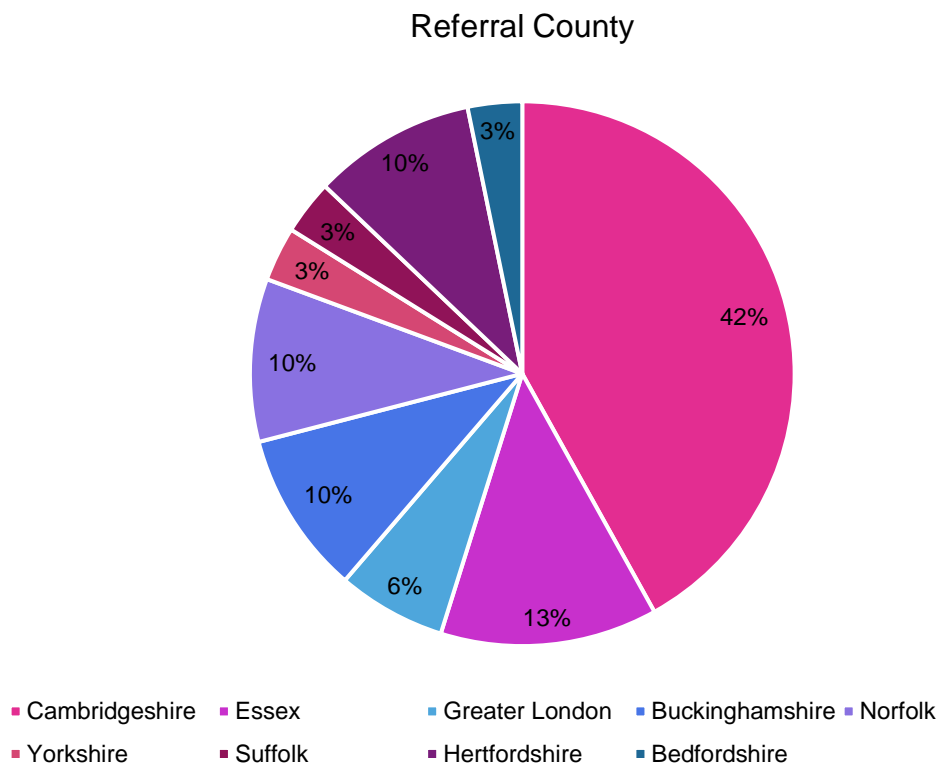


Figure 1: the counties from where referrals were received and accepted from.

### Diagnosis Upon Admission

Some of the young people admitted during this period had a working/hypothesized diagnosis upon admission; others had no formal diagnosis. It should be noted that diagnoses are often tentative and may change throughout admission and as the presentation of the young people changes too.

Figure 2 shows the spread of diagnostic 'parent' categories from Chapter 6, ICD-11, of the primary diagnosis of the young people admitted during this period.

### Primary Diagnosis upon Admission (n = 31)

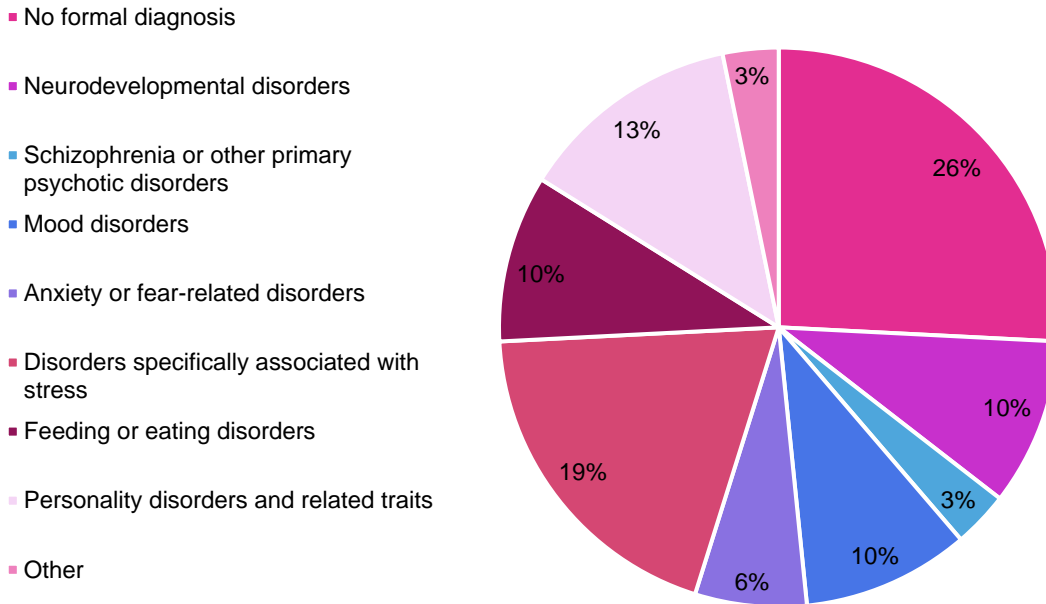


Figure 2: primary diagnoses upon admission.

### Mental Health Act Status Upon Admission

Eleven young people were admitted under Section 2 (admission for assessment) of the MHA. Five of the admissions (four young people) were admitted under Section 3 (admission for treatment) of the MHA. One young person was admitted under recall of their Community Treatment Order as per the MHA.

### Length of time known to Mental Health Services

The time that each young person was known to mental health services varied, from six months to four years. Of those admitted, most (29%) were known to mental health services in some form from 1 ½ years to 2 years before admission. Figure 3 shows the full spread of time known to mental health services.

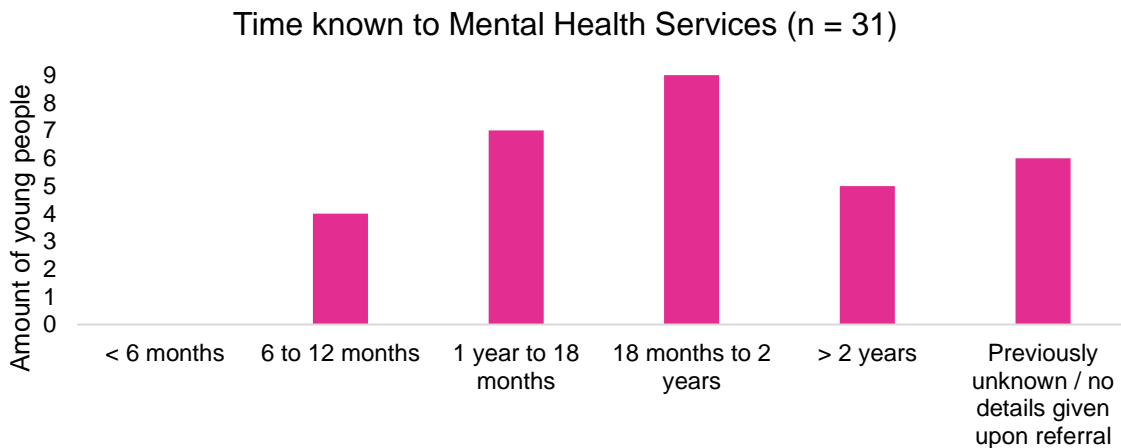


Figure 3: time known to mental health services.

## Discharges:

### *Number*

There were 32 discharges during this period; 2 of the discharges were for the same young person. All were planned discharges.

### *Treatment after discharge*

Of those discharged, most of the young people (27; 84%) were discharged to the care of the relevant outpatient CAMHS or Adult Community teams, including Tier 3 and Tier 2 services. Three young people (four discharges) were transferred to other CAMHS inpatient beds in wards more suitable for their current needs. One young person went to a therapeutic placement.

## Bed Occupancy

The Darwin Centre for Young people is commissioned for 12 beds. The mean percentage of occupied beds at the beginning of each month, including young people on leave, was 77%. The Royal College of Psychiatrists recommend no more than an 85% bed occupancy rate for the most efficient service, and so the Darwin Centre is in line with this recommendation. Figure 4 shows the occupancy of commissioned beds over these months.

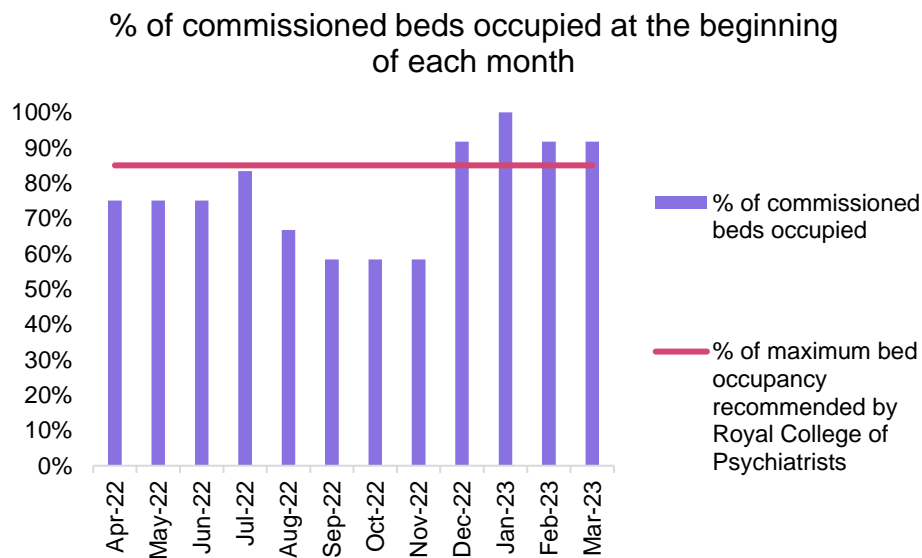


Figure 4: the number of beds occupied each month in terms of beds commissioned.

However, it should be noted that although we are commissioned for 12 beds, sometimes it is not possible to have all the beds open. This is a common issue among inpatient units (Health Committee, 2014) and can occur due to staff shortages and acuity.

On average, the number of beds open at the beginning of each month is 9, and the mean percentage of occupied beds at the beginning of each month, including home

leave, was 94%. This shows that the Darwin Centre does admit as many patients as is feasible and safe for the current situation. Figure 5 highlights the percentage of beds occupied, compared to the actual number of beds available, at the beginning of each month.

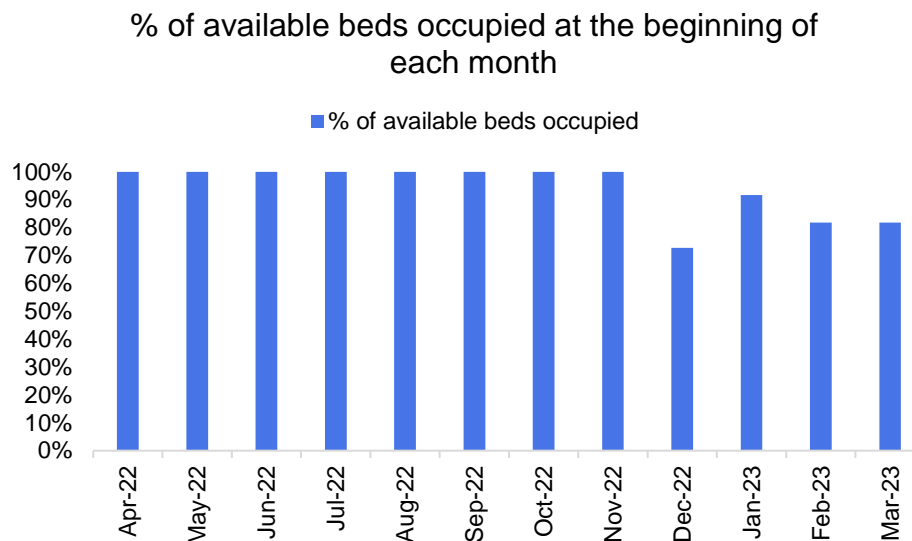


Figure 5: the number of beds occupied each month in terms of beds open.

### Length of Stay

The mean length of stay of all young people that were treated by and discharged from the Darwin Centre between the 1<sup>st</sup> of April 2022 and 31<sup>st</sup> March 2023 was 104 days (approximately 3 ½ months).

Figure 6 shows the variation that can occur within this, with patients staying from 7 days to 501 days ( $SD = 109$  days). It is worth noting that part of the young people's treatment involves spending time on home leave and integrating back into the community. Therefore, there will be periods during the admission when young people will not be spending all their time on the unit.

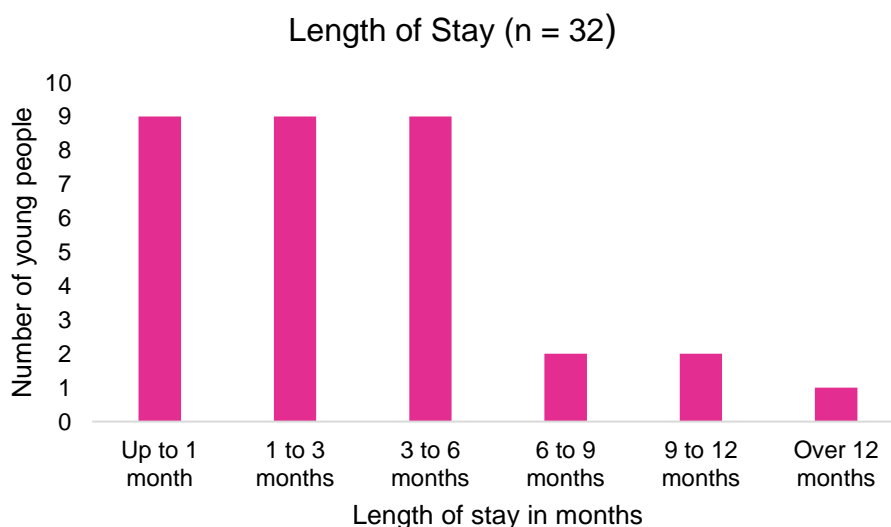


Figure 6: variation in the length of stay on the unit.

## Serious Incidents

There was one serious incident during this period, in May 2022.

## Learning Lessons

After this incident, neighboring units were given access to wards and bedrooms so that, going forward, there is another level of external accessibility to the ward environment. The need for training on the SBAR tool for effective, concise handovers was also considered.

## Formal Complaints

There were no formal complaints made during this period.

## Reducing Restrictive Practices

The Darwin Centre for Young People operates using a 'least restrictive' approach. We are committed to monitoring and reducing restrictive practices. Restrictive practices are only used on the ward when all other alternatives, such as distraction, DBT-based interventions, monitoring etc., have been exhausted. Young people and staff members are offered a debrief after any incidents have occurred, during which it is discussed how the incident made them feel, how it came about, and how future situations could be handled differently to reduce the likelihood of further incidents or restrictive interventions being needed.

Table 2 highlights the types of restrictive practices which may be used in a Tier 4 CAMHS unit, such as the Darwin Centre.

Type	Explanation
Safe holding	Restricting movement in approved ways.
Full Physical Intervention	When staff take control over patient movement for the shortest period to administer medication or prevent further harm.
Rapid Tranquilization	Giving medication which may help reduce agitated or dangerous behaviour.
Seclusion	Providing an isolated safe space where a person can stay until their behaviour is more settled in presentation.
Search (environment)	Searching for contraband in the personal belongings / room of a young person.
Search (personal)	Searching for contraband which may be secreted upon a young person or their clothing.

Table 2: restrictive interventions used at the Darwin Centre.

However, a least restrictive approach doesn't mean a no restrictions approach, and sometimes it is necessary in the course of best care to use them. When a restrictive intervention occurs, it is logged by the team member who was involved on a system called DATIX. This is monitored by ward managers, matrons, and consultants. Figure 7 shows the number of restrictive practices used for each month over the previous financial year.

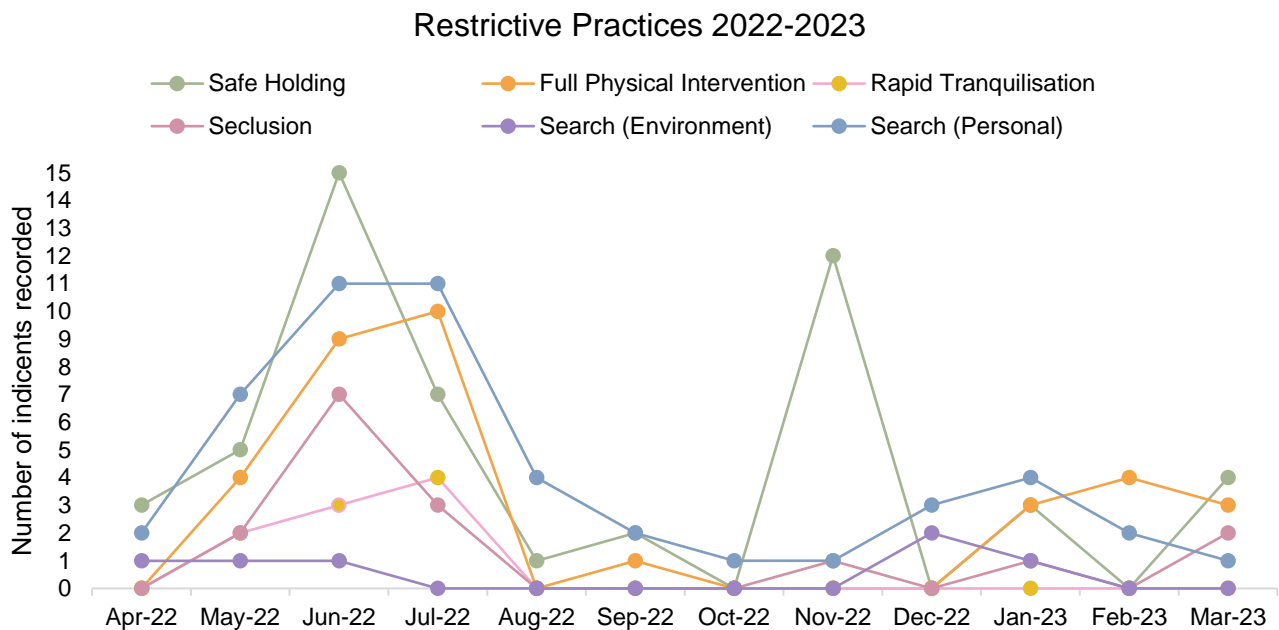


Figure 7: number of restrictive practices recorded over the past year.

As previously mentioned, part of the Darwin Centre's commitment to reducing restrictive practices is only utilizing them when necessary. This does partly depend upon the patient mix, as some clinical presentations may require them more often due to their nature, than others. Nevertheless, the team at the Darwin continue to utilise them only when essential. Figure 8 below shows a comparison on the numbers of restrictive practices from last year's figures. The number of restrictive practices being used at the Darwin Centre has decreased between 2021/2022 and 2022/2023. Please see Appendix A for a summary of the number of restrictive practices.

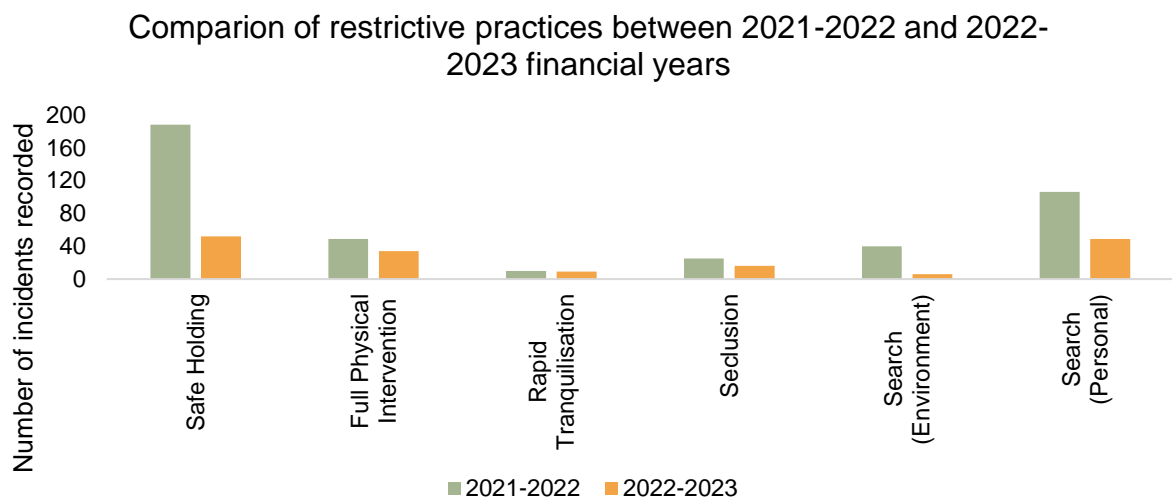


Figure 8: comparison of restrictive practices.

## Our Service: Caring

### Analysis of Patient and Parent/Carer Experience Reports

Every month, young people and their parents/carers are asked to fill out an experience survey, which asks questions about how they have experienced the unit over the previous month. This is a survey mandated by CPFT.

There is opportunity for both patients and parents/carers to fill out the monthly survey. There are QR codes around the ward for the young people to scan using their mobile devices to fill out the questionnaire. There are also paper copies of the QR code circulated about regularly during meetings, and the HoPPI will also approach young people to fill the survey out using the link. Parents/carers get emailed the link monthly, and there is also a QR code in the ward waiting area to scan on their phone and complete from there. Nevertheless, it should be noted that the HoPPI role was not filled for much of the financial year, and so it could be the case that many young people/parents and carers in this cohort were not approached as often as they could have been.

Analysis of Patient and Parent/Carer surveys is limited because of a low response rate from both groups. Therefore, the following section should be interpreted with caution.

### Patient Surveys Analysis

Over the course of the year, 23 surveys were filled out by young people. The number of surveys filled out differed by month; below is a graph showing the number of surveys filled out by young people per month.

As the answers are anonymous, and young people are offered to complete the survey on repeated occasions (every month during their admission), it is unclear how many young people completed the 23 surveys.

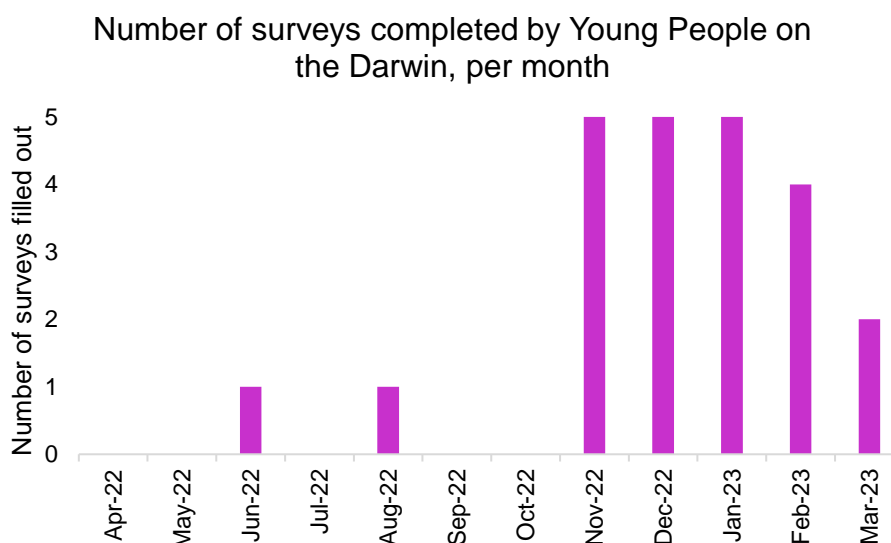


Figure 16: Number of Patient Experience Surveys completed per month.

Young people get asked various questions when they fill out the experience survey, a full list of which can be found in Appendix I. The topics primarily cover experience of the service, care and welfare, and nutritional needs.

Of the 23 surveys completed:

Experience of the service:

70% (16) of the responses rated their experience of the service as 'Very Good' or 'Good'.

61% (14) of the responses rated the care they received as 'Good', 35% (8) of young people rated the care they received as 'Fair', and one young person declined to answer the question.

Care and Welfare:

96% (22) of the responses said that staff supported them to feel safe during their stay on the ward. One young person declined to answer the question.

100% (23) of the responses felt that staff are polite and friendly, and that they treated young people well.

87% (20) of the responses stated that they had a weekly meeting with a doctor/nurse to discuss their care.

Nutritional needs:

52% (12) of the responses stated that the food on the ward was 'Very Good' or 'Good', and 30% (7) of the responses stated that the food on the ward was 'Fair'.

Overall comments:

This cannot be seen as a representation of how all young people who were in our care during April 2022 to March 2023 felt. Young people can choose not to participate in the surveys and many of them, for whatever reasons, choose not to.

It does seem that the majority of young people who did fill out the surveys did feel somewhat positively about elements of their admission at the Darwin, especially in areas concerning staff. Written comments about the staff include 'the staff have been amazing', and 'they are kind'.

### Young Person 'Have Your Say'- Topics and Themes

As previously mentioned, young people can attend a weekly 'Have Your Say' meeting with a peer support worker and the advocate, where they have a free space to talk about their opinions and thoughts on the ward. There is a structure to the 'Have Your Say' groups: they firstly talk about positives, then worries and concerns, followed by current ward environment, then participation opportunities, and then the

sessions end with suggestions, where the young people can make suggestions on how to improve the ward.

Below is a list of recurring topics and themes from the 'Have Your Say' meetings:

*Recurring Topics*

CPA's  
Ward Rounds  
Peer on Peer conflict  
Agency Staff  
Staff Presence  
Activities  
Information Sharing  
Privacy  
Engagement Opportunities  
Repairs / Improvements  
Disruptive Behaviours  
School

*Recurring Themes*

Safety  
Trust  
Respect  
Empowerment  
Collaboration  
Choice

The Darwin Centre is responsive to 'Have Your Say' feedback and demonstrates a ward culture of proactivity in relation to patient experience. Reviewing 2022/2023 feedback does identify several recurring topics brought forward by the young people. The specific worries, suggestions, and positive comments related to the recurring topics does vary. However, thematically, it is clear that young people want:

- To feel safe- amidst ward-based conflicts and/or unsettling behaviours associated with some young people's struggles.
- Adults to invest in developing relationships with them and gain their trust – this is in relation to transient staffing, and the use of bank and agency staff.
- To feel respected and acknowledged – for example, in the ward rounds/CPAs, but also in relation to staff presence around the ward.
- To collaborate – ranging from choosing recreational activities, to co-creating ways of working with the MDT.
- To make choices about their journey – including their discharge plans and influencing their rhythms and routines on the ward.

Where possible, the suggestions that the young people put forward in their 'Have Your Say' group are implemented. For example, it was reported that sometimes attending ward round can be daunting, and some young people didn't want to attend theirs. Young people now get the choice whether they attend or not. A member of the ward team meets with the young person a day prior, to discuss through their feelings on how the week has gone, to write down any requests, and to make any comments they would like to. They are then met with after their ward round, where feedback can be given.

Young people also reported that they didn't feel as though staff were entirely present sometimes. In response to this, staff have been reminded to introduce themselves to patients who they may be unfamiliar too, to refrain from using their phone on the ward as much as possible, and to knock on doors before entering, to ensure privacy

is maintained. Young people are also given ample opportunity to suggest activities that they would like to do – the occupational therapist is quick to facilitate requests and has also made the ward activities a lot more accessible for young people when needed, as a result of the feedback received during previous ‘Have Your Say’ meetings.

### Parent/Carer Survey Analysis

Over the course of the year, 16 surveys were filled out by parents/carers. The number of surveys filled out differed by month; below is a graph showing the number of surveys filled out by parents/carers per month.

As the answers are anonymous, and parents/carers are offered to complete the survey on repeated occasions (every month during their child’s admission), it is unclear how many parent/carers completed the 16 surveys.

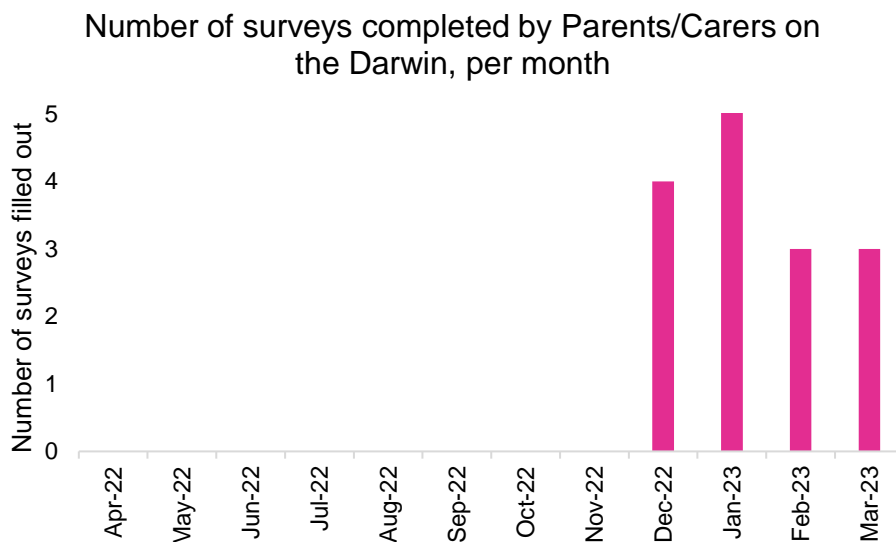


Figure 17: Number of Parent/Carer Experience Surveys completed per month.

Parents and carers get asked various questions when they fill out the experience survey, a full list of which can be found in Appendix J.

Of the 16 responses:

50% (8) of respondents said ‘Yes’ and 44% (7) said ‘Sometimes’ when asked if they felt valued and listened to about the support the person they care for has received.

50% (8) of respondents said ‘Yes’ and 31% (5) said ‘Sometimes’ when asked if they felt included and involved in all stages of the journey for the person they cared for.

75% (12) of respondents said ‘Yes’ and 19% (3) said ‘Sometimes’ when asked if they felt able to raise concerns about the care received for the person they cared for.

38% (6) of respondents said ‘Good’, and 56% (9) said ‘Satisfactory’, when asked how they would rate the overall service received for the person they cared for.

40% (6) of respondents said 'Good' and 47% (7) said 'Satisfactory' when asked how they would rate the support they received as a carer.

### Parent Support Group – Topics and Themes

There are opportunities for the parents/carers of the young people who are being treated at the Darwin Centre to attend parent support groups. Below is a list of the recurring topics/themes that are commonly discussed during these groups.

<i>Recurring Topics</i>	<i>Recurring Themes</i>
Least Restrictive Practice	Safety
Information Sharing and Communication	Trust
Safety of the young people	Respect
Recovery progress of the young people	Empowerment
Ward Access	Collaboration
Acceptable risks and risk management	Choice

Reviewing 2022/2023 feedback from the parent/carer support groups shows some clear, recurring themes and topics can be identified:

- Safety and Trust – new families often report fearing for the safety of their young person when being asked to entrust them to a new team.
- Respect and Collaboration – families have shared that they do not feel their expertise as the parent/carer of these young people is respected or acknowledged adequately. Parents would like to be more involved collaboratively in supporting their young person through their recovery.
- Empowerment – young people can sometimes choose to limit information sharing with their parents/carers. This process makes families feel disempowered, excluded, and ultimately, not communicated with.
- Choice – the notion of choice is something that families struggle with; 'We had no choice about whether our young person was admitted', or, 'we have no control over whether our young person is given certain freedoms while admitted'.

In May 2023, a multi-family therapy group will replace the parent support group format. The intention is that there can be an opportunity for processing and educating families in the new format, more so than in the support group format.

### Survey Comments for Young People and Parents and Carers

Below is a selection of comments made by young people and parents/carers:

'The staff here are really nice. We can get bored sometimes, but I think that's the nature of being in a ward like this. The staff do everything they can to try and reduce that feeling.'

'Our young person is currently choosing not to communicate with us and has also

asked that information is withheld. I think that the ward needs to develop new ways of working where they develop new ways to hold the families on the outside when they can't share information in a traditional way.'

'We have been in the ward for nearly a year. We have gone through different phases. There have been periods that were unsatisfactory, and there have been periods where good decisions have been made, and the experience has been very good. Overall, I would have to say an average of satisfactory.'

'Individual conversations are encouraging with MDT, but there is a feeling that they (MDT) need to get more joined up, or if they ARE joined up, they need to show us that more so.'

'We have raised the occasional concern, and these have been responded to quickly and effectively.'

### Overview of Involvement Opportunities

The Darwin Centre aims to involve young people and their parents/carers in the care and service it provides. Throughout 2022/2023, activities to involve patients and their families in the service have included:

- Weekly visits from the NYAS advocate, who provides 1:1 advocacy for the young people.
- Weekly 'Have Your Say' groups with the young people.
- Opportunities for the young people to provide feedback via monthly inpatient surveys.
- Opportunities for parents and carers to provide feedback via monthly carer surveys.
- A weekly Community Meeting.
- Exit surveys for the young people (including a CAMHS satisfaction survey).
- Exit surveys for parents and carers (including a CAMHS satisfaction survey).
- Peer support 1 to 1 sessions among other things provide an ad-hoc daily space for young people to share their experience and influence the service offering where possible.
- Shared experience sessions, which allow young people to hear the stories of other service users.

## Our Service: Responsive

### Waiting Times

For those admitted within this financial year, the mean waiting time between referral and admission was 15 days ( $SD = 21.3$  days). Table 3 shows the waiting times from referral to admission, for each referral type. Please note that we only record a referral upon receipt of a NHSE CAMHS Tier 4 Referral Form.

Referral Type	Mean Waiting Time in Days ( $SD$ )	% admitted within one week of referral	% admitted within one month of referral	% admitted within two months of referral
Emergency	21.8 (27.3)	50%	75%	100%
Urgent	9.7 (8)	47%	95%	100%
Planned / Routine	32 (51.3)	50%	75%	75%
Not known	17.3 (11.3)	0%	75%	100%
All referral types	15 (21.3)	45%	87%	97%

*Table 3. Note: these figures only include young people admitted to our service, and not those who were referred but not admitted.  $SD$  = standard deviation.*

There are many reasons why there may be a delay to admission: these include recovering from physical injury, trying to find more suitable placement for that young person, or awaiting a bed to become free.

## Our Service: Effective

The effectiveness of our service can be evaluated by validated clinical outcome measures and experience and satisfaction surveys we give to young people and their families, both of which are presented in the current report. We also work in line with QNIC (Quality Network for Inpatient CAMHS) recommendations and CPFT standards on key areas such as care planning, treatment goals and the ward environment.

We have previously been accredited by QNIC, and we are currently working towards re-obtaining the accreditation.

### Overview and Aims of Routine Outcome Measurement

At the Darwin Centre, we routinely evaluate changes in young people's difficulties, functioning, symptom severity and progress by collecting data at and during admission, and at discharge. This is known as routine outcome measurement and helps us to evaluate the performance of the service. Questionnaires are completed by young people, their parents/carers, and their clinicians, to ensure a range of perspectives are considered.

The aim of routine data collection is to interpret a service's outcomes in such a way that they can directly inform and improve clinical practice. This includes guiding treatment, supporting the team to reflect on the care they give, encouraging multiple perspectives, and actively seeking the young person's views on their own strengths and difficulties. If they are used in a meaningful manner, outcome measures can foster engagement, and help to promote a more person-centered approach to treatment. Our service is actively working towards achieving these goals.

### Outcome Measures Used at the Darwin Centre

The measures that are used at the Darwin Centre are recommended by QNIC and CORC. They aim to measure various aspects of a young person's current presentation. This includes symptoms and their severity, physical health, cognitive and behavioural measures, functioning in social, family, and educational domains, and the impact these cause upon the young persons life.

<i>Measure</i>	<i>Why do we use it?</i>
Affective Reactivity Index (ARI)	To assess changes in irritability and proneness to anger during admission.
Mood and Feelings Questionnaire (MFQ)	To assess how someone has been feeling or acting recently.
Health of the Nation Scale for Children and Adolescents (HoNOSCA)	To measure behaviours, impairments, symptoms, and social functioning of a young person.

Strengths and Difficulties Questionnaire (SDQ)	To measure behaviour and symptom severity, and their impact upon functioning.
Children's Global Assessment Scale (CGAS)	To measure social and psychological functioning.
Systemic Clinical Outcome and Routine Evaluation (SCORE-15)	To assess family functioning and identify any potential areas which may benefit from therapeutic change.
Revised Children's Anxiety and Depression Scale (RCADS)	To assess and measure symptoms of anxiety and depression.
Demographic data	To keep a track of previous treatment received, family composition, ethnicity, school attendance, etc

#### How we use Outcome Measures on the ward

An analysis of the outcome measures collected from each young person are disseminated amongst the team at admission, each Care Programme Approach (CPA) meeting, and at discharge. The reports aim to be easy to interpret and help improve our understanding of a young person's strengths and challenges.

During admission to the Darwin, the young people are asked to complete the RCADS and MFQ prior to each CPA. A clinician is also asked to complete a CGAS rating prior to each CPA. Analyses of these measures are integrated into CPA reports for discussion with wider networks, including community and school teams.

Completion of the outcome measures in this way allows us to examine changes in a young person's presentation over the course of their admission.

#### Caution on Routine Outcome Measure Data and its interpretation

In this section, we would like to draw attention to some of the challenges involved in routine outcome measurement, and thus the reasons as to why the reader should interpret the data presented with caution. We would also like to explain the benefits that routine outcome measurement can offer for evaluating and improving the care we provide.

There are various factors which can impact upon effective data collection. These include brief admissions, unplanned discharges, staffing shortages, low return rate of questionnaires, and the patient themselves – sometimes a young person may be too clinically unwell to be able to fill out the questionnaires during most of their admission. These factors are challenges that most, if not all, CAMHS services face when trying to implement routine outcome measurement collection (Hall et al., 2014;

Johnson & Gowers, 2005; Law & Wolpert, 2014; Dawson et al., 2010). As a result, the data we have presented and analysed may be under-representative of the young people who received treatment at the Darwin Centre during the year. Those who completed the measures may present with different characteristics from those who did not complete the measures (Wolpert et al., 2014). Indeed, routine data collection requires considerable resources and attitudinal shifts within services, and it is recognized that implementing these processes take time and effort.

There were also additional challenges to effective data collection this year, namely not having a Research Assistant or Head of Patient and Parent Involvement in post during part of the year. As it is these staff members who are responsible for data collection, the data presented in the following sections may be an under-representation of the young people who received treatment at the Darwin Centre during the relevant period.

Due to the aforementioned reasons, we do not have complete data for all patients; not all the young people and their parents/carers completed the measures at admission and discharge. This is a challenge faced by all CAMHS services- a 2014 audit of three CAMHS services found that only 16% of cases had complete datasets. (Hall, et al., 2014). This is a challenge which CAMHS are collectively working to improve.

Furthermore, other services which implement routine outcome measurement (for example, CYP IAPT) only report and publish outcomes at service level if 90% of cases have complete data sets. This further confounds analysis by not providing a sufficient level of comparison groups.

Due to these important considerations, we encourage the reader to interpret the results presented in the following section with a sense of caution.

### Analysis of Routine Outcome Measures

The outcome data presented in the following section was collected from patients who were discharged from the Darwin Centre between 01.04.2022 and 31.03.2023. These patients were not necessarily admitted in the same financial year.

We have presented our collected data using simple descriptive summaries, to give the reader a general overview of our patient group and service. Statistical testing would not be appropriate because by its very nature, it may oversimplify conclusions. We would like to encourage the reader to take a critical perspective that acknowledges the complexities and uncertainties of routine outcome measurement.

The following data is from young people who were discharged between 1<sup>st</sup> April 2022 and 31<sup>st</sup> March 2023, their parents/carers, and a clinician on the Darwin unit.

#### *Mental Health Status*

The Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA);

Gowers et al., 1999) is a measurement tool that assesses young people’s current mental health status, including behaviour (disruptive behaviour, overactivity, self-injury, inattention, substance misuse); impairment (physical illness and disability, problems with language skills); symptoms (problems associated with hallucinations, delusions, or abnormal perceptions); and social functioning (problems with peers, family relationships, problems with self-care and independence, poor school attendance). There are three versions of the HoNOSCA: self-rated, parent-rated, and clinician-rated. A higher score indicates more impaired functioning.

Figure 9 below shows that during admission, on average, the HoNOSCA score reported by young people, their parent/carers, and the clinician, decreased. This is indicative of an increase in functioning during admission. See Appendix B for a summary of HoNOSCA scores.

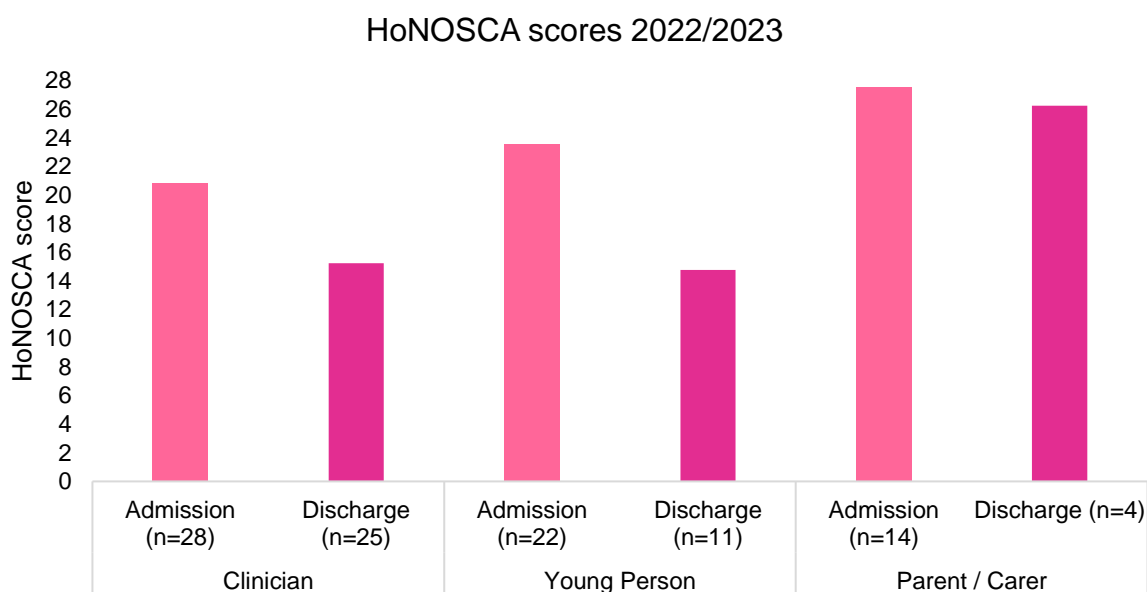


Figure 9: comparison of HoNOSCA scores

### Symptoms of Anxiety and Depression

The Revised Children’s Anxiety and Depression Scale (RCADS; Chorpita et al., 2000) is a self-reported questionnaire that measures youth anxiety and depression. The sub scores generated correspond to the DSM diagnoses of Separation Anxiety Disorder, Social Phobia, Generalized Anxiety Disorder, Panic Disorder, Obsessive-Compulsive Disorder, and Major Depressive Disorder. The measure also yields a Total Anxiety Score (mean of five anxiety subscales) and a Total Anxiety and Depression Score (mean of all subscales). Higher scores indicate greater severity of symptoms.

Figure 10 below suggests that for this cohort, there was a minimal difference in severity of symptoms reported between admission and discharge. See Appendix C for a summary of RCAD scores.

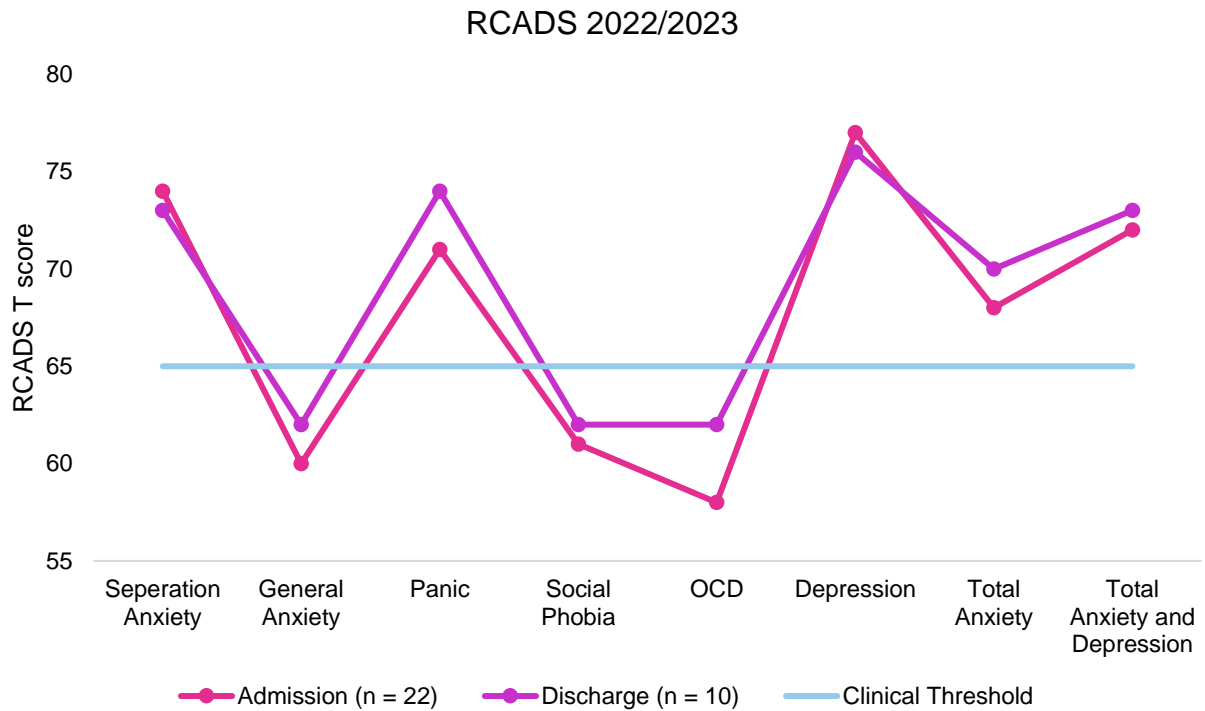


Figure 10: a comparison of RCAD scores

The Mood and Feelings Questionnaire (MFQ; Angold et al., 1995) is a self-reported questionnaire that measures adolescent depression by providing a series of descriptive phrases about how they've been acting and feeling in the last two weeks, to which the user chooses 'true', 'not true', or 'sometimes'. Higher scores indicate greater severity of symptoms.

Figure 11 below shows a slight improvement in symptoms from admission to discharge. See Appendix D for a summary of MFQ scores.

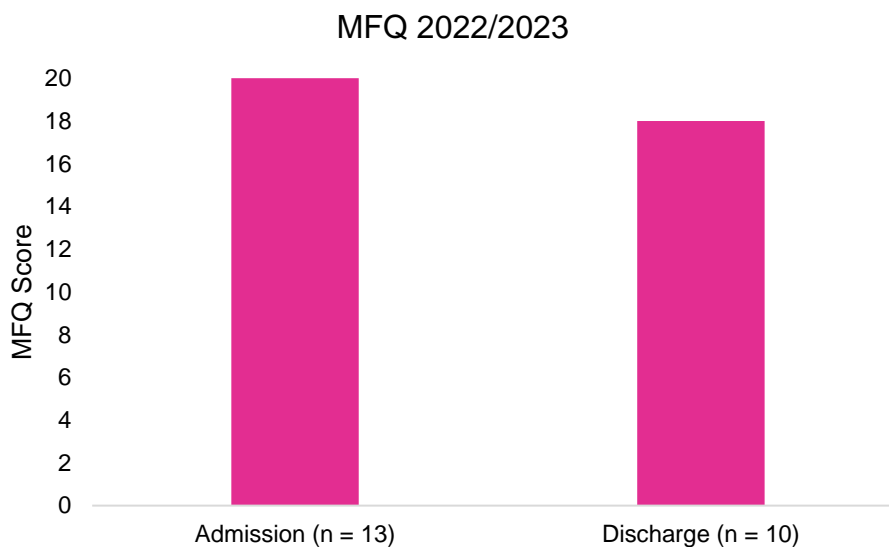


Figure 11: a comparison of MFQ scores

### *Irritability and Proneness to Anger*

The Affective Reactivity Index (ARI; Stringaris et al., 2012) is a self- and parent-report measure of irritability and proneness to anger. It consists of six questions assessing the threshold for an angry reaction; the frequency of angry feelings and behaviours; the duration of such feelings and behaviours and the extent to which irritability interferes with everyday life. Higher scores indicate higher irritability.

Figure 12 shows the mean total ARI scores at admission and discharge reported by young people and their parents/carers. Self-reported and parent-reported total ARI scores decreased from admission to discharge, indicating that the young people and their parents/carers perceived improvements in their irritability and anger. The data represents 26 young people for admission, 10 young people for discharge, 17 parents/carers for admission, and 6 parent/carers for discharge. See Appendix E for a summary of mean ARI scores.

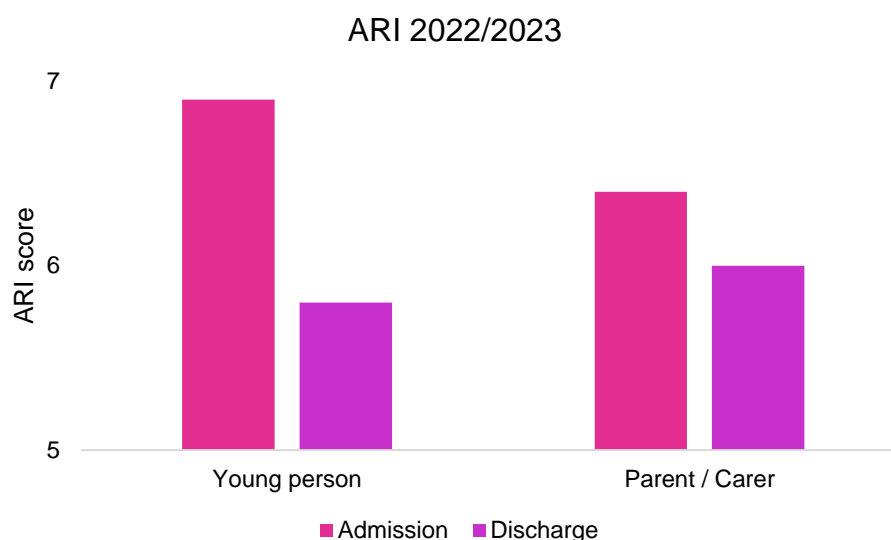


Figure 12: a comparison of ARI scores

### *Behaviour and symptom severity*

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is a self- and parent-report measure of behaviour and symptom severity and the impact of this on functioning. The questionnaire generates five subscale scores: emotional symptoms, conduct problems, hyperactivity, peer problems and pro-social behaviour. A total difficulties score is generated by summing all subscales except the pro-social subscale. A higher score indicates greater severity, apart from the pro-social behaviour scale, for which a higher score indicates better functioning.

Figure 13 shows the mean total difficulties scores at admission and discharge, reported by young people and their parent/carer. At admission, the parent-reported mean total fell into the “very high” range, and at discharge reduced to the “high” range. The self-reported mean total difficulties score remained similar at admission and discharge and fell into “very high” range at both time points. The data represents 22 young people for admission, 10 young people for discharge, 18 parents/carers for

admission, and 5 parent/carers for discharge. See Appendix F for a summary of mean SDQ subscale and total difficulties scores.

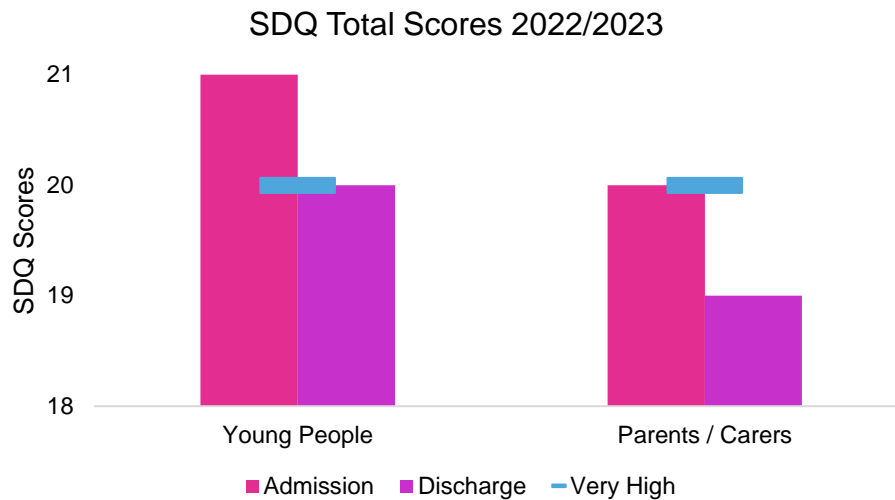


Figure 13: a comparison of SDQ scores

### Global Functioning

The Children’s Global Assessment Scale (CGAS; Shaffer et al., 1983) is a clinician-rated measure of global functioning, including psychological, social, and school functioning, on a continuum from 1 (“needs constant supervision”) to 100 (“superior functioning”). A higher CGAS score indicates better global functioning.

Figure 14 shows the mean CGAS score at admission and discharge for this cohort. On admission, the mean CGAS score fell within the 31-40 range, indicating that young people presented with “serious problems”. At discharge, the mean CGAS score fell within the 41-50 range, indicating “obvious problems”. The increase in mean CGAS scores from admission to discharge suggests that the young people in this cohort improved in overall functioning during their stay at the Darwin Centre. Please see Appendix G for a summary of the mean CGAS scores at admission and discharge.

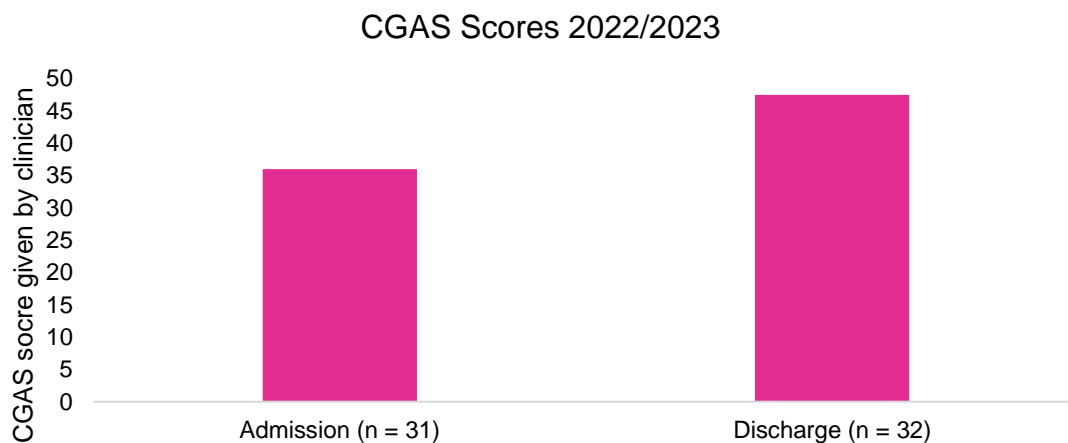


Figure 14: a comparison of CGAS scores

## Family Functioning and Change

The Systemic Clinical Outcome and Routine Evaluation (SCORE-15; Stratton et al., 2010) is a self-report measure completed by both the young people and their parents/carers. The questionnaire assesses aspects of family life that are important for therapeutic change. The measure is structured so that different family members' perceptions of the family can be compared. The scale generates a total score, three dimension scores and a mean score. The three dimensions are: Strengths and Adaptability, Overwhelmed by Difficulties and Disrupted Communication. Higher scores indicate poorer family functioning.

Figure 15 and 16 shows the SCORE-15 scores at admission and discharge from young people and their parents/carers respectively. The self-reported scores have very little difference between admission and discharge, suggesting that this cohort did not feel as though the functioning within their family improved. The parent-reported scores seem to decrease on discharge, suggesting that their parents felt that throughout admission, the level of family functioning had improved. Please see Appendix H for a summary of the mean SCORE-15 scores at admission and discharge.

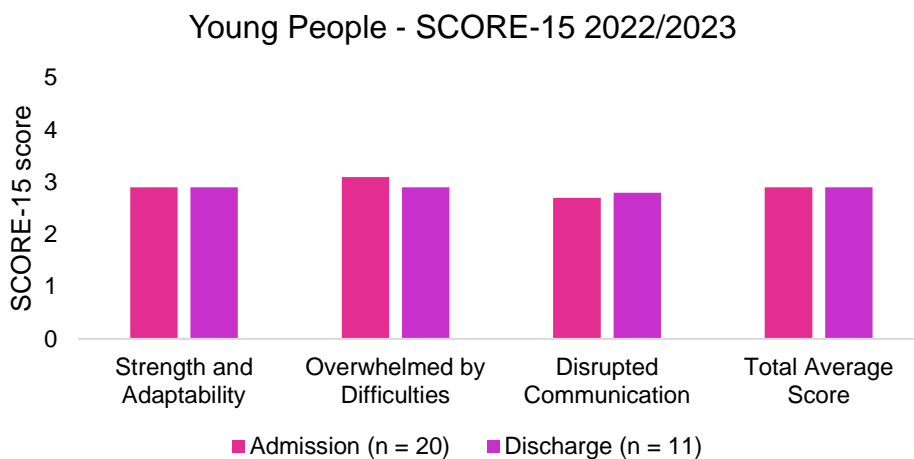


Figure 15: a comparison of SCORE-15 scores from young people

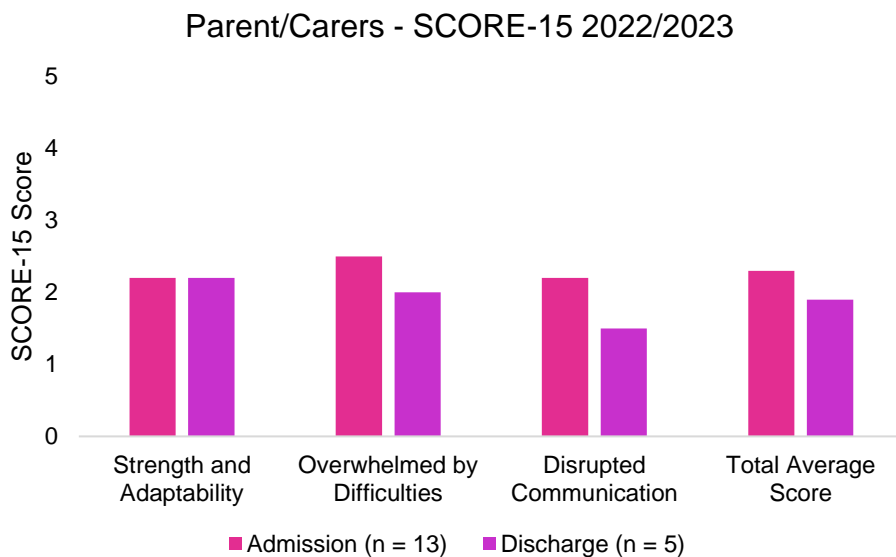


Figure 16: a comparison of SCORE-15 scores from parents/carers

## Summary of Routine Outcome Measures

During the 2022/2023 financial year, the Darwin Centre for Young People continued to collect Routine Outcome Measures from young people, their parents and carers, and clinicians, as an indicator of the services performance.

The analysis of the outcome measures we collected demonstrates improvements across multiple measures. Responses to the HoNOSCA indicate improvements in mental health status according to all three respondents (young people, parents/carers, and clinicians). Young people's irritability and proneness to anger improved during their stay at the Darwin, according to both parent and young person reports on the ARI. Both the young people and parents perceived a slight improvement in behaviour and symptoms severity in the domains measured by the SDQ. The self-reported scores from the MFQ suggest that in this cohort, symptoms of depression reduced in severity during admission.

An important goal of treatment at the Darwin Centre is to improve a young person's functioning in their everyday lives, including family, social and education. Improvements were shown in global functioning, indicated by the change in clinician rated CGAS scores. Parents/carers report overall improved family functioning throughout admission, as shown by their responses to the SCORE-15. However, young people perceived no change in their family's functioning, which highlights an important area for improvement for the team.

## Our Service: Well Lead

### Our Team

During a young person's admission, they are offered a comprehensive range of assessments and treatments by our multi-disciplinary team, which is composed of nursing staff, consultant psychiatrist, doctors, family therapist, clinical psychologist, youth intensive psychological practitioners, occupational therapist, music, art and drama therapists, head of patient and parent involvement, research assistant, activity coordinators, peer support workers, dietician, and teachers.

### Teaching and Training

The unit offers ongoing placements for junior doctors, psychiatrists in higher training, student nurses, and trainee clinical psychologists. Occasionally, placements are also offered to student social workers, and trainee art therapists.

Staff are offered additional training from both internal and external agencies. This includes training on behavioural support plans and how to implement them, disordered eating and meal support, social story writing, safeguarding, neurodevelopmental conditions and how they can present differently, nasogastric feeding, and nova glucometer.

### Co-production with Young People

We are committed to involving our young people in service design, development, and evaluation. We regularly ask the young people about their care, and gather feedback in a Have Your Say group, led by a peer support worker. This feedback is disseminated amongst all members of staff and is implemented whenever possible.

Young people can participate in recruitment panels, for posts such as family therapists, the head of patient and parent involvement, and peer support workers. Interview participation is a paid opportunity for young people. We included young people in the designing of a new seclusion suite, which has been built. Young people can also provide feedback via service evaluations; a current service evaluation is looking into the implementation of peer support workers on the ward, to which young people are asked their opinions and can give feedback on this.

### Developments

The Darwin Centre is part of the East of England Providers Collaborative, which brings together providers from across the NHS and the independent sector to deliver services using consistent approaches and agreed shared criteria. As part of this service, a centralised referrals system via the Patient Flow Hub has been developed, with an aim to improve the flow of patients and admit people as close to home as possible.

We have implemented a 'red to green' process at the Darwin Centre. This includes a daily assessment of barriers to discharge for our young people, using a red/green status. This helps us as a team to focus on outstanding items in the young person's

care and reduce the time they spend in the system.

We are using ICD-11 coding within our care, especially in the CPA process. Our newly developed Home Treatment Team has been integrated into our work at the Darwin Centre, and we also work with the psychological therapies' hub, which is a team of psychology colleagues that work between the Home Treatment Team and the Darwin. This improves the continuity of the care we provide during admission and post-discharge and allows for a better consistency between inpatient and community services. It has been valued by families and young people and found to be a helpful model to support young people through their journey.

### Moving Forward

The team at the Darwin Centre has had an intense and busy year, with a significant number of improvements being carried out, and developments being made. We continue to work hard to complete these projects. Going forward, we aim to prioritise improving parents and carers experiences, reducing the duration of stays, and continuing to reduce restrictive intervention practices. We are also working towards re-obtaining QNIC accreditation.

The team work extremely hard to ensure the service runs as efficiently as possible, and they are a testament to the NHS. We are proud of our work to date, and we continue with our commitment to serve the population of young people in our service as best we can.

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## Appendices

Appendix A: Number of restrictive practices recorded on DATIX.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Safe Holding	3	5	15	7	1	2	0	12	0	3	0	4
Full Physical Intervention	0	4	9	10	0	1	0	0	0	3	4	3
Rapid Tranquilisation	0	2	3	4	0	0	0	0	0	0	0	0
Seclusion	0	2	7	3	0	0	0	1	0	1	0	2
Search (Environment)	1	1	1	0	0	0	0	0	2	1	0	0
Search (Personal)	2	7	11	11	4	2	1	1	3	4	2	1

Appendix B: HoNOSCA scores on admission and discharge

Clinician		Young Person		Parent / Carer	
Admission	Discharge	Admission	Discharge	Admission	Discharge
21	15	24	15	28	26

Appendix C: RCAD scores on admission and discharge

	Separation Anxiety	General Anxiety	Panic	Social Phobia	OCD	Depression	Total Anxiety	Total Anxiety and Depression
Admission	74	60	71	61	58	77	68	72
Discharge	73	62	74	62	62	76	70	73

Appendix D: MFQ scores on admission and discharge

Admission	Discharge
20	18

Appendix E: ARI scores on admission and discharge

	Young person	Parent / Carer
Admission	6.9	6.4
Discharge	5.8	6

Appendix F: SDQ scores on admission and discharge

	Young Person		Parents/Carers	
	Admission	Discharge	Admission	Discharge
Emotional	7	7	8	7

Symptoms				
Conduct Problems	3	3	2	2
Hyperactivity	7	6	6	6
Peer problems	6	5	4	4
Pro-social	7	5	6	5
Total	21	20	20	19

#### Appendix G: CGAS scores on admission and discharge

	Admission	Discharge
CGAS score	35.93548	47.4375

#### Appendix H: SCORE-15 scores on admission and discharge

	Young Person		Parents/Carers	
	Admission	Discharge	Admission	Discharge
Strength and Adaptability	2.9	2.9	2.2	2.2
Overwhelmed by Difficulties	3.1	2.9	2.5	2
Disrupted Communication	2.7	2.8	2.2	1.5
Total Average Score	2.9	2.9	2.3	1.9

#### Appendix I: Questions in the Patient Experience Survey

1. Overall, how was your experience of our service?
2. Please can you tell us why you gave this answer?
3. Would you like to answer further questions on this survey?
4. When you arrived on the ward did staff make you feel welcome?
5. Do staff support you to feel safe during your stay on the ward?
6. Are staff polite and friendly?
7. Do you feel staff treated you well?
8. Are you involved in decisions about your health?
9. Do you know who is the main person organising your care and treatment during your stay on the ward?
10. Do you have a written care plan?
11. Do you understand what is in your care plan?
12. Have you had a weekly meeting with your Doctor/Nurse to discuss your care?
13. Do you know what your medication prescribed by this ward is for?
14. Were you told about possible side effects of your medication prescribed by this ward?
15. Were you asked your views when medication was prescribed by this ward?
16. Are there activities, groups, or things to do during the weekday?
17. Are there activities, groups, or things to do during the evening and weekend?
18. How would you rate the food on the ward?
19. Has a member of staff ever talked to you about keeping healthy (for example, diet, exercise, sleep, stopping smoking)?

20. How would you rate the care you received?
21. What has been good about the service you have received from this team?
22. What could this team do better?

#### Appendix J: Questions in the Parent/Carer Experience Survey

1. Have you felt values and listened to about the support the person you care for has received?
2. Have you felt included and involved in all stages of the journey for the person you care for?
3. Have you felt able to raise concerns about the care received for the person you care for?
4. How would you rate the overall service received for the person you care for?
5. How would you rate the support you receive as a carer?