Yorkshire & the Humber CAMHS Event

24th March 2015
Welcome & Housekeeping

Fire Alarms & Exit

Toilets

Mobiles

Breaks

#YHCAMHS

Presentations

www.england.nhs.uk
Aims & Objectives

- To discuss issues and opportunities arising from the recent National CAMHS Taskforce Report

- To discuss possible ways forward of addressing the CAMHS provision for Looked After Children

- Identify ways of improving the interface between Tiers 3, 3.5 and 4

- Discuss and identify potential opportunities around cross-locality specialisms
## Agenda

<table>
<thead>
<tr>
<th>Session</th>
<th>Item</th>
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<tr>
<td>09:30 – 11:00</td>
<td>National CAMHS Taskforce Review</td>
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<tr>
<td>11:15 – 11:30</td>
<td>Refreshments</td>
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<tr>
<td>11:30 – 13:00</td>
<td>CAMHS and Looked After Children</td>
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<td>13:00 – 13:45</td>
<td>Lunch</td>
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<td>13:45 – 15:00</td>
<td>Tier 3, Tier 3.5 and Tier 4 Interface</td>
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<td>15:00 – 15:15</td>
<td>Refreshments</td>
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<td>15:15 – 16:05</td>
<td>Cross Locality Specialisms</td>
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<td>16:05 – 16:30</td>
<td>Round-Up of Other Developments and Closing Remarks</td>
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National CAMHS Taskforce Review

Jane Mischenko
Lead Commissioner for Children and Maternity Services
Leeds CCGs
Future in mind

Promoting, protecting and improving our children and young people’s mental health and wellbeing
Taskforce Overview

- **Announced:** August 2014, inaugural meeting September 2014
- **Co-Chairs:** Jon Rouse, Department of Health and Martin McShane, NHS England
- **Membership:** Cross sector experts on children and young people’s mental health and with knowledge of wider system transformation, including education, social care and health.
- **Purpose:** To identify actions to help increase joined up working across the system and improve outcomes for children and young people’s mental health.
- **Engagement:** Over 770 professionals and 1,700 children, young people, parents and carers participated in surveys and focus groups.
- **Outcome:** Published final report 17 March 2015
Five key themes provide the structure of the report:

- Promoting resilience, prevention and early intervention
- Improving access to effective support - a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Participation and collaboration identified as a core principle - services designed with children, young people and families to meet their needs

Contains 49 proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs
A Case for Change: prevalence

9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder

In an average class of 30 schoolchildren, 3 will suffer from a diagnosable mental health disorder

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
<th>Number of Children</th>
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</thead>
<tbody>
<tr>
<td>Conduct disorders</td>
<td>5.8%</td>
<td>510,000</td>
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<tr>
<td>Anxiety</td>
<td>3.3%</td>
<td>290,000</td>
</tr>
<tr>
<td>Depression</td>
<td>0.9%</td>
<td>80,000</td>
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<tr>
<td>Hyperkinetic disorder (severe ADHD)</td>
<td>1.5%</td>
<td>132,000</td>
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</table>
A Case for Change: expenditure

NHS expenditure on mental health

Expenditure on mental health disorders, England

<table>
<thead>
<tr>
<th>Year</th>
<th>Adult mental health disorders</th>
<th>Child and adolescent health disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/07</td>
<td>7.8</td>
<td>0.61</td>
</tr>
<tr>
<td>2007/08</td>
<td>8.6</td>
<td>0.62</td>
</tr>
<tr>
<td>2008/09</td>
<td>9.1</td>
<td>0.68</td>
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<td>2009/10</td>
<td>9.9</td>
<td>0.71</td>
</tr>
<tr>
<td>2010/11</td>
<td>10.2</td>
<td>0.71</td>
</tr>
<tr>
<td>2011/12</td>
<td>10.4</td>
<td>0.71</td>
</tr>
<tr>
<td>2012/13</td>
<td>10.6</td>
<td>0.70</td>
</tr>
</tbody>
</table>
A Case for Change: Inadequate investment in early intervention and early years of mental health is a false economy

UK annual costs of mental illness during childhood and adolescence vary between £11,030 and £59,130 per child (Suhrcke et al 2008)

Mental illness during childhood also has longer term economic impacts across the life course

Costs of illness e.g. Conduct disorders

Lifetime costs of 1-yr cohort of children with conduct disorder (6% of the population) estimated at £5.2billion

Each affected individual is associated with costs around 10 times that of children without the disorder

Cost of crime by those with conduct problems in childhood is £60 billion per year in England and Wales (SCMH 2009)

Costs of Interventions e.g. Group Cognitive Behavioural Therapy (CBT) for depressed adolescents

Aims to improve general functioning and prevent risk of major depressive episodes. A series of group sessions lead by a therapist, suggested duration of 3 months of weekly meetings

Unit Cost £229
Total Lifetime Benefit £7,252
Lifetime Benefit to taxpayers £3,520
Lifetime Benefit to participants £3,455
Lifetime Benefit to others £277
Lifetime Benefit-cost ratio (Benefits/Costs) 31.67
Budget announcement

Announced £250m recurrent annual increase from 1st April 2015 for:

• Improved access to perinatal mental health
• Improved access to mental health care for children and young people with mental health problems:
  – Introduce new access targets (at least 110,000 additional children and young people over next five years)
  – New waiting time standards for children’s mental health
• Rolling out and extending CYP IAPT programme to the whole country/to include children with learning disabilities and the under-5s
**Future In Mind Overview**

The Government’s aspirations are that by 2020 we would see:

- **Improved crisis care**: right place, right time, close to home
- **Improved transparency and accountability across whole system**
- **A better offer for the most vulnerable children and young people**
- **Improved public awareness**: less fear, stigma and discrimination
- **Timely access to clinically effective support**
- **More evidence-based, outcomes focussed treatments**
- **More visible and accessible support**
- **Professionals who work with children and young people trained in child development and mental health**
- **Model built around the needs of children and young people, and a move away from the ‘ tiers’ model**
- **Improved access for parents to evidence-based programmes of intervention and support**
Promoting resilience, prevention and early intervention

Act early to prevent harm, by investing in the early years, supporting families/carers and building resilience through to adulthood, to reduce the burden of mental and physical ill health over the whole life course.

This can be delivered by:

- A hard hitting anti-stigma campaign to raise awareness, promotes improved attitudes to children and young people affected by mental health difficulties. Build on the success of the existing Time to Change campaign
- Promoting and driving work on prevention and early intervention
- Whole school approaches to promoting mental health and wellbeing

With additional investment:

- Enhancing existing maternal, perinatal and early years health services and parenting programmes further
- Supporting self care through development of new apps and digital tools (possibly with a kite-marking)
Improving access to effective support

Change how care is delivered and build it around the needs of children, young people and families, to ensure that children and young people have easy access to the right support from the right service at the right time.

This can be delivered by:

• Moving away from tiered system learning from existing best practice
• A joint training programme to support lead contacts in mental health services and schools
• Harnessing the vital contribution of the voluntary sector
• Promoting implementation of best practice in transition
• Continuing to implement the Mental Health Crisis Care Concordat

With additional investment:

• Every area having named points of contact in mental health services and schools, and one stop shops
• A comprehensive set of access and waiting times standards that bring the same rigour to mental health as is seen in physical health
• A national, branded web-based portal for online tools/services
• Legislating to ensure no young person under the age of 18 is detained in a police cell place of safety
Care for the most vulnerable

Dismantle barriers and reach out to children and young people in need.

This can be delivered by:

- Actively following up those who do not attend
- Develop appropriate and bespoke care pathways, incorporating models of effective, evidence-based interventions
- Comprehensive assessment and referral to appropriate services for those who have been sexually abused and/or exploited
- Strengthening the lead professional approach for the most vulnerable

With additional investment:

- Pilot roll-out of specialised teams, possibly on a sub-regional basis
- Embedding mental health practitioners in services or teams working with those who are most excluded from society
Accountability and transparency

Drive improvements in delivery of care and standards of performance, to ensure a better understanding of how to get best outcomes for children, young people and families/carers and value from investment.

This can be delivered by:

• Lead commissioning arrangements in every area for children and young people’s mental health and wellbeing services, responsible for developing a single integrated plan
• DH prevalence survey of children and young people’s mental health and wellbeing
• Health and Wellbeing Boards challenging and confirming Joint Strategic Needs Assessments and the Health and Wellbeing Strategies

Subject to decisions taken by future governments:

• Repeating a prevalence survey every 5 years
Developing the workforce

A workforce that is ambitious, excellent in their practice, able to deliver the best evidenced care, committed to partnership and integrated working.

This can be delivered by:

- Targeting the training of health and social care professionals and their continuous professional development
- Implementing the recommendations of the Carter Review of Initial Teacher Training (ITT)

With additional investment:

- Expanding CYP IAPT transformation programme to the rest of the country and extending competencies based on the programme’s principles to the mental wellbeing workforce, as well as providing training for staff in schools.
- Developing comprehensive workforce strategy, including an audit of skills, capabilities, age, gender and ethnic mix.
Making change happen

By 2020 we want England to lead the world in improving the outcomes for children and young people with mental health problems

This will be delivered by:

• A local Transformation Plan in each area during 2015/16 to deliver a local offer in line with the national ambition
• Establishing clear national governance to oversee the transformation of children’s mental health and wellbeing provision country-wide over the next five years
• Enabling more areas to accelerate service transformation through co-commissioning

With additional investment:

• Development of an improved evidence base, on the safety and efficacy of different interventions and service approaches, supported by a world class research programme
Next Steps

• Building on what’s already happening, and learning from what works in different areas
• Delivering commitments already made and the initiatives already started
• Working together across sectors, statutory, voluntary and independent, at national and local level, and in collaboration with children, young people and their families
• It’s ‘Everybody’s Business’; everyone who works with or for children and young people to take responsibility
• Clear governance at the national level to oversee the transformation of children’s mental health with clear accountability for progress to the relevant Accounting Officers and Ministers. But it cannot all be done from the centre…
• Ownership at local level to taking these principles and starting work to design local transformation plans
What does this mean for me?

Professionals working with children and young people in any setting

• equipped with skills and knowledge to deal with children and young people’s emotional and mental health needs, whether providing an intervention themselves or directing to a service
• understand importance of their role in children and young people’s mental and emotional health

Local Authority and Health Commissioners

• work together to ensure children and young people have access to range of evidence-based services/interventions, across voluntary, independent and statutory sectors, with emphasis on early support
• feel confident they have skills, information and support to make commissioning decisions and to engage with children and young people and families/carers as they are crucial partners and have a role to play in commissioning
What does this mean for me?

Health and Well-Being Boards

- ensuring that Joint Strategic Needs Assessment and Health and Wellbeing Strategy address children and young people’s mental health needs effectively and comprehensively

Children’s Social Care

- key role as commissioner and provider, and bring specialist knowledge in identifying and supporting the needs of many vulnerable children, young people and families
- social work teams need clear routes of referral into specialist child mental health services where appropriate and access to consultation and advice

Health providers

- work collaboratively to deliver best possible care, to improve outcomes for children and young people mental health problems,
- using evidence based approaches and taking full account of the views of children, young people and their families/carers
What does this mean for me?

**Education providers**
- continue developing whole school approaches to promoting mental health, wellbeing, and resilience amongst children and young people
- early years settings, schools and colleges should have clear routes of access to mental health expert advice and be able to easily make referrals to more specialist services where needed

**Voluntary and Community Sector**
- play a crucial role in providing support and expert advice to children and young people, including through accessible community-based ‘one-stop-shop’ settings
- greater use made of the VCS in local service design and commissioning
Thank you, and if you wish to see further information please go to: https://www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce

You can also follow us on Twitter: @DHChildHealth
Feedback from LA/DPH Event
20th March 2015

Paul Theaker
Operational Commissioner
Rotherham Metropolitan Borough Council
SCN Support to Taskforce Review Implementation

Ashley Wyatt
CAMHS Lead
C&M SCN
Options

• Implementing the taskforce report will be challenging for individual areas.

• Potential to put in place arrangements whereby there is an element of mutual help across the region.

• All areas can gain from this, as all can access additional central Government funding if their Transformation Plan is in place and of sufficient quality.
Two Possibilities

• Opportunities for Regional, and/or Sub regional, meetings over the next 9 months to share issues, good practice, challenges in relation to implementation

• Opportunities for some ‘mentoring’/ individual consultation from myself at individual area level (as proposed in para 103 of the Taskforce sub group report).

This model would enable a combination of direct sharing between areas at regional level and, for example, individual comments on drafts of transformation plans, of individual comments on investment collation data at local level (as was done for CYP IAPT applications in many areas), or even one-off meetings in an area concerning an aspect of implementation.
Overarching Principles

• Not to do the work for areas, but to provide constructive comments on the work that areas do themselves.

• Focus on a small number of areas of work where the requirements are new.
Possible Areas this Approach Could Cover

- Benchmarking at local level in terms of investment across all sectors, and workforce across all sectors - as it will be important to know the current position before any new resources are received.
- Development of lead commissioning arrangements - what this might look like in practice.
- Development of collaborative commissioning approaches;
- Development of Transformation Plans – including clearly articulating the ‘local offer’.
- Drawing up annual declarations of current investment - (this will be a complex process).
- Comparing different models of involving schools/school clusters in this process.
Cont.

• All of this will need to be integrated with the support coming from the CYP IAPT Collaborative - for those services who are IAPT services.

• The level of input to individual areas will depend on the level of demand for this proposed service from the SCN.
Final Points

- Monitoring the amount of new money that is actually allocated to CAMHS at commissioner level, and at provider level. Mustn’t necessarily take the national £1.25 billion figure at face value.

- We could establish a system to monitor this across the Region as a whole.

- Please provide feedback on these tentative proposals in the discussions groups we are now moving into.
Table Discussions - 1

Locality Issues and Opportunities for Implementing the National CAMHS Taskforce Review

• Which taskforce recommendations do you think will make the most impact in your area?

• What recommendations will be the most challenging to implement?

• What type of support from the SCN would be most useful to you?
CAMHS & Looked After Children

Cara Pursall
Project Manager
Y&H CSU

Alex Espejo
Clinical Psychologist
Improving Access to Mental Health and Emotional Well-Being Services for Looked after Children from West Yorkshire in Out of Area Placements

Cara Pursall, Project Manager, Paediatrics, Healthy Futures
cara.pursall@nhs.net
07871 482 631
The 10cc and HaRD is a commissioning collaborative comprised of the ten Clinical Commissioning Group of West Yorkshire and Harrogate and Rural Districts (HaRD) CCG.

The collaborative is a forum where collective decisions on the planning, procurement and review of services can be agreed.

Healthy Futures refers to a group of initiatives where the 10cc and HaRD commissioners are working collaboratively to improve specific health services.

The collaborative recognised opportunities to improve outcomes for patients if the healthcare system was looked at from a broader geography.
The first part of work was to develop a planning document to outline the strategic intentions of the collaborative.

“The West Yorkshire Chapter” was developed in early 2014 and has been included in the Five Year Unit of Planning Strategic Plans for each of the CCGs.

It focuses on four key areas:

- Stroke
- Cancer
- Urgent and Emergency Care
- Paediatrics
“To promote the best healthcare for Children and Young People in West Yorkshire through the provision of innovative, high quality, integrated and sustainable services in an appropriate environment that is as close to home as possible, allowing them to fulfil their potential and supporting the best health and wellbeing outcomes.”
Through consultation with commissioners and providers, two projects have been identified for progression through the Paediatrics Programme:

- To improve access to and the quality of provision of mental health and emotional well-being services for looked after children placed out of area whilst ensuring that services provided offer value for money.

- To undertake a strategic review of acute paediatric service provision across the 10cc and HaRD footprint to ensure that services are safe and sustainable.
## Paediatrics Leadership Team Group (Steering Group)

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Carol McKenna</td>
<td>Chief Officer, Greater Huddersfield CCG (Project Lead)</td>
</tr>
<tr>
<td>Andrew Pepper</td>
<td>Chief Finance Officer, Wakefield CCG</td>
</tr>
<tr>
<td>Clare Hillitt</td>
<td>Strategic Clinical Network Manager, Yorkshire and Humber SCN</td>
</tr>
<tr>
<td>Dr Akram Khan</td>
<td>General Practitioner, Bradford City and District CCG</td>
</tr>
<tr>
<td>Geraldine Sands</td>
<td>Assistant Director of Nursing, Patient Experience, NHS England</td>
</tr>
<tr>
<td>Cara Pursall</td>
<td>Project Manager, Paediatrics, Yorkshire and Humber CSU</td>
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### Fortnightly LTG

### Monthly Healthy Futures Programme Board (Representation from Senior Staff from across the conurbation)
Looked after children have considerably higher mental health needs than the general child and adolescent population:

- Nationally, 8% of the general child and adolescent population have a diagnosable mental health need.
- Nationally, 45% of looked after children have a diagnosable mental health need.
- Whilst 72% of looked after children display some indications of behavioural and emotional problems at the outset of their care journey.
Local authorities, health commissioners and health providers have statutory responsibilities to work together to improve health outcomes for children and young people who are looked after.

Originating CCG remains responsible for secondary healthcare services.

However, looked after children in out of area placements are experiencing significant difficulties in accessing emotional well-being and mental health services.

Ad hoc arrangements for provision and historical charging arrangements are breaking down across West Yorkshire and in placements further afield.
Evidence suggests that some looked after children are not receiving provision for emotional and mental health support whilst others experience a lengthy delay or do not receive a ‘full service’.

CAMHS providers in ‘accepting’ CCGs localities are rejecting referrals

- Local waiting list issues
- Lack of funding for the cohort (not included in the block contracts)
- Not meeting referral criteria (but not being signposted to other services)

Provision for the cohort is often very costly whilst the quality and outcomes of the provision is not clear.
A full review of service provision is taking place, to include financial modelling.

Systems to monitor a range of performance indicators will be put in place and a performance dashboard delivered.

An Options Appraisal has been commenced to consider service models for the cohort.

A service directory is in development which shows available providers of mental health and emotional well-being services in areas where there are high numbers of looked after children.

Service models are being considered and will be taken through an option appraisal.
LAC in out of area placements will experience:

- Reduced waiting time for assessment and treatment
- Improved quality and range of services
- Improved patient experience
- Reduction in admissions to Tier 4 services

It is also anticipated that the project will have an impact on the need for adult services in the future such as Substance Misuse, NEET, Drug & Alcohol and Teenage Pregnancy etc.
Benefits of the Project

• Commissioners and providers will experience:

✓ Assurance of the quality of services
✓ Clear understanding of the outcomes of the provision
✓ Cheaper service options due to economies of scale
✓ Straight forward charging protocols
Need to Know - Fundamentals

- The number of looked after children in out of area placements?
- The location of these looked after children around the country?
- What mental health service are available in the local area?
- What are the difficulties with the local mental health services?
- The processes LAC go through in order to access mental health
- What are the barriers for service users
- What are the commissioning barriers?
- What are the costs involved?
- What data systems are used in their care?
- How much need/unmet need?
- Waiting times for looked after children in out of area placements
• Some data is straightforward - number of and type of broken leg; number and type of heart attacks and strokes; the number of diabetics - are all measured by providers.

• LAC cohort is not flagged; not measured by any systems; and is hidden on my many systems; different systems hold different information in a different format.

• Looking at an out of area cohort so to get the full picture of need to consider over 100 providers of mental health care.

• Difficulties sourcing and sharing information – information governance minefield!
• The numbers of LAC in OOA during the financial year 2013 to 2014 available from LA and CHIMAT
• Based on LA rather than CCG areas and very little detail available
• There were 569'955 children and adolescents from WY, of whom 31’200 are expected to have mental health disorder
• There were a total of 3’640 LAC originally from WY, of whom 970 were placed outside of their original local authority/CCG
The Number of Looked after Children (In and Out of Area)

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Total No. of LAC</th>
<th>No. of LAC OOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradford</td>
<td>875</td>
<td>145</td>
</tr>
<tr>
<td>Calderdale</td>
<td>335</td>
<td>110</td>
</tr>
<tr>
<td>Kirklees</td>
<td>650</td>
<td>255</td>
</tr>
<tr>
<td>Leeds</td>
<td>1375</td>
<td>280</td>
</tr>
<tr>
<td>Wakefield</td>
<td>445</td>
<td>135</td>
</tr>
</tbody>
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Healthy Futures Better health for all across the West Yorkshire region
### The Number of Looked after Children (In and Out of Area)

#### Local Authority | No. of LAC per 100,000 of children (0-19) | No. of LAC OOA 100,000 children (0-19)
--- | --- | ---
Bradford  | 576  | 95  
Calderdale | 667  | 219 
Kirklees  | 598  | 234 
Leeds     | 752  | 153 
Wakefield | 582  | 177 

- **Bradford**: 576 LAC per 100,000 children (0-19), 95 LAC OOA 100,000 children (0-19)
- **Calderdale**: 667 LAC per 100,000 children (0-19), 219 LAC OOA 100,000 children (0-19)
- **Kirklees**: 598 LAC per 100,000 children (0-19), 234 LAC OOA 100,000 children (0-19)
- **Leeds**: 752 LAC per 100,000 children (0-19), 153 LAC OOA 100,000 children (0-19)
- **Wakefield**: 582 LAC per 100,000 children (0-19), 177 LAC OOA 100,000 children (0-19)

**Healthy Futures** Better health for all across the West Yorkshire region
Importers and Exporters of LAC

- Bradford
- Calderdale
- Kirklees
- Leeds
- North Yorkshire
- Wakefield

Placed outside LA boundary
External children placed within LA boundary

HEALTHY FUTURES Better health for all across the West Yorkshire region
Event held on the 10th of December 2014 to understand the fundamentals:

- Good engagements from key stakeholders (commissioners, SCN, LAC Nursing Team, CAMHS professionals and LA colleagues)
- Service user pathway mapped
- Commissioning processes and arrangements mapped
- Barriers and issues identified
- Sources of data and data systems identified
The Mental Health Pathway of LAC
Where are West Yorkshire’s Looked after Children?
Top Ten Placement Areas for LAC

Bradford
Leeds
West Yorkshire
Wakefield
Calderdale
Huddersfield
Kirklees
Barnsley
North Yorkshire
Doncaster

PAEDIATRICS
PROGRAMME

HEALTHY FUTURES Better health for all across the West Yorkshire region
Top Ten Placement Areas for LAC (Outside of West Yorkshire)

- Barnsley
- East Riding of Yorkshire
- Doncaster
- Lancashire
- Confidential
- Vale of York CCG
- CCG outside the NYCC Boundary
- Sheffield
- Durham County
- Staffordshire
Anecdotal evidence to suggest that there is a high cost associated with providing a service to the cohort.

Sought to understand:
- The cost of mental health provision for looked after children
- The cost of looked after children in out of area placements (total and per head)

Requested information directly from commissioners – not available to them.

Directly to CCGs Finance Department – not there either.

Potentially available to the CSU – however significant data governance issues due to needing to identify the cohort (patient identifiable data required).

Permissions sought from SIROS of CSU and CCGs to use patient identifiable data for the cohort and access granted as of the 6th of March 2015.

Databases of ‘non-contract activity’ now available to the Healthy Futures team – details of children out of area who have been seen in private provision or where they have been seen by NHS providers who have received payment for services.
Based on national prevalence rates, it is anticipated that a total of 1’638 LAC from WY will require CAMHS services during the year.

Around 437 in OOA placements will need to access these services.

Whilst an additional 261 OOA LAC need some form of support at the start of their journey.
Demand and Unmet Need

- Indications from discussions with commissioners, practitioners and initial work on non-contract activity data that there is a huge amount of unmet need
- Now sign-off received from responsible officers can access patient identifiable data
- Had hoped to access to SystmOne – run reports on referrals of the cohort
- However, referral information kept as PDF or Word document and not able to audit in any automated way
Unmet need = Additional resources

Met Need = Long-term Financial Savings

(Reduction in need for Tier 4; Teenage Pregnancy; Substance Misuse and Youth Justice Service)
Demand and Unmet Need

- Opening a can of worms!
  - Number of LAC not being seen
  - LAC being seen OOA but no charging in place
- Still need an understanding of the situation to understand the number and costs involved
- Financial modelling showing the costs involved over a five to ten year period
Some regions work with out of area children who are placed at a distance of less than 20 miles from their boundary - inconsistent across WY and not practical for some areas.

- Proposals must include a full service not just elements such as ‘assessment’
- All proposals will include direct service provision and provision of consultation to those involved in the care of looked after children.
- Options Appraisal and Tender Process
- National CAMHS PbR Programme looks likely to be in place 2016/17/18
Service Proposals
Provide Additional Resources to OOA CAMHS

- ‘Block Contract Arrangements’ and ‘Agreed Tariffs’
- Capacity increased in CAMHS teams where there are high numbers of looked after children out of area according to identified need.
- Areas where there is less demand should work to agreed tariffs for CAMHS provision
- Additional resources:
  - Diversion of current ‘non-contract’ spend on the cohort into existing CAMHS Teams or
  - Additional resources provided by statutorily responsible CCGs for the cohort
- The numbers of OOA LAC should remain quite consistent over time and changes to placement areas planned in advance
Service Proposals

Establish OOA LAC CAMHS Teams (B)

- Additional resource identified (diversion of current spend or extra funding)
- OOA Team for LAC developed in each area where there are high numbers of Looked after Children in out of area placements.
- For example, a new team in each of the top ten locations to provide services only for the cohort
- Funded by CCG commissioners from wherever the children originate from.
• Protocols put in place to work with private providers
• All private providers of mental health to be identified in areas where there are high numbers of looked after children.
• Minimum standards of care and agreed tariffs for care packages, which represent economies of scale and are transparent, should be agreed for these providers and a provider directory of ‘approved providers’ made available to commissioners.
Service Proposals
West Yorkshire Tariff for CAMHS (D)

- Agreement between NHS providers to work to an agreed tariff for service provision.
- Funding received through tariff arrangements used to ensure appropriate capacity.
- Agreements that no looked after child will be refused a service.
- Using ‘tariff’ to build capacity
- New West Yorkshire team set-up for the cohort
- Capacity (and funding) to match current demand (not just those not being seen)
- Funded by all 11 CCGs in the conurbation
- Services put out to tender
MAPS for Looked After Children
(Multi-Agency Psychological Support)

Dr Alex Espejo
Consultant Clinical Psychologist
And
Service Lead
Who are we?

We are a Multi-Agency Specialist Mental Health Team for Sheffield Looked After Children.
Jointly funded and steered by Health and the LA.

Our task is to respond to the Child’s needs in a holistic way which considers every issue that can impact on a Child’s Mental Health, including the stability or ‘health’ of the child’s placement and education.
Mental Health is Everybody’s Business!
“Anyone in contact with the child has an impact on that child’s mental health and psychological well-being”
(Jo Davidson, chair of the National CAMHS Review Nov 2008)
Who do we work with?

Children and young people up to 18 years on the following orders:-

• Interim care order
• Full care order
• Placement order
• Section 20 (voluntarily accommodated)

Community CAMHS Teams work with:-

• Special guardianship order
• Residence order
• Adoption
Sheffield LAC Population

- Approximately 550 at any one time
- MAPS – 140-150 open cases.
- SDQ data (4 to 16 year olds over 1 year in placement) last year, 91% return rate = 260
- 45% (117) scored in the concerning range (17+).
- Only 11 where not known to CAMHS or closed over 12 months ago.
What do we offer?

- Advice Line
- Consultations (145) within a month 86% (91%)
  - Example of 6 year old girl
- Assessments of children’s emotional and therapeutic needs.
- MSI (Multi-systemic Intervention)
- Consultations to Children’s Homes
- Training
- Participation in strategic meetings
MSI starts with a Initial Network Intervention

• To develop a coherent narrative about the child's history and experiences. (To understands the child’s functioning taking into account the impact of Trauma).

• To hear what everyone’s concerns and aims are.

• To jointly plan our interventions.

and
Network Intervention

Create a Safe Base
Multi-Systemic Intervention

• Network Intervention (every 3 months)
• Assessments
• Therapeutic re-parenting
• Dyadic/family work (Theraplay, DDP)
• Individual work
• Training and advice to school
• Advice and support to other professionals
Client Satisfaction

April 2013 to March 2014 data

1) Consultations – 86% return rate,
92% happy with outcome
95% reduced concerns

2) MSI network intervention (70 responses)
99% found it relevant
99% satisfied with outcome
The Team

Clinical Psychologists
Therapeutic Social Workers
*Specialist Mental Health Practitioner
Senior Clinical Nurse Specialist
Art Therapist
Child and Adolescent Psychotherapist
Educational Psychologist
Child and Adolescent Psychiatrist

WTE 7

*Based in Permanence Social Work Team
Table Discussions - 2

Locality Issues and Opportunities for CAMHS and LAC

- For W Yorks - discuss challenges to implementation, and which option you would prefer

- For S and N Yorks - discuss whether you would want to undertake a similar process to that ongoing in W Yorks. What do you see as the current key challenges and strengths in your area?
Tier 3, Tier 3.5 and Tier 4 Interface

Ashley Wyatt
Lisa Weldrick
Anita Bird
Hannah Beal
Helen Rutherford
Hull and East Riding Intensive Intervention Team

Successes, Challenges, Recommendations and Solutions.
When admission is needed how do we get it right?
Successes

- Attempt to implement standards for all young people requiring an in-patient CAMHS admission.
- Robust arrangement for parents reclaiming travel costs (Hull)
- Building relationships with some units
Challenges

• Understanding changing face of tier 4 units. Criteria/Pressures
• Ability to manage/ contain risks in the community
• Local crisis/ out of hours services vary massively often resulting in ‘Friday crisis’
• Sharing expectations for admissions
• Role of access assessor in decision making
Recommendations and Solutions

Case by Case;

• Expectations for admission (Young person/ family/ unit/ community team)
• Clarity of roles
• Shared care plan (MDT/ agency/ family)
• Regular planned communication/ handover of information (Unit/ family/ community team)
• Planned leave as soon as possible (convenient to all with risk plan)
• Notice of meetings
Recommendations and solutions cont’d

General thoughts:

• Regional data base of service criteria
• Regional relationship building forum (shop floor staff)
COMMUNICATION, COMMUNICATION, COMMUNICATION
Prior to, during and following an admission……….

What do Units need from Community Teams?

What do Community Teams need from Units?
History of Local CAMHS
From 2009 LPFT provided day time service with Navigo (AMHS) providing out of hours service
2013 LPFT awarded contract for 24/7 cover
Restructure, staff turnover and priority caseload
December 2013 moved to Freshney Green and new model became operational
Service Structure

Core Team (historically called Tier 2 and 3 – link worker roles PRUs, YOS, NEST)
Tier 3+ - Crisis and Intensive Home Treatment
Looked After Children’s Team
Learning Disability Team
ADHD Team
Clinical Staffing

1 x Head of Service (Clinical Psychologist 8c)
3 x Team coordinators
1 x AD/HD Nurse prescriber
14 x CAMHS workers (nurses & social workers)
1 x groupworker
3.5 x 8a clinical psychologists
1 x 8c clinical psychologists
2 x assistant psychologists
2 x CAMHS consultants psychiatrists
Communication and Liaison

Whole team in one building
Structures in place allow for ease of communication between Core team (Tier 2&3) and Tier 3+.
Step up, step down model
Attend Tier 4 CPA in person and teleconference. Close communication and facilitate early discharge.
Tier 3+ outcomes

Reduction in Tier 4 admissions
Timely response to emergency and urgent assessments
Multi-agency working to problem solve ‘crisis’ – not always mental health
Excellent working relationships with A&E, Paediatric Ward, Police
LEEDS CAMHS OUTREACH SERVICE

Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.

Hannah Beal

Tuesday, March 24, 2015

Successes

What works well...

- Continue with remit of outreach
- Preventing young people being admitted hospital or reducing the length of admission
- Structure of the working week
- Preserved and developed
- Recruiting
- Outcomes
- Experienced multidisciplinary team working
- Location
- Good relationships with Tier 4 and Tier 3

Challenges

Even better if...

- More resources
- More weekend and evening provision
- More accessible Tier 4 beds
- Collaborative commissioning
- Evaluations/research

Casestudy

13 years low mood, anxiety, panic attack, suicide attempt

Referred to Leeds CDS
- Intensive risk management in response to significant suicidal voices, anxiety following several months' history of low mood and anxiety
- Medication prescribing & monitoring
- Community CAMHS loan
- Education — school & Medical Needs Teaching Service

Thank you for listening

Feedback

CHH-esque feedback — what was really good?

- An outstanding service across the board, maybe above what I expected to receive. Well done to all involved in this service.
- Your awesome engagement and management.
- Well supported staff.
- Individual work
- Dynamic sessions
- Family work
- Clinical involvement
- Medical Needs Teaching Service
- Parent support group

Leeds CAMHS:
- Significant changes
- Hub & spoke model (tier 3)
- Pathway development
- Collaborative commissioning
- COS workforce planning

continue to have outreach function
for young people & families
Implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.

Hannah Beal

Tuesday, March 24, 2015
Successes

What works well...

- Continue with remit of outreach
- Preventing young people being admitted to hospital or reducing the length of admission
- Structure of the working week
- Recruiting
- Outcomes
- Experienced multidisciplinary team working
- Location
- Good relationships with Leeds community and inpatient teams
Challenges

Even better if...

More resources
More weekend and evening provision
More accessible beds
Collaborative commissioning
Evaluations/research
Case study
14 years anorexia nervosa (77.5% weight for height), low mood

Referred to Leeds COS
- Risk assessment and management
- Introducing regular meal plans
- Meal support in home
- Individual work
- Parent sessions
- Family Work
- Dietician involvement
- Medical Needs Teaching Service
- Parent support group

Graph showing frequency of appointments with COS

- To return to sporting activity
  Score 0 ➔ 5
- Not to have loads of people coming to the house
  Score 0 ➔ 7
- To be able to eat socially i.e. not deny herself contact with friends due to eating concerns
  Score 0 ➔ 8
Case study
13 years low mood, anxiety, panic attack suicide attempt

Referred to Leeds COS

Intensive risk management in response to significant serious overdose attempt following several months’ history of low mood and anxiety.

Medication prescribing & monitoring

Community CAMHS team

Education – own school & Medical Needs Teaching Service

Graph showing frequency of appointments with COS

<table>
<thead>
<tr>
<th>number of weeks in COS</th>
<th>number of contacts</th>
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<tr>
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</tr>
<tr>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
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<td>1</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
</tr>
</tbody>
</table>

To be able to stay out overnight
Score 0 ➔ 8

To be able to go back to school
Score 0 ➔ 10

To be allowed in my own room to sleep
Score 0 ➔ 10
Feedback
CHI-esq feedback - What was really good?

An outstanding service across the board, way above what I expected to receive. Well done to all involved in this service.

The expertise of doctors and nurses was apparent as was their concern on our behalf. They created confidence at a stressful time for my family.

I felt I was listened to and having regular appointments was good for me.

I felt very supported staff really approachable supportive informative caring and very patient.

Individualised to our needs- very experienced caring staff.

Your awesome Consistant. Available, Well explained, helpful. Good to have home support. Excellent support, great people fabulous communication Thank you.

Friendly people who listened to our problems and being able to speak about anything that has happened in the past.

The genuine care provided by staff. The flexibility to hold appts at home. The expertise of the staff and the thoroughness of all her care and additonal agencies being involved to support everyone as a package.

I was listened to and taken seriously regardless of my worreis or struggles. The people I worked with were honest about my situation which I feel accelerated my choosing recovery.
Feedback
CHI-esq feedback – What did you not like?

My Plans aren’t that helpful We did mine in a list format which I found more helpful

I do have to juggle my working hours around the appointments although my manager is very accommodating

the building needs a little work

more dietetic input for community team
Dietician fab more input
services could be extended beyond 1700 at night

Different opinions on medication from Doctors

The questionnaires they use a lot of words I don’t understand like caseworker for example or initial planning engagement Having to read and sign shift.

The lack of child psychiatric beds in the region meant that our young person had to be taken to south coast. The care was excellent as was the day care at LWH beforehand. We would support the introduction of more beds at LWH.

very warm in the waiting room

I didn’t find my appoint with he dietician helpful, I would have liked her to educate me on a balanced diet but she just told me things others already have.
Future Developments...

Leeds CAMHS:
- significant changes
- hub & spoke model
- pathway development
Collaborative commissioning
COS workforce planning

continue to have outreach function for young people & families
Thank you for listening
Table Discussions - 3

Issues and Opportunities for Effective Liaison Between Tiers

• What are the messages for your area from the presentations?

• What are the key challenges for you in terms of good liaison between Tiers 3/3.5 & 4
Cross Locality Specialisms

Ashley Wyatt
CAMHS Lead
Children’s & Maternity SCN
Specialisms

• Areas of potential collaboration – gathered from submissions from providers and commissioners

• Some process issues highlighted

• Need to discuss whether an initiative is viable – as few returns received
General Comments - Commissioner Responses

- ‘We need to develop hub and spoke models to ensure resilience of services.’

Specific ideas:
- ‘A multi-CCG eating disorder service. We have a relatively high number, but not enough for a cost-effective robust resilient service.’
- ‘Sharing forensic CAMHS assessments would be good.’
- ‘On-call out of hours services and particularly for consultant Psychiatrist when Tier 4 assessments are required.’
- ‘Tier 3+? - This situation would be helped by NHS England being able to release Tier 4 funding to support such a service.’
‘DBT interventions – we would have around 20 young people per year who could benefit from this.’

‘DBT supervision may be an area in which we would benefit from some support.’

Numbers from a ‘small service’ in the region who would be interested in buying in to a sub regional specialism: MST – 10 families per year, intensive home treatment for eating disorders – 20 young people per year, psycho-dynamic psychotherapy – 5 to 10 young people per year.
Cont.

- ‘Adopted children with trauma issues.’
- ‘LAC children living out of area.’

WHAT OTHER AREAS MIGHT THERE BE?
One Way to Progress This Agenda?

- Ask the three groups of commissioners (West, South and North) to consider potential areas collectively - after individual conversations with their respective providers?
- Agree a first area of collaboration?
- Agree a scale of service, and service location issues: a service that is ‘mobile’ across the patch, or other models?
- Agree lead commissioner arrangements, and the proportion of service to be allocated to/ funded by, each area?
- Tendering arrangements for such a service - ring fenced to current providers, or open tender?
Specific Issues That May Arise for Specific Services

Some initial thoughts, others will have other thoughts:

- Locality wide ‘on call’ psychiatrist - already in operation in other specialities?

- Out of area LAC children – possible commissioning models covered this morning

- Regional supervision of more specialist staff - models already in operation within CYP IAPT in NE/Y&H
Cont.

- Intensive services such as eating disorder or MST - particular issues in terms of needing locally based staff throughout the week?

- Services such as forensic assessments and therapeutic interventions for adopted children: ideal for a sub regional or regional model – as long as the staff travel rather than the young people/ their families? (Lessons to be learnt from the current Wakefield forensic service?)

- Could neighbouring areas share a Tier 3.5 service?
Table Discussions - 4
Locality Opportunities for Specialisms

• Is your area interested in progressing this initiative?
• Are there potential areas not suggested in the presentation?
• If interest - agree/discuss a process for progressing this agenda.
• Discuss a potential first pilot area?
• Discuss potential lead commissioner arrangements?
CAMHS Systems’ Modelling Tool

Feedback from Event
9th February 2015

Laura Whixton
Quality Improvement Lead
C&M SCN
Project Background

- Aim to develop a strategic CAMHS modelling tool to support commissioners, including co-commissioning

- Tiers 2 to 4 across whole health, social care and education pathway

- Intended to be available by end of May 2015
Progress So Far

- Extensive data collection and analysis to understand the whole system and its inter-relationships

- Draft tool design has been produced…
Features of the Tool

• To work at CCG geography or LA level, or on a wider footprint for Tier 4

• To guide users through three steps:
  • Baseline activity per service
  • Shifting and changing activity
  • ‘What if’ report
Baseline Activity

![Image of Baseline Activity](www.england.nhs.uk)
Shifting Activity

Then the magic happens…
### What If...

<table>
<thead>
<tr>
<th>ARE Activity</th>
<th>Attending Activity</th>
<th>WHAT IF</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Select a provider to examine

<table>
<thead>
<tr>
<th>Provider</th>
<th>Activity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford LA</td>
<td>Education Department / Counselling</td>
<td>100%</td>
</tr>
<tr>
<td>Oxford LA</td>
<td>Social Services / Child Protection</td>
<td>50%</td>
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<tr>
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<td>Social Services / Child Counselling</td>
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</tr>
<tr>
<td>Oxford CCG</td>
<td>Oxford Health Provider / Assessment</td>
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</tr>
<tr>
<td>Oxford CCG</td>
<td>Oxford Health Provider / Casing</td>
<td>100%</td>
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<tr>
<td>Oxford CCG</td>
<td>Oxford Health Provider / Treatment</td>
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<td>Oxford CCG</td>
<td>Third Sector Provider / Group Sessions</td>
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#### Estimated Performance of Service

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Average POC</td>
<td>4.3 weeks</td>
</tr>
</tbody>
</table>

#### Service Analysis INPUT

- Waiting List Choices: Average POC = 4.3 weeks
- Turn away after wait reached

#### Service Analysis OUTPUT

- Average Turn Wait Away
- Cost per patient = £34.4
- Utilisation = 35%
- Estimated Total Staff Cost = £150,000

#### "What If" Performance of Service

**Input:**

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<th>Option</th>
<th>Description</th>
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<tbody>
<tr>
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<tr>
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<td>Increase Flow</td>
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<td>Float No. Appointments</td>
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<tr>
<td>None</td>
<td>Waiting Time</td>
</tr>
<tr>
<td>None</td>
<td>Half of max</td>
</tr>
<tr>
<td>None</td>
<td>Limit at max</td>
</tr>
</tbody>
</table>

**Output:**

- Average Wait: 5 weeks
- Average Turn Away: 3
- Cost per patient: £22.3
- Utilisation: 63%
- Estimated Total Staff Cost = £190,000
Areas to Consider

- Data reliance
- Strategic planning tool v’s conversation starter
- Strength lies at Tier 4
- Outcomes

laura.whixton@nhs.net
Mental Health Crisis Care Concordat

Andrew Clarke
Quality Improvement Lead
C&M SCN

www.england.nhs.uk
Mental Health Crisis Care Concordat

Andrew Clarke
Quality Improvement Manager
Strategic Clinical Network (Children’s)
NHS England – North (Yorkshire and the Humber)
The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat.

It focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.
Role of SCN

• Mental Health Network:
• Children’s Network:
  • Contact children’s commissioners to ensure contribution and sight of the action plans
  • Review Action Plans for Y&H with the MH Network
  • Ensure there is children’s content present
Closing Remarks