Attain

Improving health and wellbeing

North East London CAMHS service mapping Report Final

DATE: December 2021

Contents - needs to be updated

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Improving health and wellbeing

1. Executive summary

Executive summary introduction

- Attain were requested to undertake a review of CAMHS services within the North East London (NEL) Integrated Care System, following a similar project for NCL. This executive summary has been reviewed and edited by SW/MW Co Chairs of NEL CYP Delivery Group and DC, Programme Director of NCEL CAMHS T4 collaborative.
- This report should be used alongside other reports and intelligence such as the Public Health-led NCEL CAMHS Strategic Health Needs Assessment to inform NEL planning and transformation.

The review had two elements:

- The first consisted of interviews with each commissioner, main community CAMHS provider, and the largest provider of digital mental health support for children and young people to understand at a high-level strengths, challenges and the impact of Covid-19. The interviewees varied but all interviews were with at least one senior team member.
- The second element was a quantitative analysis of data from the two main providers of CAMHS community, specialist eating disorder and crisis teams; North East London Foundation Trust (NELFT) and East London Foundation Trust (ELFT).
  - While these are the two largest providers there is a wide range of other providers such as other public sector (e.g. other NHS or LA provision, First Steps at Homerton and Headstart in Newham), private sector (e.g. Kooth) or providers from the Voluntary, Charity and Social Enterprise sector who deliver services to the population of Children and Young People in NEL.
  - Where activity data is available this has been referred to however this report does not provide system demand or capacity data
  - In each of the Borough sections in this report the provider make up is outlined in further detail, including the role of partners such as the local Borough provision, Headstart, Kooth and from Voluntary, Community and Social Enterprise.

- Detailed borough sections and background are included as appendices and provide more detail of the interviews and analysis.
- Specialist eating disorder, crisis services and the digital services from Kooth are included separately to the Integrated Care Partnerships because their service provision are not co-terminus to integrated care partnerships.

Executive summary 1

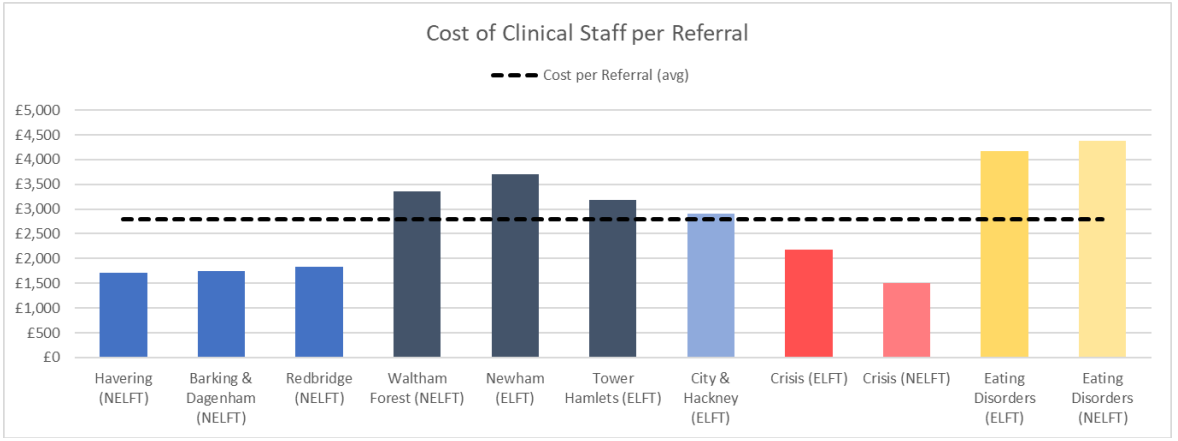
Funding of CAMHS teams varies across the ICS.

CAMHS community services are stretched and caseloads are increasing in all teams. The investment across NEL has significant variance that is not all related to demand but reflects historic decisions about priorities. The marker of overall mental health prevalence* had very little variance across NEL. Specific conditions had a wider variation but not at a level to influence the varied levels of funding. The variance in investment is impacting on access and care. There are multiple funding sources through historic commissioning decisions as well as various initiatives that impact on service provision. For example; in 2017 a joint commissioner / provider fundamental service review resulted in additional funding for CAMHS services in BHR. In all Boroughs there is a range of providers, not just ELFT and NELFT, that provide services within the CAMHS portfolio.

In BHR, the provider spend on frontline resources per new referral is the lowest and contacts shortest. As well as BHR having smaller CAMHS community teams, the interviews indicated that the BHR localities had less community assets to support lower-level need. The service models and workforce profiles differ between the main providers. ELFT-provided services typically have more medical roles and a particular difference in the numbers of nurses, therapists and psychologists employed at Band 8a.

Recommendations

1. ICS-level review of total all age investment (CCG and LA, and other sources) and how that funding has been deployed by providers to identify best strategies to increase access to resources for CYP.
2. Share the different workforce models being employed across the ICS



Actual service costs – unadjusted for differences in in service model, type, outcome, quality or London weighting. This is based on pay costs of ELFT and NELFT

Eating Disorder services are particularly pressurised. The demand for specialist eating disorder services has increased between 2% (NELFT) and 69% (ELFT) between 2019 and 2020. It was reported that there are concerns about staff wellbeing and staff working excessive hours.

Recommendation

1. Review model and workforce within the eating disorder teams
2. Share learnings between the teams of how they responded to the Covid pandemic
3. Providers consider options to provide appropriate pathways including ability to provide intensive support for Eating Disorders for both NELFT and ELFT

***NCEL CAMHS Provider Collaborative Strategic Health Needs Assessment**

Executive summary 2

Managing CYP in crisis

Referrals to the crisis teams have risen between 9% and 16%. *This analysis is for activity in the Crisis Team, it does not include activity from other teams, such as Emergency teams, when combined the referral increase is more than 30%. The Crisis teams have responded to additional workload by reducing the contact time by almost a third between 2019 and 2020 to between 73 min (ELFT) and 95 min (NELFT). Acute providers all reported via a focus group that they typically have 2 – 3 CYP inpatients with mental health issues at any time.

Recommendations

1. Acute Trusts should consider how a Young Person in emergency department / inpatient could be cared for in a separate side room facility to manage the risk to themselves and others
2. Increase the uptake of training across, nursing and security workforce in acute hospitals
3. Provide training on de-escalation to staff within acute providers
4. Review how staff in acute settings can rapidly access specific and personalised information (through digital systems/ tools) to help a YP in crisis and in their care de-escalate
5. Develop stronger, more integrated links with community CAMHS and other agencies to reduce presentations in ED, including improved community CAMHS service signposting for acute staff

Chart showing the change in minutes / case / month within the NEL teams

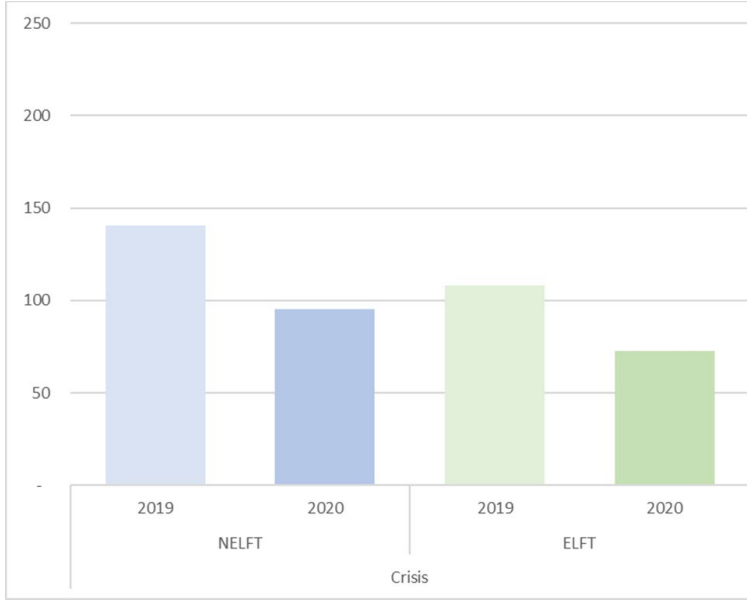


Chart showing the clinical team funded wte in the NEL crisis teams

Role Type / Grade	NELFT Crisis (Interact)	ELFT Crisis
Consultant		0.5
Clinical - 8b		1.0
Clinical - 8a	0.6	1.0
Clinical - 7	2.0	9.3
Clinical - 6	5.0	
Clinical - 5	1.0	1.0
Clinical - 4		
Unspecified	0.0	
Grand Total	**8.6**	**12.8**

Executive summary 3

Use of The Thrive Framework

There is **no common language** used across the ICS or within a place to describe CYP need for mental health support. The Thrive Framework is at best used by the CAMHS community team and some partners. Eating Disorder teams and crisis teams do not use Thrive although there are examples of successful use in these areas*. A common language can help support job planning for clinicians and the involvement of other resources providing lower level support.

Recommendations

1. A common language is established across the ICS to enable a consistent and meaningful approach to describing services that can support children with emotional and mental health issues.
2. Share how Havering and Waltham Forest community teams have used The Thrive Framework to provide clarity for job planning
3. Agree and roll out a standard lexicon for labelling the different teams and the different pathways against which activity is recorded

Access

Access to services is complicated without a health and care single point of access for all children's services. Access for those in crisis needs to be simple, widely understood to support interventions to reduce attendance at hospital.

Recommendations

1. Review Front door models and establish consistency building on good practice
2. Drive integration that "feels" like a single organisation for CYP and families accessing and using mental and physical health services in each Place.
3. Establish an ICS approach for CYP access to work in an integrated way that can be delivered at a Borough level
4. Further promote the 24/7 crisis lines
5. Commission crisis function 24/7
6. Establish model for social prescribing and a digital catalogue of support that is periodically refreshed and updated
7. Review and share the varied non-standard staffing models to inform local team workforce planning
8. Enable the accelerated development of intensive community crisis services, as outlined in the long term plan

***Eating Disorders: Greater Manchester specialist eating disorder service**
Crisis: Camden Adolescent Intensive Support Service (CAISS)

Executive summary 4

Partnership

- It is clear from our conversations that where services are co-produced they can better address issues of stigma, promote access and meet a communities need. There is significant variation across localities of experience around co-production

Recommendations

1. The Kooth contract is reviewed for commissioning at an ICS level. Kooth insights are shared to the teams on the ground as well as commissioners. Kooth coproduction and engagement resources are quantified to consider where Kooth can best lead coproduction to release locality team resources.
2. Recommendation: Create regular "summits" where insights, knowledge and support can be shared

Staff Health and Well-being

Staff have been exposed to increase workload that contains increasingly more complex cases. All staff have been stretched and it is important that interventions for staff are available to reduce the risk of staff taking sick leave or leaving the industry

Recommendation:

1. Develop the Keeping Well NEL hub to ensure sustainability and promote the use of the hub amongst employees
2. Establish communication campaign to raise awareness of work-related issues and stresses, providing visible leadership, as well as enhanced and capable line management to support staff.

Proactive prevention

Where proactive prevention resources are in place this can help manage demand into and out of the specialist CAMHS services. It is important to have an integrated approach in each Borough. Across the system a principle is that there is no wrong front door. In Hackney, there is a First Steps service that has no lower threshold of need, for the Getting advice and Getting help part of the system. The most common outcome of this service is step down to the universal offer. These services can also support stepping down from the CAMHS community teams. This can reduce the numbers of clients the CAMHS community services hold onto post intervention.

Recommendations

1. Consider the benefits and costs of commissioning mental health support in primary care. This should review the opportunity to access the Additional Roles Reimbursement Scheme. This scheme provides funding to PCNs for roles that include social prescribing link workers, physicians' associates, care coordinators, heath and wellbeing coaches, occupational therapists and mental health practitioners
2. Establish a social prescribing strategy for the ICS that ensures a richer source of community-based voluntary and third sector organisations able to provide support for mild mental health issues (See UCL and Anna Freud – led project)
3. Promote the development of an integrated School age offer that spans Mental Health Support teams and other schools programme
4. Consider sharing the learning from the Barking and Dagenham team multi organisation approach for supporting routine referrals

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1. Insights

Comparison of 2020 Metrics Please fit to page

% change from 2019 = comparison of data from calendar year 2020 with data from calendar year 2019

Locality	New Referrals *% change from 2019*	New Referrals per thousand 5-17 popn *% change from 2019*	Average Open Cases per Month *% change from 2019*	Average Direct Contact mins per Case per Month *% change from 2019*	Average Indirect Contact mins per Case per month *% change from 2019*	% Face-to-Face Contacts *% change from 2019*	Annual Cost of Clinical Team (inc. overheads)**	Clinical WTEs #
Havering	1,500 *-11%*	36.24 *-13%*	1,424 *+9%*	40 *-1%*	3 *+13%*	37% *-54%*	£2,566k	26.6
Barking & Dagenham	1,540 *-36%*	31.62 *-37%*	970 *+9%*	38 *-32%*	6 *-15%*	51% *-34%*	£2,678k	21.9
Redbridge	1,433 *-14%*	26.62 *-15%*	1,159 *-4%*	40 *+18%*	3 *+21%*	35% *-50%*	£2,639k	19.3
Waltham Forest	1,592 *+2%*	35.37 *+1%*	1,428 *+17%*	45 *+15%*	7 *+1170%*	40% *-53%*	£5,329k	57.7
Newham (Includes 600k embedded LBN team providing consultation and advice/schools inoput)	1,593 *-24%*	29.05 *-25%*	1,137 *+16%*	45 *+9%*	45 *+64%*	31% *-48%*	£5,893k	67.4
Tower Hamlets*	1,606 *+6%*	39.63 *+4%*	570 *+22%*	43 *-10%*	34 *+69%*	38% *-44%*	£5,406k	57.4
City & Hackney	1,790 *+9%*	42.27 *+9%*	728 *+14%*	43 *-25%*	20 *+391%*	43% *-52%*	£5,259k	59.0

- *Tower Hamlets' refe*
- *Includes XYZ rrals and activity exclude the Patient Liaison Team. The TH workforce costs have been adjusted accordingly.*

**Inner london weighting applies to costs for City & Hackney and Tower Hamlets

#Costs and WTEs have not been adjusted to account for different population size so will have a different clinical size Does NELFT data include 2.1 m funding for

Source: ELFT & NELFT local data, does not include HUH data

Insights into Locality teams 2020 metrics – service models differ

- At this stage the availability of a consistent set of outcome measures is not available across the whole system. Each locality is recording outcome measures however, there are inconsistencies in approach and this remains a work in progress for system.
- Waltham Forest, Tower Hamlets and City & Hackney received increased referrals in 2020 (2%, 6% and 9% respectively). The other boroughs had a reduction of between 14% and 36%. Referral rates have increased again in 2021
- The rates of referral by population do vary. Redbridge has the lowest rates of referral at 26.62 referrals per 1000 population. The highest rates of referral are in City & Hackney. The pattern does not match the prevalence data across the ICS and indicates other factors are affecting the rates of referral.
- Although many areas experienced a drop in referrals, the monthly case load increased in all teams except Redbridge (-5%). The increase in caseload suggests an increase in the complexity of cases meaning that the CYP needs longer intervention or there are issues in stepping the CYP down once interventions are complete.
- Despite the decrease in new referrals, anecdotally, areas did experience a surge in demand during 2020, linked to Covid-19, causing bottlenecks and pressures in workforce capacity.
- The average total contact time per case per month varies. The BHR community providers provide an average of 44 min. Newham (90 min), Tower Hamlets (77 min) and City and Hackney (63 min) provide significantly more.
- There is significant variance in the levels of investment and historic commissioning decisions in the frontline CAMHS services for the main providers. Funding of other services that support CYP, for example Lottery funding is not included in these data.
- These appear to correlate with time per case per month. The three BHR community teams have the lowest team spend per referral by the provider. NELFT, in 2017, following a joint full-service review did receive additional finance from the commissioners but the three borough teams appear to have less than half the team investment per case than the next lowest team cost. This issue needs further exploration. These localities also provide the least time per case per month. The make up of the workforce is also significantly different in the BHR teams. They have far lower numbers of medical (psychiatrists) staff and far lower levels of all nurse / AHP staff. All the non-BHR teams also have some band 8C resource whereas 8b is the maximum band for non-medical staff in BHR teams.

Comparison of 2020 Metrics – Eating Disorder

Provider	New Referrals % change from 2019	New Referrals per thousand 5-17 popn % change from 2019	Average Open Cases per Month % change from 2019	Average Direct Contact mins per Case per Month % change from 2019	Average Indirect Contact mins per Case per Month % change from 2019	% Face-to-Face Contacts % change from 2019	Annual Cost of Clinical Team (inc. overheads)	Clinical WTEs
ELFT	220 +69%	1.50 +68%	133 +60%	119 -3%	66 -17%	46% -22%	£917k	10.1
NELFT	172 +2%	0.91 +0%	103 +55%	175 +27%	1 +8%	36% -63%	£752k	9.6

Key points

- Both providers of eating disorder services have seen a significant rise in referrals in 2020. ELFT has seen the largest increase and has 65% more referrals per population compared to NELFT. This may relate to differences in provision of earlier support in the community or other factors.
- The caseloads have also increased for both providers. ELFT has 26% more caseload compared to the NELFT service.
- The average contact minutes per case per month have changed in 2020 and now are similar between the two services with around 180 total min per month per case, although a significant proportion of ELFT's contact time is recorded as "indirect".
- The delivery approach appears significantly different between the two services in the numbers of face to face appointments. The ELFT team sees approximately two thirds face to face, whereas the NEFLT team see just over a third face to face.
- The teams both have medical psychiatry support but the ELFT team has a full time consultant compared with NELFT's 0.6 WTE.

Source: ELFT & NELFT local data, included manual amends from NELFT to correct original indicative figures.

Comparison of 2020 Metrics – Crisis

Provider	New Referrals *% change from 2019*	New Referrals per thousand 5-17 popn *% change from 2019*	Average Open Cases per Month *% change from 2019*	Average Direct Contact mins per Case per Month *% change from 2019*	Average Indirect Contact mins per Case per Month *% change from 2019*	% Face-to-Face Contacts *% change from 2019*	Annual Cost of Clinical Team (inc. overheads)	Clinical WTEs
ELFT	552 *+64%*	3.78 *+63%*	84 *+132%*	48 *-54%*	2 *+349%*	84% *-15%*	£1,200k	12.8
NELFT	771 *+9%*	4.08 *+7%*	79 *-6%*	93 *-33%*	3 *+12%*	90% *0%*	£1,158k	8.6

Key points

- Both services received had an increase in referrals. The NELFT service received 40% more referrals than ELFT in 19/20 when ELFT had a new team of 3wte. which is 8% more referrals per population. Cases receive differing amounts of contact time with NELFT providing total of 96 min / case / month compared to 50 min. the data above shows the wte for teams in 20/21 with a significant growth in ELFT team demonstrated..
- The team structure is different between the two teams. The ELFT team is (as of 2021) larger than the NELFT team.
- The level of skill mix is different, specifically, the ELFT team has profiled in significantly more band 7 staff above band 6 compared to NELFT.

Source: ELFT & NELFT local data

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2. Introduction

National and Local Priorities

The NEL integrated system

Strategic summary

North East London integrated care system (NHS England)

"*We want north east London to be a place where everyone's mental health and wellbeing is supported and where the NHS plays its part through promoting mental wellbeing in care pathways, supporting the physical health of people with mental health issues and supporting the wellbeing of staff*."

1. Promoting the health and independence of local people, in particular good mental wellbeing, and the prevention of ill health and loss of independence, while tackling inequalities.
2. Improving services by providing more care outside of hospital, better integrated in primary, mental, social and community care, and improving priority services such as maternity, mental health, cancer, urgent and emergency care, with strong hospital and specialist services.
3. Developing the right staff with the right technology in the right place – focusing on skills and career development, recruitment and retention, as well as housing for key workers; better digital and online services, and provision of health work places and better buildings.
4. Building partnerships; encouraging productivity and value for money, and being better organised, bringing providers and commissioners together in new ways of working.

Map of London and integrated care systems

North East London ICS

NEL Prevalence by Borough and condition

Overall prevalence in NEL is above the England average for 5 out of 8 areas of need, with City & Hackney above average for all 8.

Borough	Mental health disorders (5-17)	Conduct disorders (5-16)	Emotional disorders (5-16)	Eating disorders (16-24)	Hyperkinetic disorders (5-16)	Autism (known to schools)	Learning difficulty (known to schools)	Special educational needs (Prim)	Special educational needs (2nd school)
England avg		5.6%	3.6%	13.1%	1.5%	1.8%	3.4%	2.2%	2.3%
NEL Avg	12.1%	6.2%	3.8%	13.2%	1.7%	1.8%	2.7%	2.0%	2.6%
Havering	12.2%	5.4%	3.4%	13.1%	1.5%	1.0%	3.5%	1.4%	2.2%
Barking & Dagenham	11.9%	6.4%	3.9%	13.1%	1.8%	1.7%	3.5%	2.2%	2.8%
Redbridge	12.2%	5.5%	3.5%	13.1%	1.5%	1.1%	2.7%	1.9%	1.8%
Waltham Forest	12.0%	6.0%	3.7%	13.0%	1.6%	2.1%	3.0%	2.1%	3.4%
Newham	12.1%	6.6%	4.1%	12.9%	1.8%	2.2%	1.5%	1.4%	2.2%
City & Hackney	12.0%	6.3%	3.9%	13.5%	1.7%	2.2%	3.7%	2.8%	3.7%
Tower Hamlets	12.0%	6.8%	4.2%	13.4%	1.8%	2.2%	2.2%	2.6%	2.8%

RAG-rating reflects relative prevalence in each Boroughs vs England averages
Red: higher than England average
Amber: close to England average
Green: lower than England average

Source: PHE Fingertips

Description of services in scope of this review

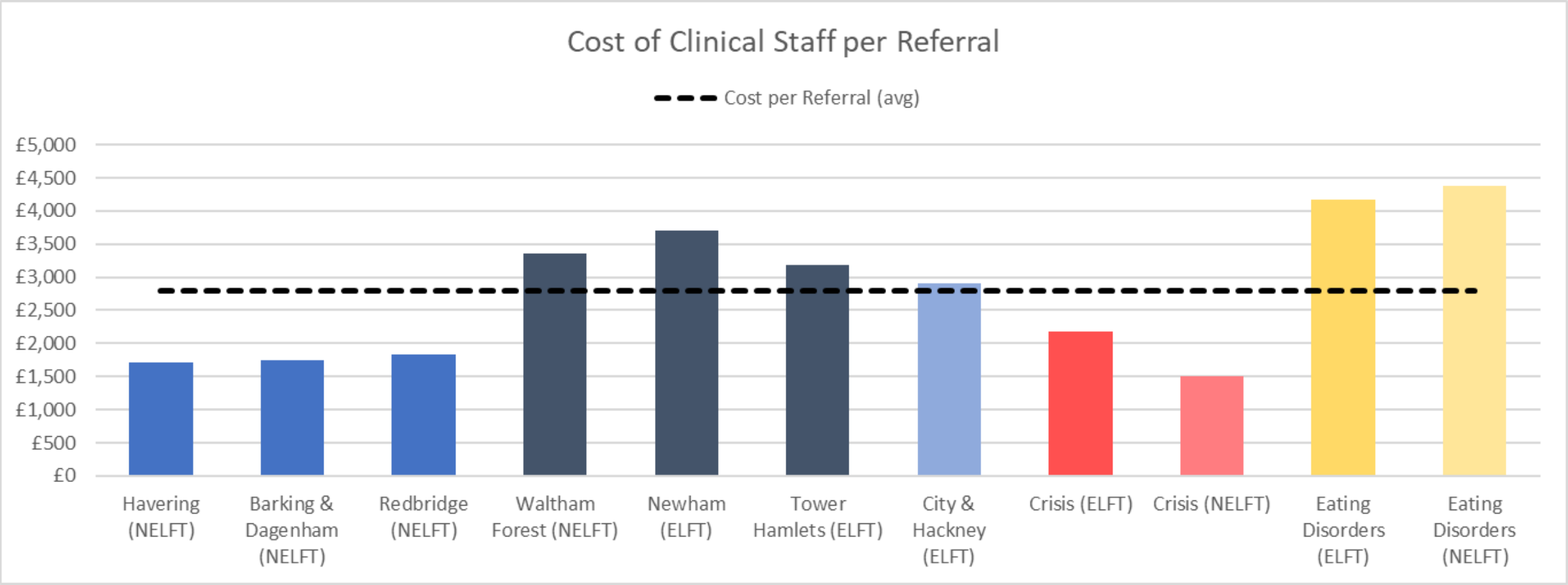
Local Systems	CCG commissioning areas	Providers			
		ELFT	NELFT	Kooth	Homerton UH NHSFT
City and Hackney Integrated Care Partnership	City and Hackney	• Locality CAMHS community teams (1 per borough) • Specialist eating disorder service (East London wide) • Crisis Team East London wide		Digital provision across all 7 boroughs	• First steps service • CAMHS Disability
WEL Integrated Care Partnership	Newham				
	Tower Hamlets				
	Waltham Forest		• Locality CAMHS community team (1 per borough) • Specialist eating disorder service • Crisis support • Home support and inpatient facility		
BHR Integrated Care Partnership	Barking Havering and Redbridge (Joint CAMHS commissioning established across the boroughs)				

Summary of CAMHS investment across NEL

1. Investment within CAMHS is variable across NEL. This report used the cost of clinical staff per referral as a comparable metric. For community CAMHS, the BHR ICP had the lowest cost per referral (£1,478 - £1, 702) and is less than half that of other boroughs. The greatest cost per referral (and highest level of investment) is in Tower Hamlets (£4,183) and City and Hackney (£4,167), who are both subject to Inner London weighting. TH also has a Local Authority funded embedded CAMHS team as does Newham.
2. For the crisis services ELFT has a higher cost per referral for compared to NELFT.
3. As would be expected the level of investment is a key determinant on the team size. The lower the investment, the smaller the team. The NELFT community teams in WEL reported issues recruiting particularly psychiatrists and these teams have between 1.9 and 2.0 WTE psychiatrists only. In comparison, the other boroughs have between 4.0 and 5.6 WTE. The team "shape" is also variable . The ELFT community teams all had significantly higher numbers of nurses, therapists and psychologists employed at Band 8a compared to the NELFT community teams.
4. The ELFT Eating Disorder team has an extra 0.5 WTE extra staff overall compared to the NELFT team. However, ELFT has 2.5 fewer clinical Band 7 staff, as well as 0.5 consultant psychiatrist.
5. The ELFT crisis team is bigger and has significantly more band 7 mental health nurses.

Relative Investment in Services

Using the 2020/21 pay costs plus non-pay and overheads for each of the 7 borough teams, the Crisis teams and Eating Disorder teams, the "cost of clinical staff per referral" has been calculated for comparison. This chart shows a significant variance in the relative investment indicator.



- *Workforce costs are actual costs and have not been adjusted to reflect differences in London weighting/outcomes , service models or service delivery*
- *Tower Hamlets' referrals and activity exclude the Paediatric Liaison Team. Associated workforce costs have also been excluded.*
- *Referral numbers and costs for NELFT EDS were amended following feedback*

Source: Local data from ELFT and NELFT

Workforce Numbers – borough teams Fit grid to page

The differing levels of investment has an impact on team size. With the exception of Waltham Forest, the NELFT CAMHS borough teams (in blue) are significantly smaller than their ELFT counterparts (in green). The charts show a particular difference in the numbers of nurses, therapists and psychologists employed at Band 8a. TH & Newham teams staffing establishment included embedded Local Authority funded teams in eg. Schools, Early Help which are not part of Core CAMHS offer

Role Type / Grade	Havering	Barking & Dagenham	Redbridge	Waltham Forest	Newham	Tower Hamlets	City & Hackney
Consultant	2.0	2.0	1.9	4.0	4.7	4.0	5.3
SAS Doctor	1.0	1.0	1.0	3.6	1.8		
Specialist Registrar	1.0		1.0	1.8	3.0	0.8	
Junior Doctor							3.7
Clinical - 8d					1.0	0.3	1.0
Clinical - 8c		0.3		0.7	2.1	1.8	2.9
Clinical - 8b	1.6	0.7	1.0	3.0	3.4	5.8	4.4
Clinical - 8a	3.0	1.5	3.9	6.0	20.0	15.4	14.7
Clinical - 7	8.0	7.4	5.5	11.6	17.0	17.3	13.0
Clinical - 6	6.0	5.0	1.0	19.0	2.5		5.0
Clinical - 5			1.0	3.0	11.0	10.0	8.0
Clinical - 4	4.0	4.0	3.0	3.0		2.0	
Clinical - 3				2.0			
Unspecified					1.0		1.0
Total WTEs	**26.6**	**21.9**	**19.3**	**57.8**	**67.4**	**57.4**	**59.0**

** Tower Hamlets' figures exclude the Paediatric Liaison Team*

Source: Local data from ELFT and NELFT, including manual amends following feedback

Workforce Numbers – specialist teams

ELFT's crisis team is bigger overall and has a significantly higher number of Band 7 MH nurses than NELFT's. In terms of Eating Disorder, overall numbers are similar, with both teams working under a consultant.

Role Type / Grade	NELFT Crisis (Interact)	ELFT Crisis	NELFT Eating Disorder	ELFT Eating Disorder
Consultant		0.5	0.6	1.0
Clinical - 8b		1.0	0.8	
Clinical - 8a	0.6	1.0	0.7	2.1
Clinical - 7	2.0	9.3	5.5	3.0
Clinical - 6	5.0		1.0	1.0
Clinical - 5	1.0	1.0	0.0	1.0
Clinical - 4			1.0	
Unspecified				2.0
Grand Total	**8.6**	**12.8**	**9.6**	**10.1**

Source: Local data from ELFT and NELFT, including manual amends following feedback

Impact of the level of investment across NEL – service model /variation

The previous slide set out the differences in investment and team structure. Our next question was to understand differences in the outputs from the different teams. We considered the number of referrals, open cases and time/ month / case.

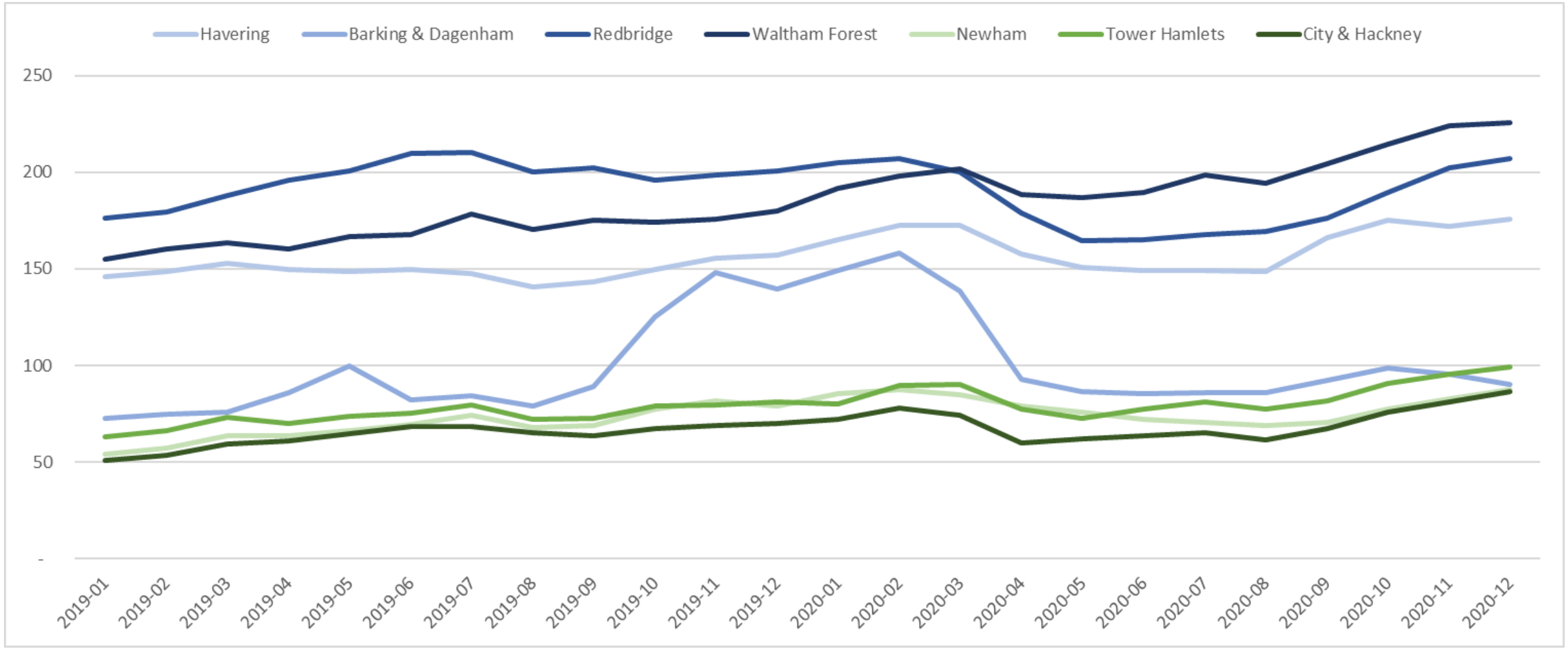
- All teams across NEL have experienced increasing referrals which is causing a demand an capacity dilemma. Each system needs to be optimized and there is a need to consider alternative resources for CYP so they can access support from other parts of the system- e.g. social prescribing, early help, integrated schools offer, self help,
- There may not be the right resource available in the right place at the right time.
- There are particular demands on Eating Disorder services in terms of volume and complexity of presentation. Additional investment has been made available. Finding the correct workforce is a challenge, therefore whole system thinking is required including more creative partnerships with paediatric colleagues.
- Within the community typically there has been a decrease in referrals and yet the average open referrals has increased. Anecdotal complexity/ vacancies/ staff fatigue/ Covid etc. Only Waltham Forest (2%) and Tower Hamlets (6%) had increases in referrals from 2019 to 2020. Despite this, all the NELFT boroughs all have higher open cases per month and lower average contact minutes per case per month. This requires more investigation but, it suggests that the BHR teams are stretched (potentially reducing contact times to be able to see more clients) and do not have access within the locality to all the required resources to manage the full workload.
- As well as BHR having smaller CAMHS community teams, the interviews indicated that the BHR localities had fewer community assets to support lower-level need.
- The children's and young peoples' mental health inequalities data snapshot shows the BHR boroughs have data that is more able to demonstrate impact (highest closed referrals with a paired score). This corresponds to the interviews where in BHR there is significant work progressing around using data insights to support decision making.

Impact of the level of investment across NEL

- The ELFT crisis team has been running for one year and will still be bedding in. The NELFT Interact service has been in place for several years, and is funded via Community CAMHS investment from the CCG.
- The two crisis services have experienced an increase in demand similar numbers of open cases. NELFT have managed to reduce their open cases.
- In 2020, the ELFT crisis team had 84% of contacts recorded as face to face, which dropped from 99% in the previous year. NELFT consistently recorded 90% face to face both years. Both teams predominantly work within the acute hospitals and naturally contacts are expected to have a higher level of face to face appointments. It would be interesting to understand the differences in delivery model and the impact of moving some of the contacts to non-face to face for ELFT.
- The average contact minutes per case per month also vary. Both teams have reduced the contact minutes by almost a third between 2019 and 2020. ELFT provides an average of 73 min and NELFT an average of 95 min.

Monthly Caseload Trends – borough teams

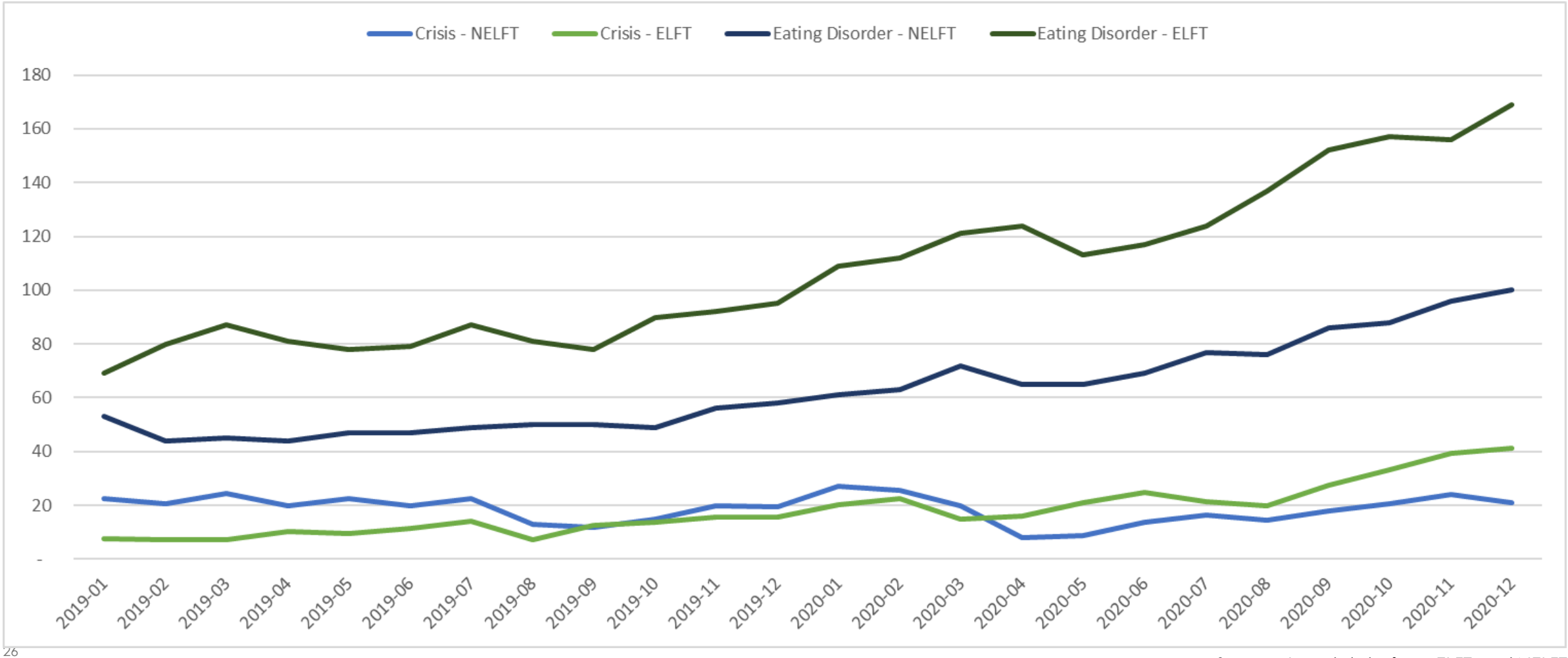
All teams have increasing caseloads, with NELFT teams having significantly higher numbers of open cases compared with ELFT teams. The spike in B&Ds figures come from the B&D team's Brief Intervention pathway.



Source: Local data from ELFT and NELFT

Monthly Caseload Trends – specialist teams

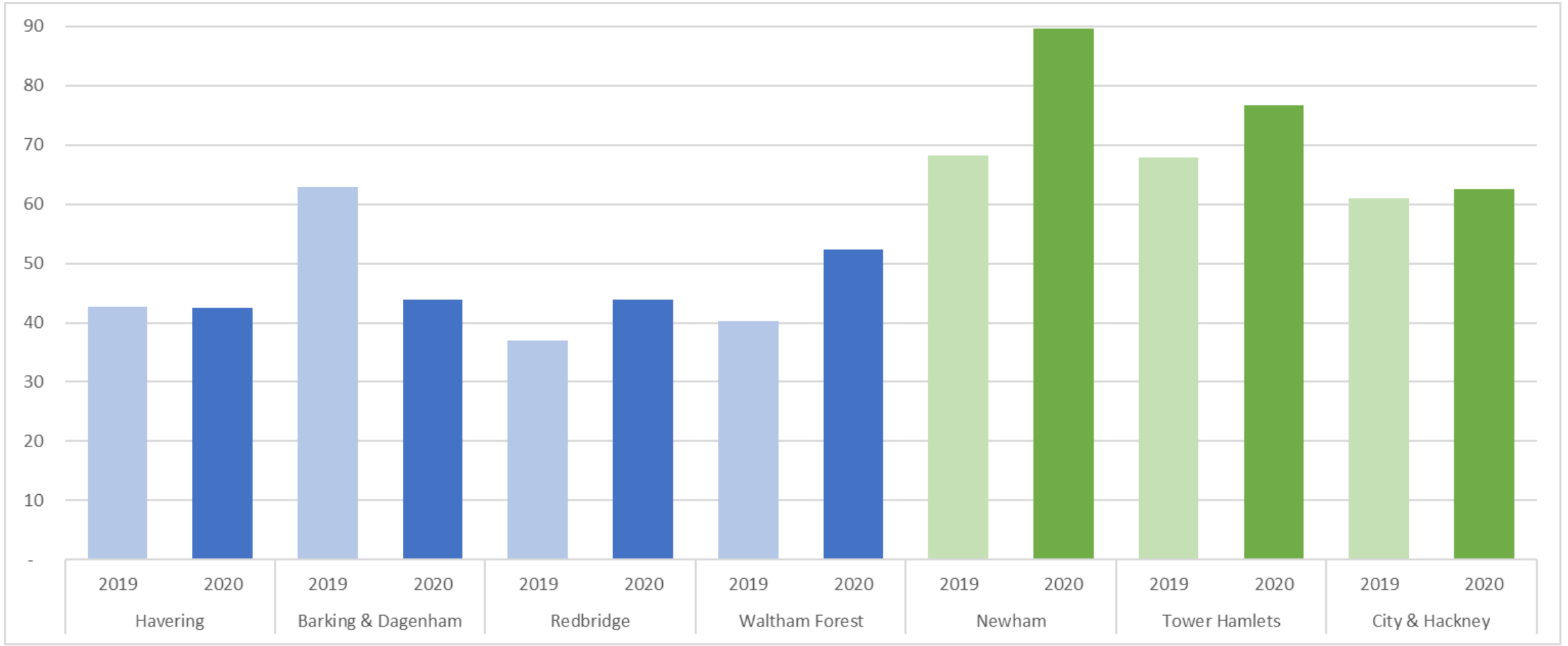
On average, caseloads for both providers' crisis teams have been fairly similar, although ELFT's grew from under 10 per month in early 2019 to just over 40 by the end of 2020. Both Eating Disorder teams have seen a significant growth in caseload since October 2019, with ELFT's total caseload 69% higher than NELFT's at the end of 2020.



Source: Local data from ELFT and NELFT

Average minutes per case per month – borough teams

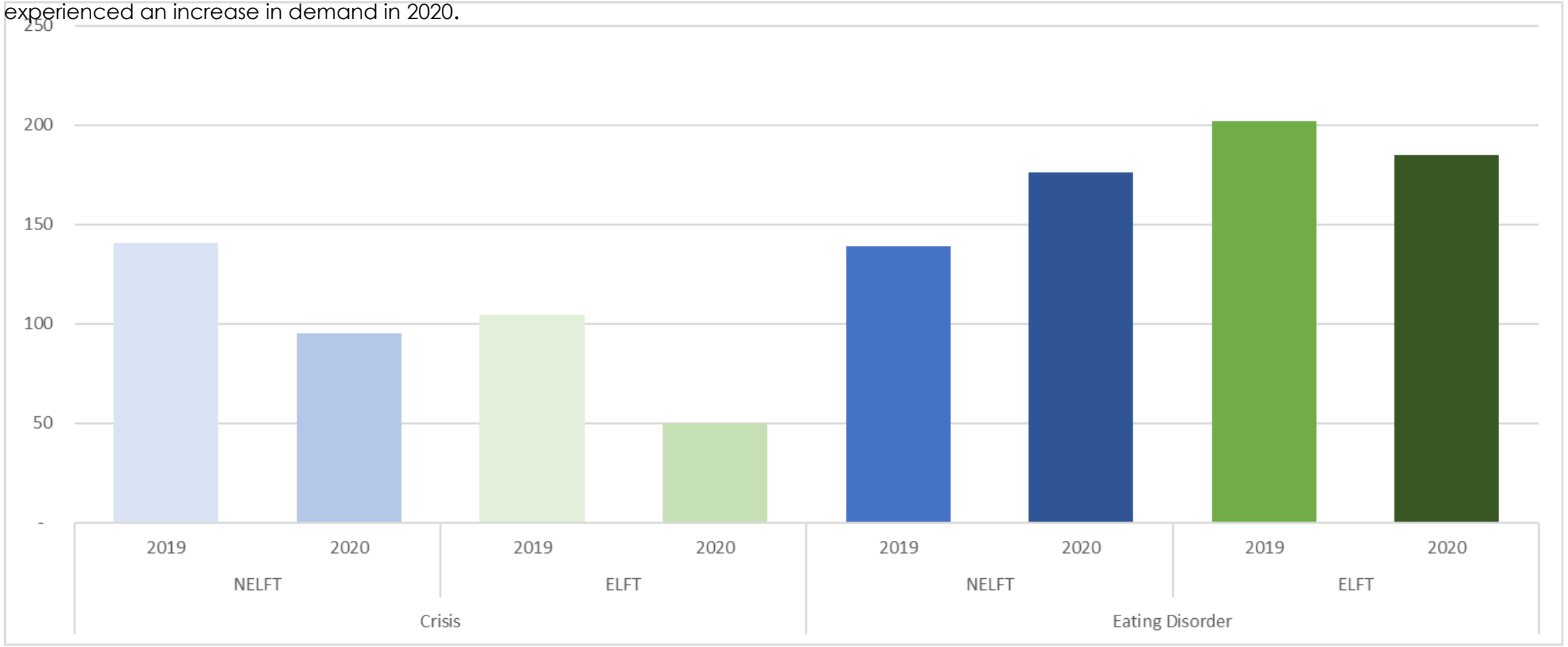
With higher caseloads and fewer staff, it follows that the number of average contact minutes per case per month is lower across the NELFT teams compared with the ELFT teams, as shown on the graph below.



Source: Local data from ELFT and NELFT

Average minutes per case per month – specialist teams

The amount of contact time per case fell for both providers' crisis teams between 2019 and 2020, The demand has not significantly changed so it would appear the model of care has altered. The ELFT crisis team is a new service. Demand has increased and workforce recruitment may not have kept pace. ELFT's contact time per Eating Disorder case fell slightly but,remained above NELFT's in 2020. Both NEFLT and ELFT experienced an increase in demand in 2020.

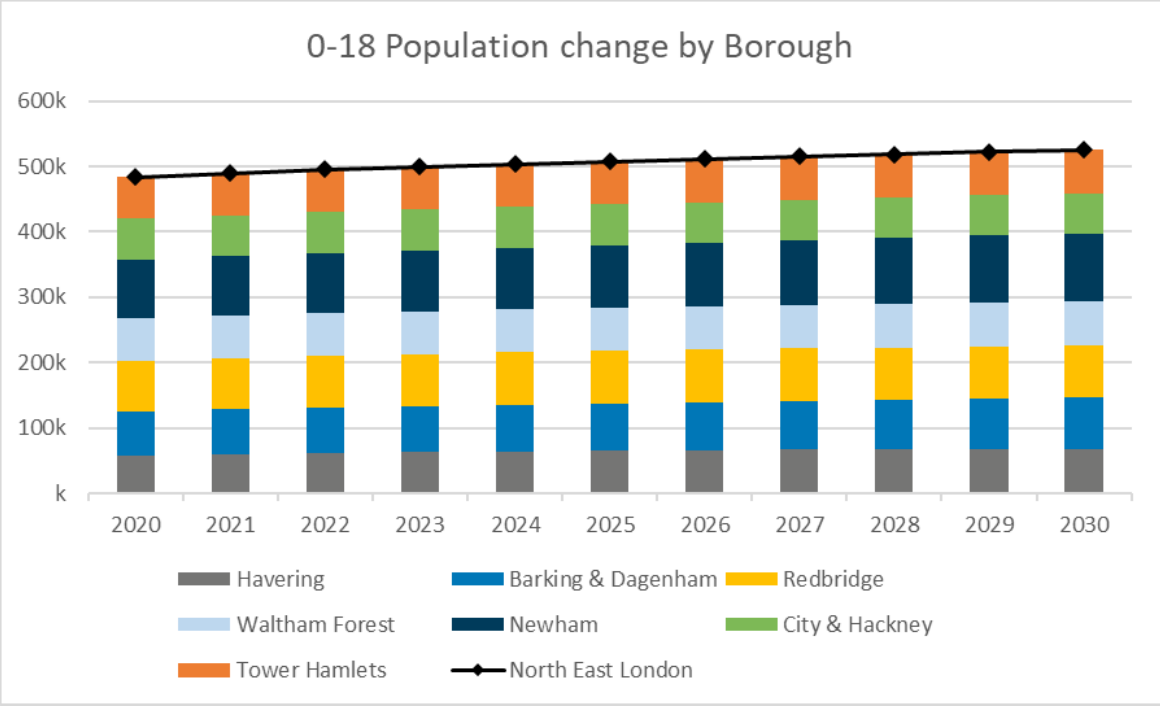


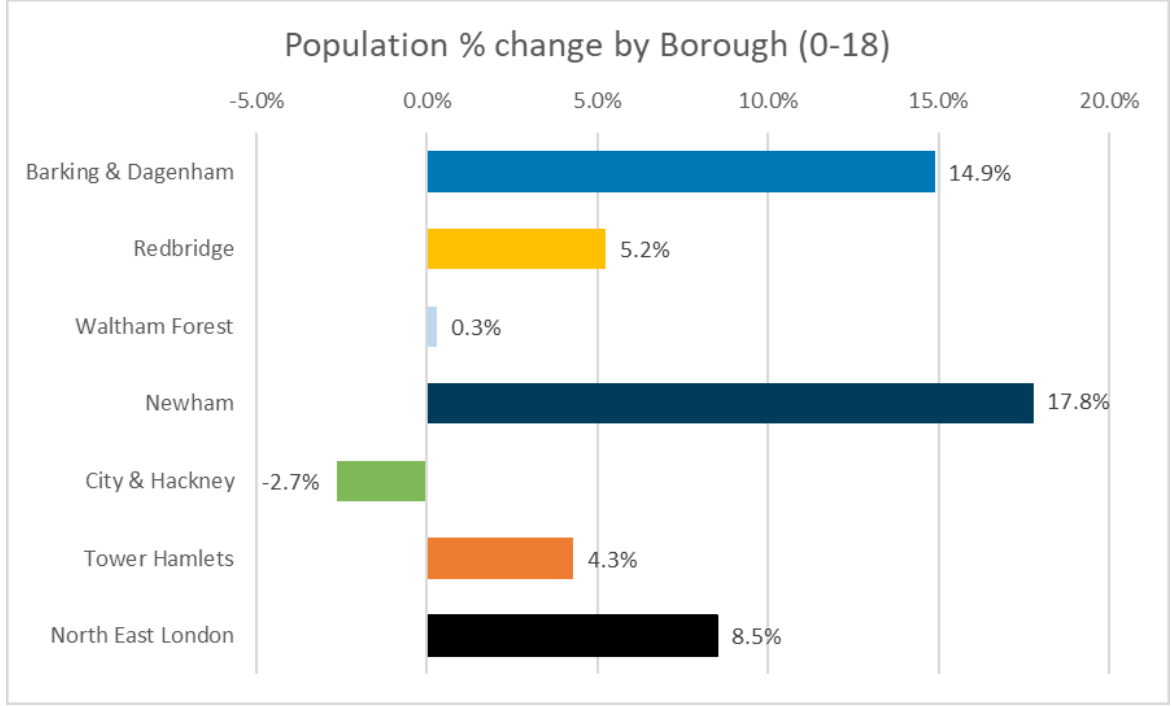
Source: Local data from ELFT and NELFT

Demographics across NEL

NEL Population by Borough

The population of CYP is expected to increase by 8.5%



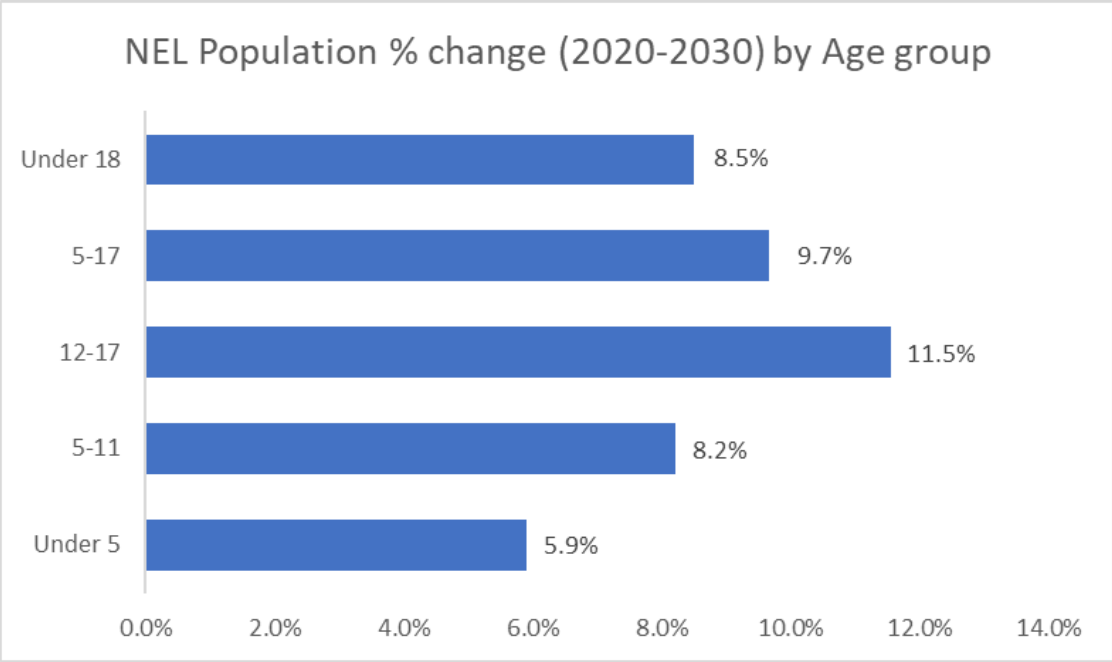


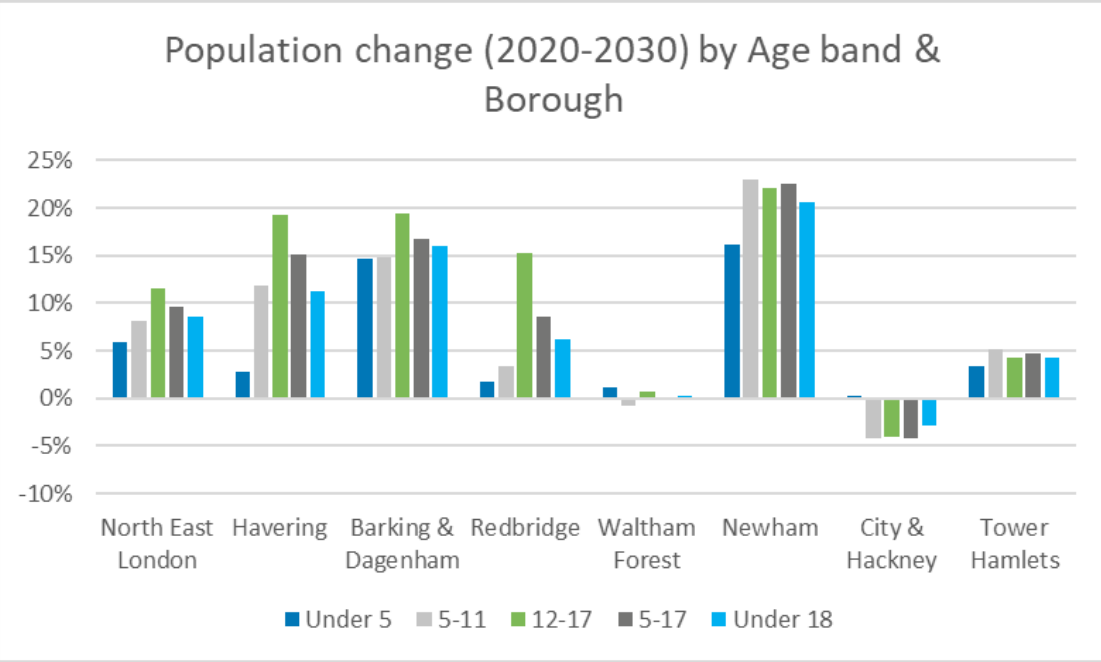
- The population of 0-18 year olds across NEL is expected to **increase by over 41,000** children between 2020 and 2030. This represents an increase of **8.5%.**
- Within Barking and Dagenham, there is an increased level of re-development and regeneration including more housing. This is not factored into the GLA figures and therefore ehe prediction growth of 14.9% may be higher with the 0-18 cohort due to many young families moving in the borough.
- In Waltham forest there is also an expectation the population will grow more based on growth given increased housing provision and other projected demographic growth data
- There is significant variation across boroughs, with Newham having the largest projected increase (17.8%), whilst City & Hackney has an expected decrease of 2.7%.

Source: GLA – housing led population projections 2018

NEL Population by Borough

There is variation in population change by borough and age band





The 12-17 age band is expected to grow by over **11%** during the next 10 years. Growth in this age group is expected across all boroughs except City & Hackney, with Newham at **21%**.

The under 5s have the lowest projected growth at **5.9%.**

Source: GLA – housing led population projections 2018

NEL Prevalence by Borough and condition

Overall prevalence in NEL is above the England average for 5 out of 8 areas of need, with City & Hackney above average for all 8.

Borough	Mental health disorders (5-17)	Conduct disorders (5-16)	Emotional disorders (5-16)	Eating disorders (16-24)	Hyperkinetic disorders (5-16)	Autism (known to schools)	Learning difficulty (known to schools)	Special educational needs (Prim)	Special educational needs (2nd school)
England avg		5.6%	3.6%	13.1%	1.5%	1.8%	3.4%	2.2%	2.3%
NEL Avg	12.1%	6.2%	3.8%	13.2%	1.7%	1.8%	2.7%	2.0%	2.6%
Havering	12.2%	5.4%	3.4%	13.1%	1.5%	1.0%	3.5%	1.4%	2.2%
Barking & Dagenham	11.9%	6.4%	3.9%	13.1%	1.8%	1.7%	3.5%	2.2%	2.8%
Redbridge	12.2%	5.5%	3.5%	13.1%	1.5%	1.1%	2.7%	1.9%	1.8%
Waltham Forest	12.0%	6.0%	3.7%	13.0%	1.6%	2.1%	3.0%	2.1%	3.4%
Newham	12.1%	6.6%	4.1%	12.9%	1.8%	2.2%	1.5%	1.4%	2.2%
City & Hackney	12.0%	6.3%	3.9%	13.5%	1.7%	2.2%	3.7%	2.8%	3.7%
Tower Hamlets	12.0%	6.8%	4.2%	13.4%	1.8%	2.2%	2.2%	2.6%	2.8%

RAG-rating reflects relative prevalence in each Boroughs vs England averages
Red: higher than England average
Amber: close to England average
Green: lower than England average

Source: PHE Fingertips

Attain

Improving health and wellbeing

The Borough summaries

Havering

Havering introduction

About Havering

The London Borough of Havering in East London, England, forms part of Outer London. It has a population of 259,552 inhabitants; the principal town is Romford, while other communities are Hornchurch, Upminster, Collier Row and Rainham. The borough is mainly suburban, with large areas of protected open space. Romford is a major retail and night-time entertainment centre, and to the south the borough extends into the London Riverside redevelopment area of the Thames Gateway. The local authority is Havering London Borough Council.

Havering CAMHS services and pathways

Draft

Service / pathway name	Lead Provider
CAMHS triage	NELFT community
Primary mental health team	NELFT community
STAR (Support, Time and Resilience) Workers in school	NELFT community
Ardleigh Green drop in centres	L.B of Havering
Primary care advice and guidance (5 day response time)	NELFT community
CAMHS vulnerable children	NELFT community
CAMHS nurse led	NELFT community
CAMHS Neurodev (ADHD / ASD) and LD	NELFT community
CAMHS YPCS tier 4	NELFT
CAMHS Eating disorder	NELFT
Early intervention in psychosis. If under 14 community team, if over; adult	NELFT community (<14) NELFT adult >14
INTERACT - Child and Young Person Crisis Outreach Service (tier 4)	NELFT
Kooth online counselling open to all children and young people	Kooth
Emotional Literacy Support Assistants (Schools)	L.B of Havering
Butterflies (perinatal mental health) peer support	NELFT community & NELFT Perinatal parent infant mental health services
Positive parenting (SEN)	Havering LBH supported Includes NEFLT support

Draft

Mapping Havering services against the Thrive Framework

iThrive Maturity level 3

There are plans within the locality to move to move to level 4. The Thrive Framework is captured into RIO. Work to use these data to provide management information is at its beginning.

Team Name	2018/19 Contacts	2019/20 Contacts	2020/21 Contacts (YTD)	2 - Giving advice	3 - Giving help	4 - Giving more help	5 - Giving risk support	Non-Thrive
CAMHS-HV- ADHD Management	458	557	646	10%	15%	50%	25%	
CAMHS-HV- Adolescent Safeguarding Team			1				100%	
CAMHS-HV- ASD Pathway	250	997	1,323	10%	15%	50%	25%	
CAMHS-HV- Pathway Team	7,211	11,047	12,871	5%	10%	60%	25%	
CAMHS-HV- Primary Mental Health Team	856	732	973	40%	60%			
CAMHS-HV- Triage Team	1,155	1,052	514	30%	25%	25%	20%	
CAMHS-HV- Vulnerable CYP Caseload			62				100%	
CAMHS-HV-ADHD Nurse Lead Pathway	210	276	284	10%	15%	50%	25%	
INT-HV- INTERACT	1,411	565	444			20%	80%	
T3-HV- CAMHS Groups	162	619	16		100%			

Draft

Havering – workforce

The locality team has a clinical workforce of **26.6 WTEs**. Over half the workforce is made up of Psychologists, Therapists and Nurses at Band 6 and Band 7, with a medical workforce of 4 WTEs. Overall there are **0.64 clinical WTEs per thousand population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads, is £2,566K, which equates to **£61.99 per child or £1,702 per referral.**

Role Type / Grade	WTEs
Consultant	2.0
SAS Doctor	1.0
Specialist Registrar	1.0
Clinical - 8b	1.6
Clinical - 8a	3.0
Clinical - 7	8.0
Clinical - 6	6.0
Clinical - 5	0.0
Clinical - 4	4.0
Total	26.6

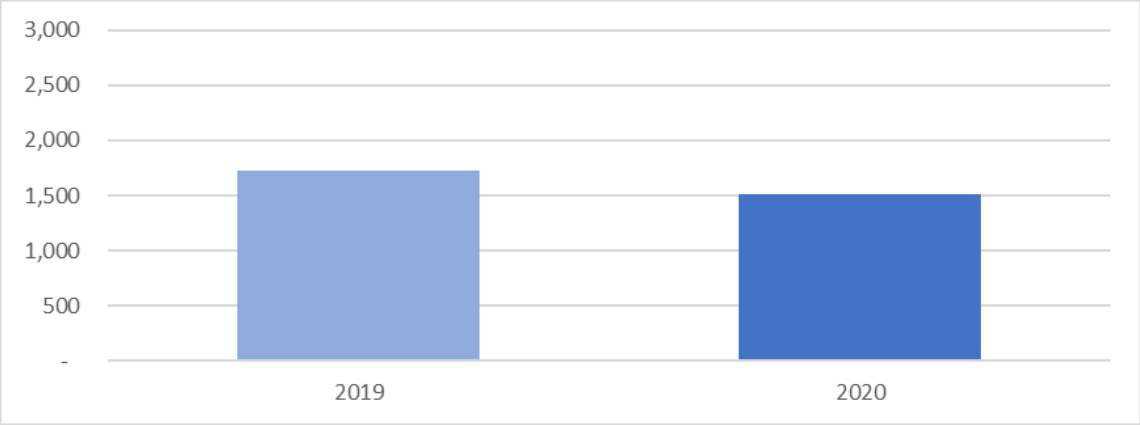
Source: NELFT local data

Draft

Havering – referrals and caseload

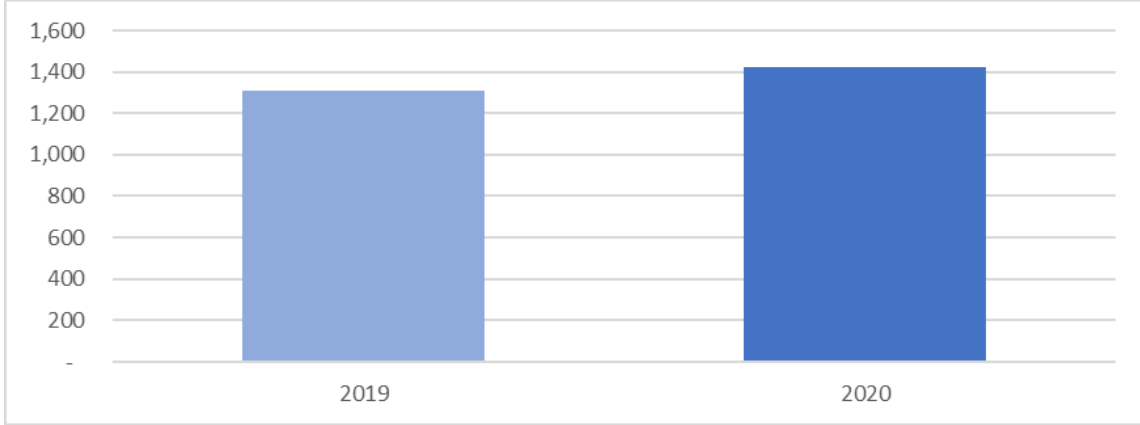
Numbers of new referrals fell across most pathways between 2019 and 2020, although ADHD Management saw a dramatic increase. Despite this, ADHD Management maintained a stable caseload, whilst the ASD Pathway's caseload saw a significant increase. Overall caseload increased by 9%.

New Referrals



Team / Pathway	2019	2020	Change	Trend
CAMHS-HV- ADHD Management	13	99	662%	
CAMHS-HV- ASD Pathway	64	42	-34%	
CAMHS-HV- Pathway Team	751	776	3%	
CAMHS-HV- Triage Team	674	428	-36%	
CAMHS-HV-ADHD Nurse Lead Pathway	13	2	-85%	
INT-HV- INTERACT	160	161	1%	
T3-HV- CAMHS Groups	49	-	-100%	
Grand Total	**1,724**	**1,508**	**-13%**	

Average Live Caseload



Team / Pathway	2019	2020	Change	Trend
CAMHS-HV- ADHD Management	135	132	-2%	
CAMHS-HV- ASD Pathway	51	125	144%	
CAMHS-HV- Pathway Team	837	955	14%	
CAMHS-HV- Triage Team	142	94	-34%	
CAMHS-HV-ADHD Nurse Lead Pathway	78	83	7%	
INT-HV- INTERACT	29	24	-17%	
T3-HV- CAMHS Groups	36	12	-68%	
Grand Total	**1,308**	**1,424**	**9%**	

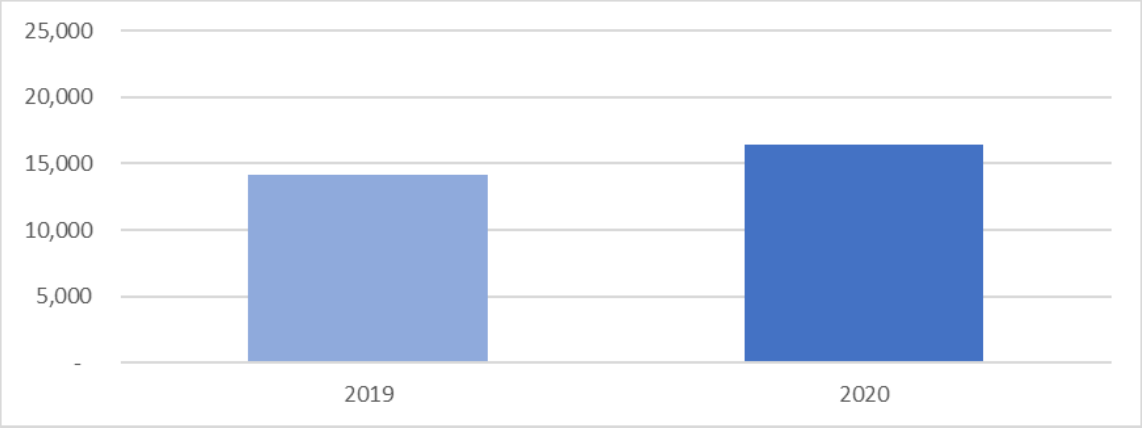
Source: NELFT local data

Draft

Havering - contacts

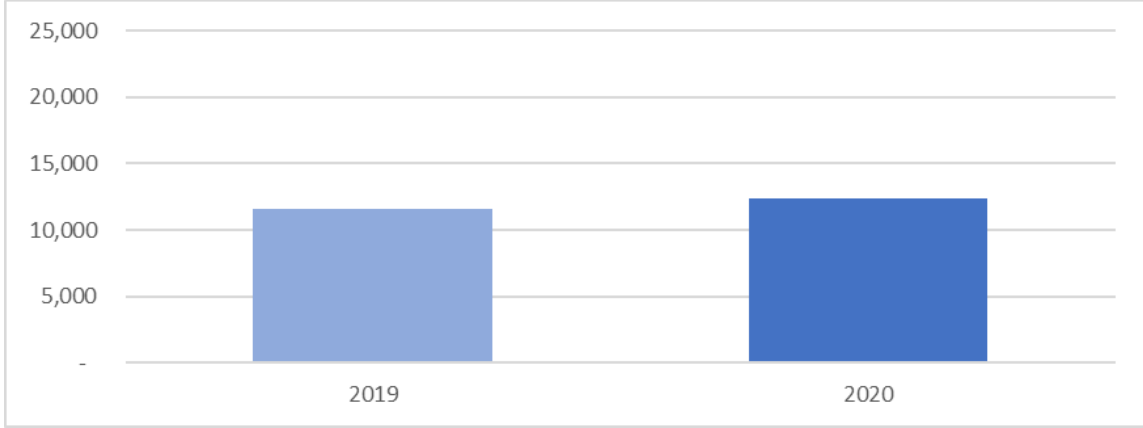
From 2019 to 2020 contact numbers increased by 16% and contact hours increased by 7% across all pathways. The ASD Pathway saw the biggest relative increase in activity, however the bulk of Havering's activity is within the Pathway Team, which accounted for over 75% of all contact time in 2020.

Contacts



Team / Pathway	2019	2020	Change	Trend
CAMHS-HV- ADHD Management	548	631	15%	
CAMHS-HV- ASD Pathway	672	1,540	129%	
CAMHS-HV- Pathway Team	10,217	12,829	26%	
CAMHS-HV- Triage Team	1,067	667	-37%	
CAMHS-HV-ADHD Nurse Lead Pathway	276	276	0%	
INT-HV- INTERACT	809	420	-48%	
T3-HV- CAMHS Groups	612	112	-82%	
Grand Total	**14,201**	**16,475**	**16%**	

Contact Hours



Team / Pathway	2019	2020	Change	Trend
CAMHS-HV- ADHD Management	406	440	8%	
CAMHS-HV- ASD Pathway	519	1,160	124%	
CAMHS-HV- Pathway Team	8,399	9,602	14%	
CAMHS-HV- Triage Team	455	330	-28%	
CAMHS-HV-ADHD Nurse Lead Pathway	216	184	-15%	
INT-HV- INTERACT	793	528	-33%	
T3-HV- CAMHS Groups	772	134	-83%	
Grand Total	**11,560**	**12,378**	**7%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

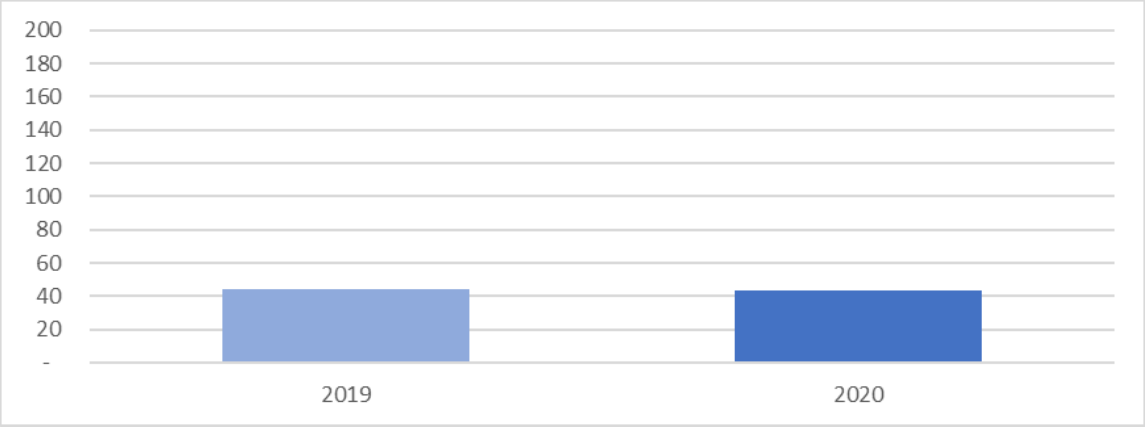
Source: NELFT local data

Draft

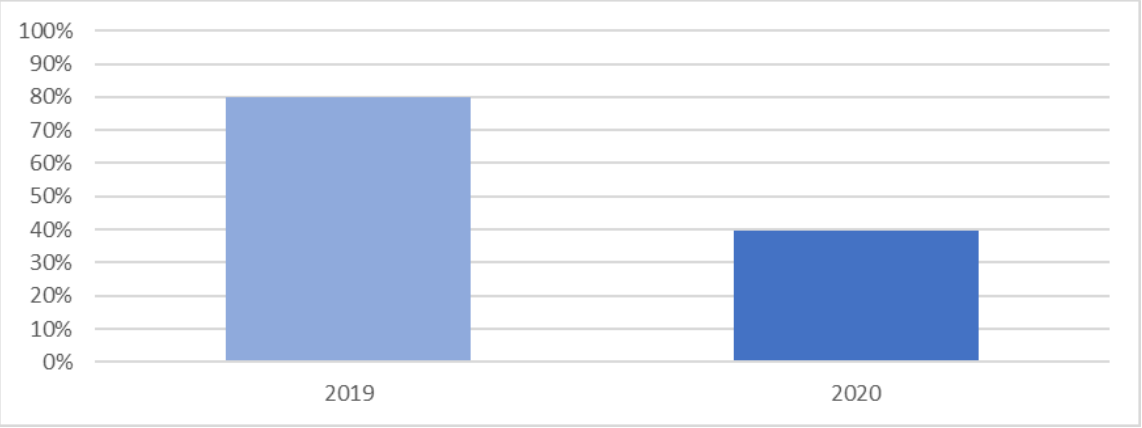
Havering – monthly time per case & contact type

The average contact time per case remained fairly static from 2019 to 2020. Whilst the ADHD Management and the Triage Teams increased time per case, there was a big drop in CAMHS Groups. All pathways except Interact saw a reduction in the proportion of time spent in Face-to-Face contacts.

Contact Minutes per Case per Month



Proportion of Face-to-Face Contact Time



Team / Pathway	2019	2020	Change	Trend
CAMHS-HV- ADHD Management	15	17	11%	
CAMHS-HV- ASD Pathway	51	47	-9%	
CAMHS-HV- Pathway Team	50	50	0%	
CAMHS-HV- Triage Team	16	18	10%	
CAMHS-HV-ADHD Nurse Lead Pathway	14	11	-20%	
INT-HV- INTERACT	139	111	-20%	
T3-HV- CAMHS Groups	106	58	-45%	
Overall Average	**44**	**43**	**-2%**	

Team / Pathway	2019	2020	Change	Trend
CAMHS-HV- ADHD Management	82%	59%	-29%	
CAMHS-HV- ASD Pathway	77%	34%	-55%	
CAMHS-HV- Pathway Team	82%	37%	-55%	
CAMHS-HV- Triage Team	4%	2%	-57%	
CAMHS-HV-ADHD Nurse Lead Pathway	85%	69%	-19%	
INT-HV- INTERACT	88%	89%	1%	
T3-HV- CAMHS Groups	96%	91%	-5%	
Overall Average	**80%**	**40%**	**-50%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

Source: NELFT local data

Assessment of Havering services against Thrive principles

Draft

Attain

Principle	Description
Common Language	Thrive is used across the system as a common language and captured on the CAMHS system (RIO).
Needs-Led	The use of The Thrive Framework supports a needs-led approach and a more collaborative offer that is also aimed at prevention. For example supporting conversations in schools with children and training mental health schools teams (MHSTs) about physical health needs has enabled the introduction of dieticians. The team is flexible and response to needs. Front door able to respond to urgent needs with on call medical resources and direct lower level need straight to clinical team member
Shared Decision Making	The locality is at the early stages of Incorporating the voice of young people in service redesign. Co production will be led by allocated transformation leads who will engage and facilitate the participation of children and young people and carers.
Proactive Prevention	The primary care mental health team is a CMHT community team that provides "tier 2" advice and getting help support.
Partnership Working	There are many examples of partnership working across the borough. These include the Multiagency Safeguarding Hub (MASH) that provides the links to adult mental health service (support transition) , enables wider family support and links to the multi-disciplinary CAMHS adolescent safeguarding team (recently set up). There is close working between social care, youth justice, CAMHS and children's health team. Ardleigh Green provide three hubs in schools that operate as a drop in for community resource, police, housing , health visitors and school staff. Multiple times a week, complex cases are discussed across partners. There still remain some CYP who have not benefited from this support and there exist some barriers to working with voluntary sector.
Outcome Informed	Outcome measures are being used consistently . There is a rigorous data quality check with a panel sitting regularly to ensure completion of outcomes. Standard assessments are in use. Electronic outcome forms are sent to families and followed up. The data is currently being scrutinised for use as a management tool.
Reducing Stigma	Meetings are often away from the CAMHS offices. There are some barriers in relation to some single-handed GP practices who may not be aligned to the current approach to support children and young people presenting with mental health issues.
Accessibility	There are a range of entry points to support ease of access. A Well being Hub has been introduced for community and mental health services with a single standard referral form. Lifeline have been commissioned to support reaching hard to reach groups. They meet every month to discuss cases and go into schools.

Havering CAMHS Strengths and Challenges

Draft

Strengths

Partnership and integration

- Havering has recently established a multi-disciplinary integrated adolescent safeguarding team for 11 – 16 yr olds that are excluded from schools and with a history of some criminal activity and pursuing risky behaviours.
- Partnership working to review children with complex needs (meets 1 – 3 times weekly basis).
- Specific focus on supporting transition of Young People (vulnerable CYP caseload) with strong links to adult services.
- Opportunity to involve speech therapy for children seen by youth justice and safeguarding teams.

Workforce

- New workforce models to reduce administrative tasks for clinicians
- Different clinical workforce to enable senior clinicians support more complex children / young people e.g. Introduce on the neurodevelopmental pathway nurse led clinics and involve HCAs for non-consultant tasks. This has enabled users to be seen more frequently
- Training on physical health to support recovery / management. Enabled introduction of dieticians
- Developmental posts to provide a clear pathway from junior roles to senior to enable the accumulation of knowledge and experience. Example includes assistant psychiatric roles (B5) able to do brief interventions as a start.

Digital

- The monthly case management calls are now virtual. They occur after the case conference when involvement is requested. NELFT with agreement can always attend and providing one representative to cover all NELFT saving significant time. The attendance is now more consistent and the organisations present has increased supporting a better offer for the person

Delivery model

- The group offer – CMHT group offer anxiety and parents group workshops in 2 groups of 6.
- Triage/assessment and early intervention team meet targets and is responsive to needs and benefit from access to on call doctor and psychiatrist for urgent cases

Challenges

Pathways

- Ensuring a distinct and defined discharge point – empowering parents and families. This can free up capacity as there are examples of variation and some patients held and supported beyond expectation by clinicians "watch and wait"
- Historic concerns working with voluntary sector about professional boundaries.
- Need to clarity of roles and responsibilities to facilitate increased use of voluntary services.

Workforce

- Psychotherapists and psychologist capacity
- Lack of capacity for CBT and family therapy
- Vacancy in safeguarding team
- Challenge is that staff are pulled to help person in crisis –e.g. helping to find beds for child in ED need a suitable location for CYP in crisis where they and families can cool down. After a person has been in ED 4 – 5 days their issues are typically resolved –
- Clear expectation within job plans to ensure staff are clear on what is expected and a reduction in variation.

Digital

- Navigation of relevant online resources. Opportunity to create a catalogue and improve website and online access

Havering response to COVID-19

Draft

Attain

Service changes

- At the start of lockdown the community CAMHS team changed its service provision to meet rising demand for early help by creating a virtual offer for consultations.
- The workshops changed to a video recording. Users and cares receive a link to the video and all users receive a follow up call.
- The service has reviewed the skill mix to reduce administrative functions of clinical staff. For example the roles of triage coordinator and ASD coordinator have been put in place to chase online forms and support access. This has had the impact of releasing time for the senior team to care
- Incorporating therapists (occupational health speech therapists) to provide a more holistic care plan e.g. dieticians

Demand changes

- 17 yr olds presenting with significant needs who have not been seen by services previously.
- Families and looked after children with complex needs have been placed within Havering from inner London boroughs. (properties –are bigger and more challenging families from inner borough families moved).
- An increase in 11 – 17 yr olds presenting with ED; particularly over doses. A review of cases showed that being part of a peer groups may be influencing risky behaviours and presentation in ED. The individuals had briefly accessed CAMHS.
- Due to face to face activity being paused, a backlog built up on the neurodevelopmental pathway (undiagnosed ADHD and CYP with communication issues most affected).
- An increase in the number of referrals into the neuro-disability pathway. This is driven by parental need to have a diagnosis. This is expected to be different to other NEL boroughs.
- Increase in the presentation of behaviour and conduct issues .
- Expectation of a surge in demand from March / April 2021 as pupils return to school.

The content arises from an interview with Pippa Ward (Assistant Director), Diana Daniel-Dawson(Clinical Nurse Specialist) and Michele De Souza (Transformation Lead) from the NELFT CAMHS team.

Attain

Barking and Dagenham

Barking and Dagenham introduction

About Barking and Dagenham,

- The London Borough of Barking and Dagenham is a London borough in East London. It lies around 9 miles (14.4 km) east of Central London. It is an Outer London borough and the south is within the London Riverside section of the Thames Gateway; an area designated as a national priority for urban regeneration. At the 2011 census it had a population of 187,000, the majority of which are within the Becontree estate. The borough's three main towns are Barking, Chadwell Heath and Dagenham. The local authority is Barking and Dagenham London Borough Council. Barking and Dagenham was one of six London boroughs to host the 2012 Summer Olympics.[3]

Draft

Barking and Dagenham services and pathways

Service / pathway name	Provider
Well being Hub and I-Thrive front door	
CAMHS triage	NELFT community
CAMHS brief intervention	NELFT community
CAMHS complex	NELFT community
CAMHS exploitation	NELFT community
CAMHS Neurodev and LD	NELFT community
CAMHS Emotional pathway	NELFT community
CAMHS Eating disorder	NELFT
Early intervention in psychosis	NELFT
CAMHS Behavioural pathway	NELFT community
Interact Crisis Service	NELFT
Mental Health Direct (24/7 telephone line)	NELFT
STAR workers	NELFT community
Kooth online counselling open to all children and young people	Kooth
Therapeutic message	
Health in Justice embedded CAMHS and therapy support	LBB&D, B&D CCG, NNELFTELFT
NHS GO	NHS E
More than Mentors	Jo Richardson Community School and Eastbury Community School
Emotional Wellbeing Peer Support Group	The Vibe Youth Centre
Triple P Positive Parent Programme	

Draft

Mapping Barking and Dagenham services against the Thrive Framework

Attain

iThrive Maturity level 1 - 2

Introduction of model allowed a drift away from Care programme approach. The use of the Thrive Framework is not central to all teams in the borough.

Team Name	2018/19 Contacts	2019/20 Contacts	2020/21 Contacts (YTD)	2 - Giving advice	3 - Giving help	4 - Giving more help	5 - Giving risk support	Non-Thrive
CAMHS-BD- Behavioural Pathway	194	408	478	25%	25%	25%	25%	
CAMHS-BD- Brief Intervention	39	2,620	1,230	25%	50%	25%		
CAMHS-BD- Complex Caseload	263	547	1,075			50%	50%	
CAMHS-BD- Emotional Pathway	957	2,681	4,082	25%	25%	25%	25%	
CAMHS-BD- Exploitation Team	118	268	120	25%			75%	
CAMHS-BD- Neurodevelopmental Pathway	1,015	1,909	1,634	25%	25%	25%	25%	
CAMHS-BD- Pathway Team	4,706	4,584	1,746	25%	25%	25%	25%	
CAMHS-BD- Primary School Therapy	161	187	160	50%	50%			
CAMHS-BD- Triage Team	1,696	4,463	1,823	50%	50%			
INT-BD- INTERACT	766	618	432			20%	80%	

iThrive mapping informed by Heather Kazingizi-Kapota (Head of Service

Draft

Barking & Dagenham – workforce

The locality team has a clinical workforce of **21.9 WTEs**. Almost half the workforce is made up of Psychologists, Therapists and Nurses at Band 7 and Band 8a, with a medical workforce of 3 WTEs. Overall there are **0.45 clinical WTEs per thousand population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads, is £2,678K, which equates to **£54.99 per child or £1,591 per referral.**

Role Type / Grade	WTEs
Consultant	2.0
SAS Doctor	1.0
Clinical - 8c	0.3
Clinical - 8b	0.7
Clinical - 8a	1.5
Clinical - 7	7.4
Clinical - 6	5.0
Clinical - 4	4.0
Total	21.9

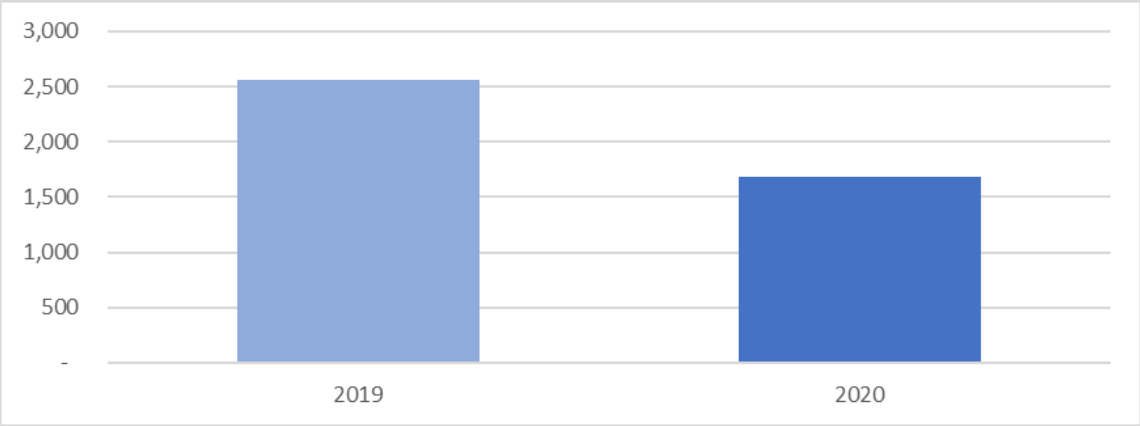
Source: NELFT local data with manual amends via NELFT feedback

Draft

Barking & Dagenham – referrals and caseload

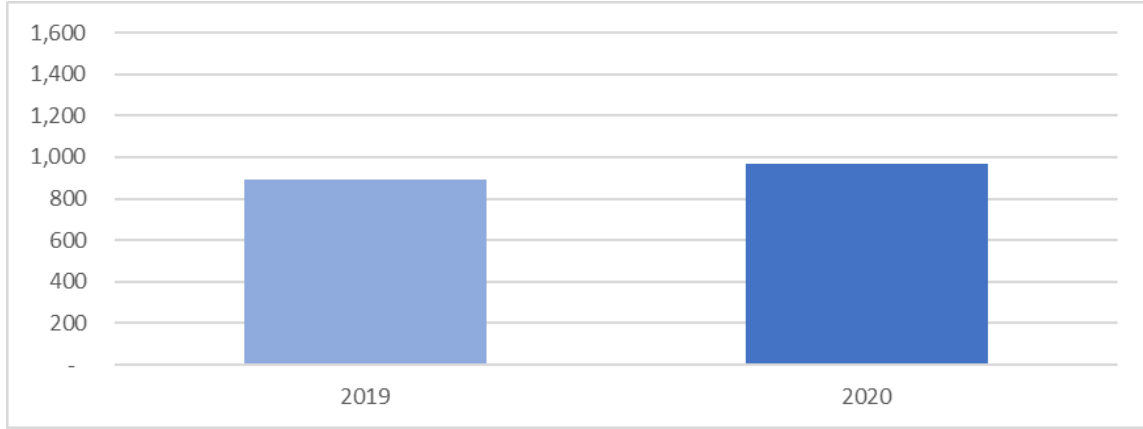
Numbers of new referrals fell across almost all pathways between 2019 and 2020, however caseloads increased by over 100% for the Brief Intervention and Emotional Pathways. Overall caseload increased by 9%.

New Referrals



Team / Pathway	2019	2020	Change	Trend
CAMHS-BD- Behavioural Pathway	18	9	-50%	
CAMHS-BD- Brief Intervention	519	404	-22%	
CAMHS-BD- Complex Caseload	12	26	117%	
CAMHS-BD- Emotional Pathway	81	142	75%	
CAMHS-BD- Exploitation Team	17	2	-88%	
CAMHS-BD- Neurodevelopmental Pathway	63	44	-30%	
CAMHS-BD- Pathway Team	258	151	-41%	
CAMHS-BD- Primary School Therapy	12	10	-17%	
CAMHS-BD- Triage Team	1,416	752	-47%	
INT-BD- INTERACT	163	143	-12%	
Grand Total	**2,559**	**1,683**	**-34%**	

Average Live Caseload



Team / Pathway	2019	2020	Change	Trend
CAMHS-BD- Behavioural Pathway	20	26	29%	
CAMHS-BD- Brief Intervention	102	204	101%	
CAMHS-BD- Complex Caseload	18	33	78%	
CAMHS-BD- Emotional Pathway	84	170	103%	
CAMHS-BD- Exploitation Team	13	8	-43%	
CAMHS-BD- Neurodevelopmental Pathway	133	175	31%	
CAMHS-BD- Pathway Team	274	166	-40%	
CAMHS-BD- Primary School Therapy	5	3	-35%	
CAMHS-BD- Triage Team	218	160	-27%	
INT-BD- INTERACT	25	25	3%	
Grand Total	**892**	**970**	**9%**	

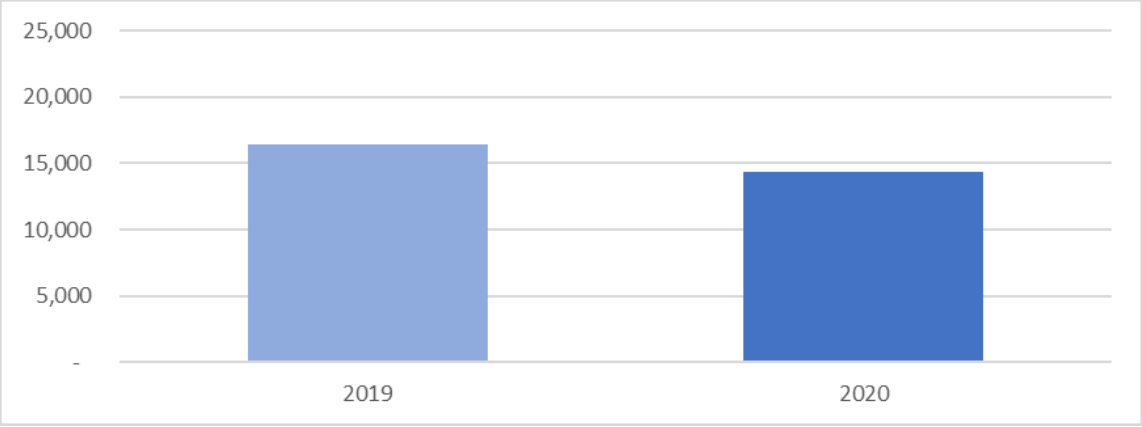
Source: NELFT local data

Draft

Barking & Dagenham - contacts

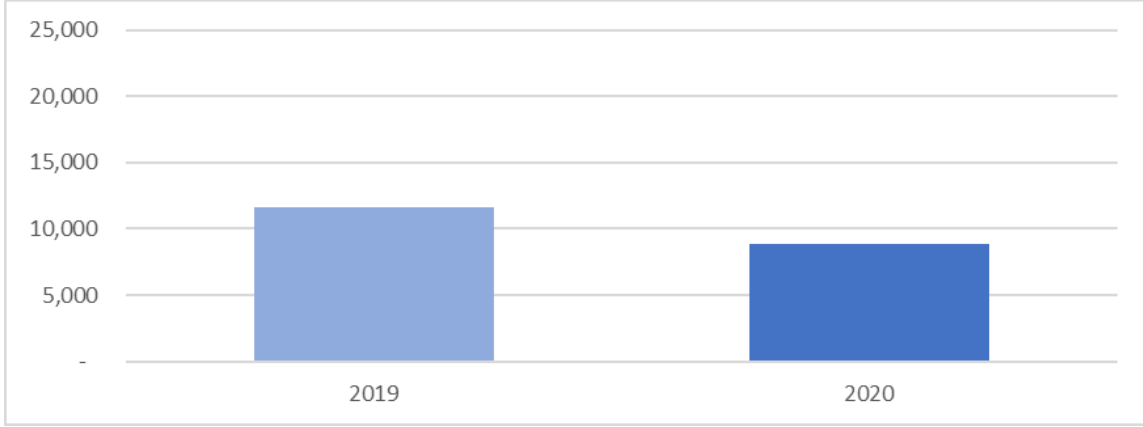
From 2019 to 2020 contact numbers fell overall by 12% and total contact hours fell by 24%. Complex Caseload and Exploitation dropped the most, with the Behavioural, Brief Intervention and Neurodevelopmental Pathways seeing increases in both numbers and contact time.

Contacts



Team / Pathway	2019	2020	Change	Trend
CAMHS-BD- Behavioural Pathway	2,287	4,016	76%	
CAMHS-BD- Brief Intervention	892	2,464	176%	
CAMHS-BD- Complex Caseload	4,310	2,116	-51%	
CAMHS-BD- Emotional Pathway	1,843	1,701	-8%	
CAMHS-BD- Exploitation Team	5,102	1,679	-67%	
CAMHS-BD- Neurodevelopmental Pathway	500	1,045	109%	
CAMHS-BD- Pathway Team	357	491	38%	
CAMHS-BD- Primary School Therapy	670	476	-29%	
CAMHS-BD- Triage Team	235	196	-17%	
INT-BD- INTERACT	189	182	-4%	
Grand Total	**16,385**	**14,366**	**-12%**	

Contact Hours



Team / Pathway	2019	2020	Change	Trend
CAMHS-BD- Behavioural Pathway	1,656	2,414	46%	
CAMHS-BD- Brief Intervention	667	1,609	141%	
CAMHS-BD- Complex Caseload	1,404	1,170	-17%	
CAMHS-BD- Emotional Pathway	3,852	1,038	-73%	
CAMHS-BD- Exploitation Team	2,330	786	-66%	
CAMHS-BD- Neurodevelopmental Pathway	395	683	73%	
CAMHS-BD- Pathway Team	662	510	-23%	
CAMHS-BD- Primary School Therapy	267	288	8%	
CAMHS-BD- Triage Team	212	193	-9%	
INT-BD- INTERACT	134	125	-6%	
Grand Total	**11,578**	**8,817**	**-24%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

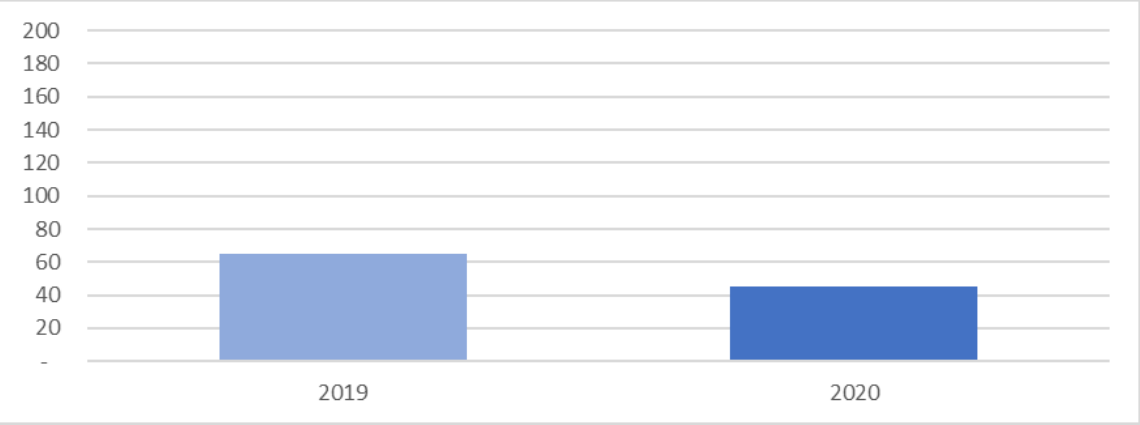
Source: NELFT local data

Draft

Barking & Dagenham – monthly time per case & contact type

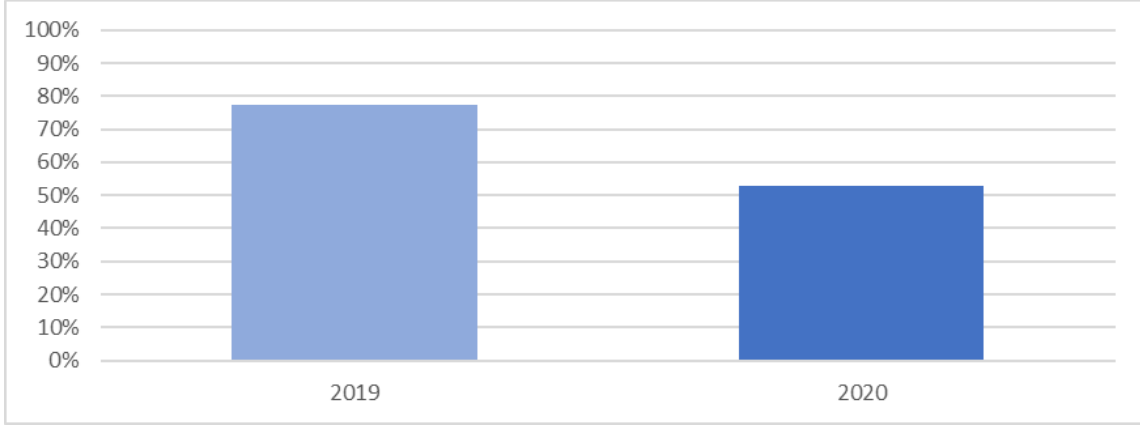
The average contact time per case per month fell by 30% from 2019 to 2020. Significant reductions were in the Triage and Pathway Teams at over 50%, with the Exploitation Team increasing by 58%. All pathways except Triage saw a reduction in the proportion of time spent in Face-to-Face contacts.

Contact Minutes per Case per Month



Team / Pathway	2019	2020	Change	Trend
CAMHS-BD- Behavioural Pathway	65	55	-16%	
CAMHS-BD- Brief Intervention	33	39	20%	
CAMHS-BD- Complex Caseload	107	104	-3%	
CAMHS-BD- Emotional Pathway	99	71	-28%	
CAMHS-BD- Exploitation Team	80	126	58%	
CAMHS-BD- Neurodevelopmental Pathway	53	33	-37%	
CAMHS-BD- Pathway Team	70	31	-55%	
CAMHS-BD- Primary School Therapy	127	183	44%	
CAMHS-BD- Triage Team	54	25	-54%	
INT-BD- INTERACT	135	101	-25%	
Overall Average	**65**	**45**	**-30%**	

Proportion of Face-to-Face Contact Time



Team / Pathway	2019	2020	Change	Trend
CAMHS-BD- Behavioural Pathway	78%	48%	-38%	
CAMHS-BD- Brief Intervention	76%	53%	-30%	
CAMHS-BD- Complex Caseload	75%	38%	-49%	
CAMHS-BD- Emotional Pathway	70%	65%	-8%	
CAMHS-BD- Exploitation Team	96%	81%	-16%	
CAMHS-BD- Neurodevelopmental Pathway	76%	47%	-39%	
CAMHS-BD- Pathway Team	74%	31%	-58%	
CAMHS-BD- Primary School Therapy	80%	42%	-47%	
CAMHS-BD- Triage Team	88%	89%	1%	
INT-BD- INTERACT	74%	41%	-45%	
Overall Average	**77%**	**53%**	**-32%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

Source: NELFT local data

Draft

Barking and Dagenham assessment against Thrive principles

Principle	Description
Common Language	The use of Thrive Framework has been accelerated by the Covid pandemic because of the need to work more closely with partner agencies. Thrive is not yet a common language and tier language is still used between some partners.
Needs-Led	The locality team use a needs-led approach that increases the opportunity for partner agencies to support the CYP within multi agency discussions.
Shared Decision Making	A patient portal exists that allows access to clinical letters, documents and nursing progress notes. Three is not a shared care record across the borough for health, social care and education. The development of one is highly desirable.
Proactive Prevention	By working together and identifying CYP for which there are initial concerns interventions are able to be provided that for some CYP reduce the need for getting help and getting more help. Barking and Dagenham does not have a significant level of voluntary sector resource to support
Partnership Working	Access is supported by improved partnership working across social care, education, primary care and mental health. At multi agency meetings to discuss cases previously felt the need to "justify" referral to CAMHS. Now can bring up CYP they are concerned about in a collaborative forum. The CAMHS services have a number of embedded workers e.g exploitation team and youth offending support.
Outcome Informed	The patient portal across NEL enables patient letters concluding an assessment or intervention to be shared. If a patient is undergoing intervention involving a series of sessions the notes are not shared. The development of a shared care plan highly desirable
Reducing Stigma	Partnership working is a seen as a key strand to reducing stigma especially with education.
Accessibility	Front door model expanded to and streamlined. CAMHS operates well as a Wellbeing Hub. Involve partners to assess and create an Initial intervention within a joint offer for the CYP. The Gascoigne Estate is hard to reach due to the presence of gangs. There are Significant issues around CYP sex--trafficking and exploitation. trafficking and exploitation due being within the M11/A12/A13 and M25 County lines routes.

Draft

Barking and Dagenham strengths and challenges

Strengths

Partnership

- Front door model is a collaborative approach between mental health, social care and education. The interventions are more episodic in nature with CYP being handed back to the universal care having resolved primary issues.
- "Hot clinics"; concept began when social care brought cases to CAMHS of looked after children with concerns about emotional and mental health. This has evolved into daily meetings to discuss vulnerable children. The approach does not allocate based on thresholds or behaviour – an approach that previously created barriers to multi agencies supporting CYP.
- Support and guidance is given to social care, education and health colleagues.

Leadership

- Partnership working across the borough has required strong leadership to make happen. Interventions include one to one sessions, team / group work and involved quality improvement resources. The introduction of a new culture was also accelerated by a number of staff leaving.
- Service change has been led and facilitated by strong medical leadership in the borough. There is an active plan-do-study-act approach that encourages creativity to deliver services differently. The CCG support the clinically-led approach through provision of transformation funding.
- The CAMHS team has received an award in recognition it is one of the top 5 CAMHS teams nationally and has a lower service cost per head of population than the national average

Digital

- Digital offer; local on-line counselling (Kooth).

Pathway

- The duty team has evolved to keep children out of crisis having two daily review points. This means it is possible to review a case referred in the morning before the end of office hours. This is one element that has enabled a reported reduction in ED presentations (this is reflected in the activity data).
- Integrated of CAMHS workers in other teams including school nurses, youth offending, exploitation services.

Challenges

Recruitment

- Need high calibre staff. For the first time there are issues in recruiting nurses. Recruitment barriers include pay differences across the NELFT and ELFT providers and Waltham Forest not benefiting from London weighting.
- Insufficient capacity to meet the demand into the neurodevelopmental pathway. The demand is currently fast growing. A straightforward case is estimated to required 30 hours of clinical time. Sufficient capacity is required to meet the demand.

Capacity

- The number of schools has increased and there are plans for further new schools. The increase has not come with any resources.
- Insufficient capacity to meet demand on the neurodevelopmental pathway
- Service gaps in "tier 2" services and mental health support capacity in schools

Pathways

- When The Thrive Framework model was introduced the Care Programme Approach received less focus.
- The community team is holding onto complex and challenging cases in the community to avoid them requiring the [stretched] home treatment team or presentation in crisis at an ED. Opportunity work with Interact and Home Treatment Team to have this working more smoothly and increase outreach into the community.
- Current repetition in assessment. Work has started to produce an integrated SOP across health and social care to implement the trusted assessor model.
- Transition; psychiatrists are unable due to professional registration constraints work beyond a patient's 18 birthday. Absence of clear support for care leavers and looked after children post 18 is an issue.
- Learning disability services only undertake diagnostic activity. The CAMHS team provide support outside their commission.

Partnership

- The Interact team sits within the Acute Directorate. This is seen as a barrier to assessing the need and formulating an appropriate action plan that can be supported in wider partnership.
- System interface with social care to enable the sharing of records and to facilitate integrated planning.
- Development of the complex care panel, this is currently relationship based and although integrated across the system is not considered fully embedded.
- Less developed voluntary sector compared to some NEL boroughs

Barking and Dagenham Response to COVID-19

Draft

Attain

Service changes

- Accelerated the front door model to reduce pressure on teams by working more collaboratively with partners to enable the CAMHS teams focus on more complex (need more help) cases and those needing risk support.
- Accelerated the use of the Thrive Framework and model.

Demand changes

- Increase in child exploitation. The borough sits along the A12/A11/A13 county line corridors. Also sex traffic exploitation
- Increase in looked after children.

The content arises from an interview with Mohammad Mohit (Assistant Director), and Heather Kazingizi-Kapota (Head of Service) from the NELFT CAMHS team.

Attain

Redbridge

Redbridge introduction

About Redbridge

- The London Borough of Redbridge is a London borough in East London, England. It is home to Redbridge Institute of Adult Education and Redbridge Football Club.

- Its administrative headquarters is at Redbridge Town Hall in Ilford. Wanstead and Woodford are the other principal settlements. The local authority is Redbridge London Borough Council

Draft

Redbridge services

Service name	Provider
Well being Hub and I-Thrive front door	
CAMHS triage	NELFT community
CAMHS brief interventions	NELFT community
CAMHS disability	NELFT community
CAMHS Neurodev and LD	NELFT community
CAMHS Eating disorder	NELFT
Early intervention in psychosis	NELFT
CAMHS Emotional pathway	NELFT community
CAMHS Behavioural pathway	NELFT community
CAMHS looked after children OT	NEFLT community
Interact Crisis Service	NELFT
Mental Health Direct (24/7 telephone line)	NELFT
STAR workers	NELFT
Kooth online counselling open to all children and young people	Kooth
Child Sexual Abuse emotional support	
Health in Justice Mental Health	
NHS GO	NHS E
First aid for schools	Young Minds
Triple P Positive Parent Programme	LB Redbridge

Mapping Redbridge services against the Thrive Framework

Draft

The Thrive Framework

Maturity level 2 – 3. Education and social care services are reported to use The Thrive Framework however, the model is seen as relatively new in the borough and tier model continues to pervade discussions at times.

Team Name	2018/19 Contacts	2019/20 Contacts	2020/21 Contacts (YTD)	2 - Giving advice	3 - Giving help	4 - Giving more help	5 - Giving risk support	Non-Thrive
CAMHS-RB- Child Development Team			1					
CAMHS-RB- Pathway	7,427	9,425	8,765	15%	35%	25%	25%	
CAMHS-RB- Primary Mental Health Team	214	4						
CAMHS-RB- Psychiatric Liaison Service		120	45					
CAMHS-RB- Triage Team	20	818	580	30%	8%	13%	50%	
CAMHS-RB-Behavioural Pathway	5	104	306	25%	10%	25%	40%	
CAMHS-RB-Brief Interventions		292	344	25%	25%	25%	25%	
CAMHS-RB-Complex Caseload			3					
CAMHS-RB-Emotional Pathway	24	159	605	10%	10%	40%	40%	
CAMHS-RB-LAC OT			44	50%	50%			
CAMHS-RB-Neurodevelopmental Pathway	73	453	1,253	10%	30%	40%	20%	
INT-RB- INTERACT	856	582	458			20%	80%	
ZZSMSC-RB- CAMHS SMS (Fusion)	214							

Draft

Redbridge – workforce

The locality team has a clinical workforce of **19.3 WTEs**. Almost half the workforce is made up of Psychologists, Therapists and Nurses at Band 7 and Band 8a, with a medical workforce of 3.9 WTEs. Overall there are **0.36 clinical WTEs per thousand population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads, is £2,639K, which equates to **£49.02 per child or £1,478 per referral.**

Role Type / Grade	WTEs
Consultant	1.9
SAS Doctor	1.0
Specialist Registrar	1.0
Clinical - 8b	1.0
Clinical - 8a	3.9
Clinical - 7	5.5
Clinical - 6	1.0
Clinical - 5	1.0
Clinical - 4	3.0
Total	19.3

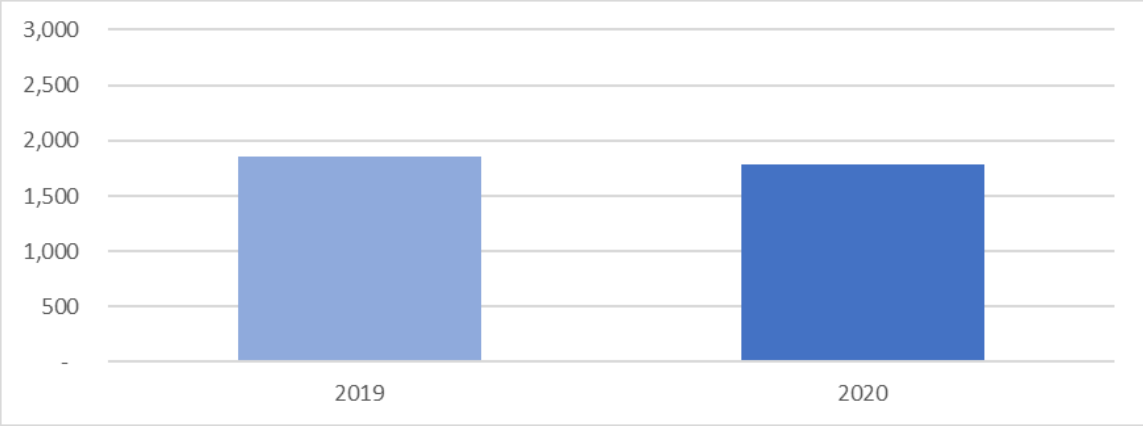
Source: NELFT local data

Draft

Redbridge – referrals and caseload

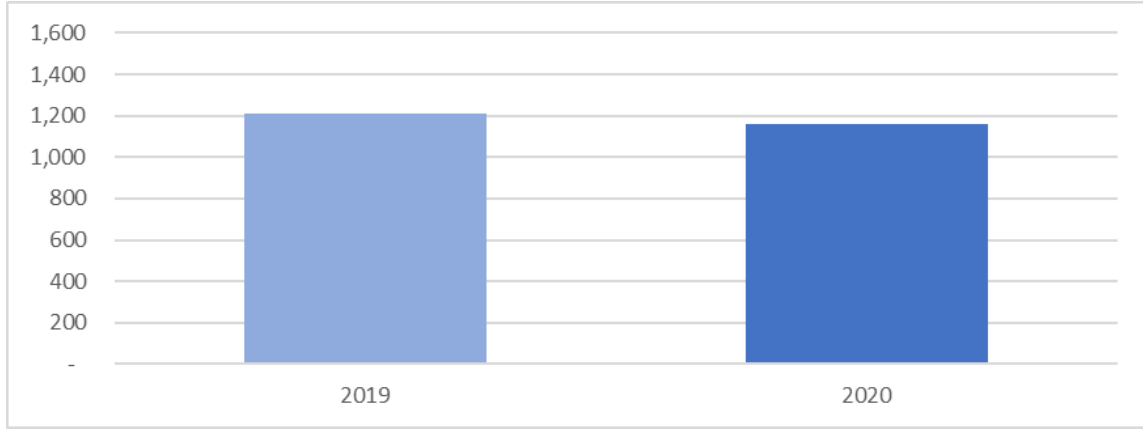
Overall there was a 4% drop in referrals from 2019 to 2020. With decreases to the Triage and Pathway teams, there were significant increases in the Liaison Service and Brief Interventions. Average caseloads also decreased by 4%, although specialist pathways all saw an increase.

New Referrals



Team / Pathway	2019	2020	Change	Trend
CAMHS-RB- Pathway	943	787	-17%	
CAMHS-RB- Psychiatric Liaison Service	40	176	340%	
CAMHS-RB- Triage Team	577	382	-34%	
CAMHS-RB-Behavioural Pathway	14	23	64%	
CAMHS-RB-Brief Interventions	63	178	183%	
CAMHS-RB-Emotional Pathway	18	12	-33%	
CAMHS-RB-Neurodevelopmental Pathway	46	51	11%	
INT-RB- INTERACT	160	176	10%	
Grand Total	**1,861**	**1,785**	**-4%**	

Average Live Caseload



Team / Pathway	2019	2020	Change	Trend
CAMHS-RB- Pathway	979	891	-9%	
CAMHS-RB- Psychiatric Liaison Service	4	15	340%	
CAMHS-RB- Triage Team	153	96	-37%	
CAMHS-RB-Behavioural Pathway	3	12	274%	
CAMHS-RB-Brief Interventions	6	18	235%	
CAMHS-RB-Emotional Pathway	10	23	137%	
CAMHS-RB-Neurodevelopmental Pathway	29	77	170%	
INT-RB- INTERACT	25	27	8%	
Grand Total	**1,207**	**1,159**	**-4%**	

Source: NELFT local data

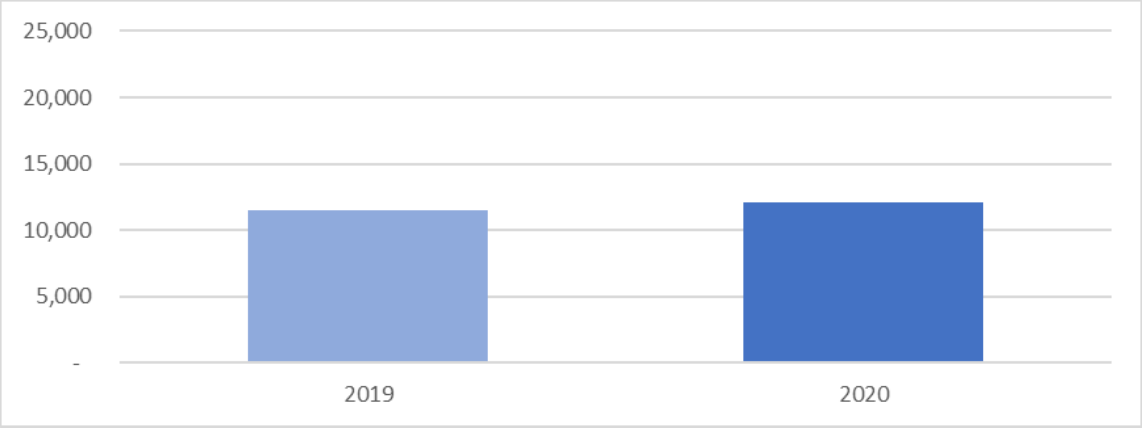
Draft

Redbridge - contacts

Numbers of contacts and contact hours increased from 2019 to 2020, by 5% and 10% respectively.

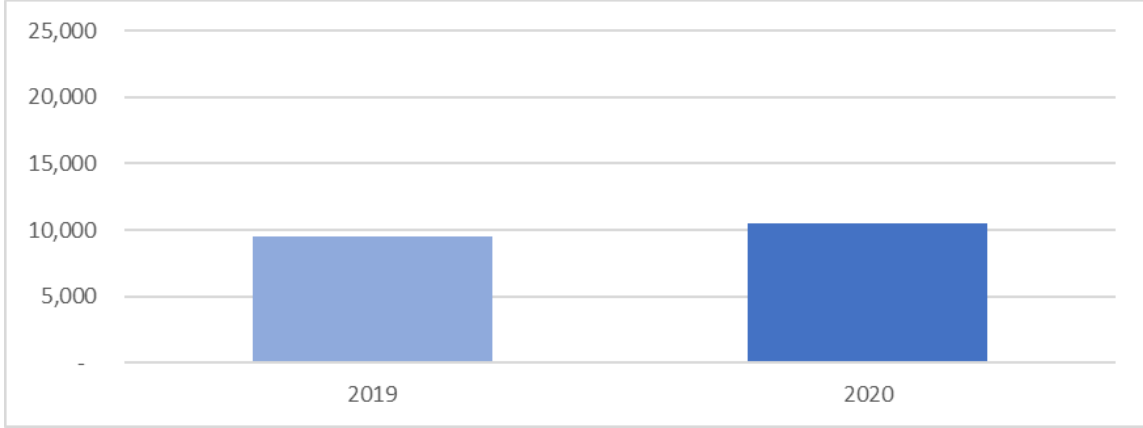
In 2019, the Pathway service accounted for 82% of Redbridge contact time. This fell to 68% in 2020 as specialist pathways increased contact time significantly.

Contacts



Team / Pathway	2019	2020	Change	Trend
CAMHS-RB- Pathway	9,571	8,758	-8%	
CAMHS-RB- Psychiatric Liaison Service	28	112	300%	
CAMHS-RB- Triage Team	586	464	-21%	
CAMHS-RB-Behavioural Pathway	31	300	868%	
CAMHS-RB-Brief Interventions	103	332	222%	
CAMHS-RB-Emotional Pathway	100	547	447%	
CAMHS-RB-Neurodevelopmental Pathway	305	1,058	247%	
INT-RB- INTERACT	738	490	-34%	
Grand Total	**11,462**	**12,061**	**5%**	

Contact Hours



Team / Pathway	2019	2020	Change	Trend
CAMHS-RB- Pathway	7,851	7,167	-9%	
CAMHS-RB- Psychiatric Liaison Service	32	159	389%	
CAMHS-RB- Triage Team	273	377	38%	
CAMHS-RB-Behavioural Pathway	22	188	755%	
CAMHS-RB-Brief Interventions	234	628	169%	
CAMHS-RB-Emotional Pathway	107	489	356%	
CAMHS-RB-Neurodevelopmental Pathway	249	932	274%	
INT-RB- INTERACT	761	548	-28%	
Grand Total	**9,529**	**10,488**	**10%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

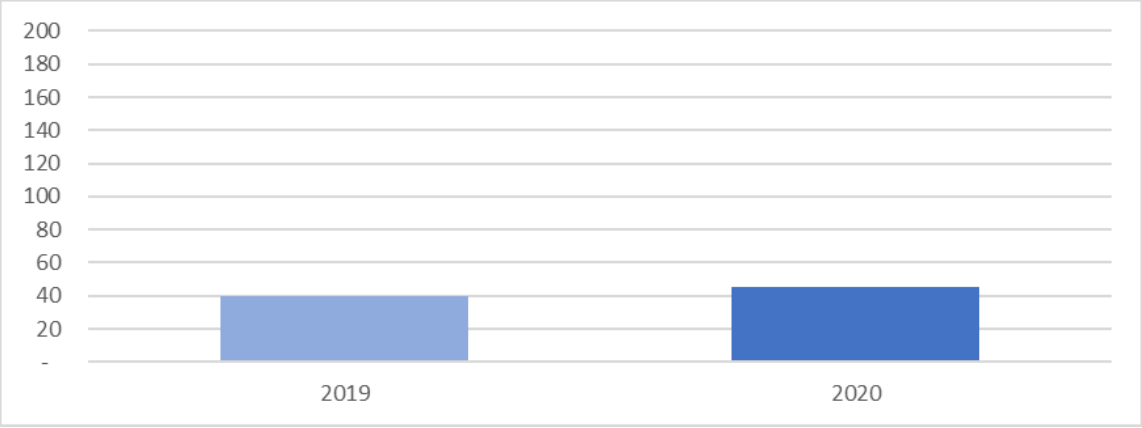
Source: NELFT local data

Draft

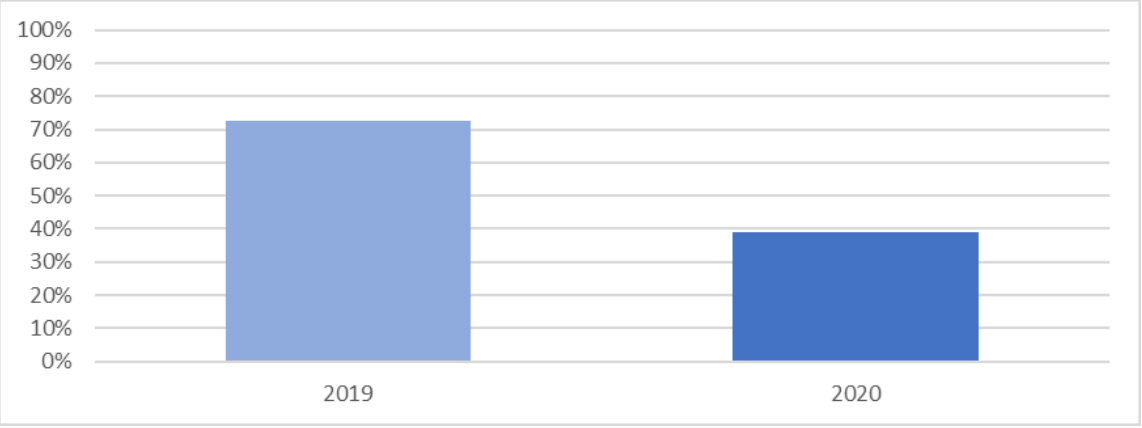
Redbridge – monthly time per case & contact type

The average contact time per case increased by 15% from 2019 to 2020, which was likely driven by the increases in Emotional, Behavioural and Neurodevelopment pathways. All pathways except Interact and the Liaison Service saw a large reduction in the proportion of time spent in Face-to-Face contacts.

Contact Minutes per Case per Month



Proportion of Face-to-Face Contact Time



Team / Pathway	2019	2020	Change	Trend
CAMHS-RB- Pathway	40	40	0%	
CAMHS-RB- Psychiatric Liaison Service	46	51	11%	
CAMHS-RB- Triage Team	9	20	121%	
CAMHS-RB-Behavioural Pathway	35	79	129%	
CAMHS-RB-Brief Interventions	212	170	-20%	
CAMHS-RB-Emotional Pathway	56	109	93%	
CAMHS-RB-Neurodevelopmental Pathway	44	61	39%	
INT-RB- INTERACT	150	100	-33%	
Overall Average	**39**	**45**	**15%**	

Team / Pathway	2019	2020	Change	Trend
CAMHS-RB- Pathway	72%	33%	-54%	
CAMHS-RB- Psychiatric Liaison Service	97%	98%	0%	
CAMHS-RB- Triage Team	17%	15%	-11%	
CAMHS-RB-Behavioural Pathway	75%	42%	-45%	
CAMHS-RB-Brief Interventions	95%	75%	-22%	
CAMHS-RB-Emotional Pathway	78%	27%	-65%	
CAMHS-RB-Neurodevelopmental Pathway	69%	34%	-50%	
INT-RB- INTERACT	90%	88%	-3%	
Overall Average	**72%**	**39%**	**-46%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

Source: NELFT local data

Redbridge locality services against Thrive principles

Draft

Attain

Principle	Description
Common Language	The Thrive Framework language is becoming the common language across partners however, the tier model does enter conversation at times.
Needs-Led	The Thrive Framework supports a needs-led approach
Shared Decision Making	There is a participation group (originally set up 2014/15). Due to recruitment issues this has been restarted since September 2020 and is still forming. The group has already input to website changes and to developing the physical spaces used by the CAMH team.
Proactive Prevention	There is very little voluntary support in the borough. An example of one is an ASD support group, "body and soul" (see CYP from 16+ and provide a CBT-based service).
Partnership Working	Partnership working is part of the culture of CAMHS. Agencies worked with include REWTSs, STAR workers, services within the universal offer. There are also embedded CAMHS posts within the Looked After children team. There is also close working with the families together and families intervention team (social care led) and involvement in the MASH (social care). The local authority education psychology team provides a more comprehensive offer (Similar to Lambeth model).
Outcome Informed	The team record outcomes and use these data to inform decisions.
Reducing Stigma	A pathway is open for schools and the school council to direct people to CAMHS workshops. Meetings with voluntary groups and GP events have been run to improve the understanding of CAMHS services. The people accessing Redbridge services are now more representative of the borough population. Hard to reach groups include those with a language barrier (particularly Easter European), although translation services do now exist and there is perceived stigma in some Asian community
Accessibility	Access is via a single point of access that triages into CAMHS (see challenges).

Redbridge strengths and challenges

Draft

Attain

Strengths

Leadership

- Adoption of new ways of working.
- The small team are proactive and yet maintain a good level of service.

Access

- Demographic better reflects the community mix.

Pathway

- Referral process changed with understanding that not all CYP referrals must be handled by CAMHS.
- Fast review at front door to establish if referral is high risk or routine. Maintain a 5 day follow up call for high risk.
- Although there are no brief intervention resources, the team have created workshops (getting advice)for schools and school councils to refer to.
- Introduced using translator to help where language is a barrier

Digital and information

- ICANS provides performance data.
- Access available to GP records and notifications on the CAMHS clinical system occur when an existing CYP service user attends ED.

Partnership

- The team work well with partners (education, social care and health services).

Challenges

Capacity

- Lack of inpatient bed capacity (this is a national issue).
- The crisis team are under great stress. The lack of inpatient capacity is a factor. This then impacts on the CAMHS team who are required to support more cases needing risk support than expected.
- SPA CAMHS allocation can result in inappropriate cases being allocated to CAMHS e,g behaviour issues.

Demand

- Increase in looked after children due to new care homes in Redbridge.
- Significant numbers awaiting assessment by CAMHS

Pathway

- Silo-working and duplication across different agencies
- No brief intervention pathway.
- A hot clinic initiative did not work well due to issues for GPs to access the clinic.
- Lack of other agencies to absorb tier 2 type referrals.

Partnership

- Ability to have the right conversation with social care about CYP in crisis to prevent them presenting in ED or on a medical ward.
- Redbridge schools are mainly independent academies. This is impacting on the access to mentors and special education support that has had to be resolved by going to a tribunal in some cases.
- Agreeing the responsible agency.

Workforce

- Recruitment issues; difficulty hiring psychologist and difficulties hiring with broad training / experience of a variety of care and support models.
- Opportunity to mirror adult health and social care integrated model for CYP.
- Recruitment is difficult and morale is low.
- Perception that new workforce models do not align to expectations from the commissioner.

Digital and information

- No access to social care records

Redbridge response to COVID-19

Draft

Attain

Service changes

- Family therapy moved to online activity from April 2020. This has been seen as a positive because the CYP and family can be seen in their natural environment.
- During COVID, hospital capacity was reduced due to the need for social distancing. This required the CAMHS teams to hold and manage CYP needing risk support in the community
- Prioritised looked after children. This has resulted in routine referrals taking longer to receive an assessment.
- Due to other health services having limited accessibility, at the point of triage, an increased number of cases were "held" that would have previously been signposted to other services and require ongoing checks.
- Routine referrals delayed as resources moved to address increased numbers of cases of CYP in crisis needing risk support.
- ADHD and ASD assessment conducted virtually (some exceptions).
- Service change to conduct more assessments but this has shifted capacity issues downstream (no additional short term resources available to address backlog).

Demand changes

- Increase in under 5 year old referrals because CY, families and carers had a perception that health visiting and schools services were not open.
- Increase in the complexity of cases presenting (rather than an increase in volume).
- Increase in the number of cases of CYP accessing voluntary counselling.
- Increase in looked after children facilitated by an increase in care home capacity.
- Changes in demand highlighted the disparity in borough resources and capacity available to meet demand.

The content arises from an interview with Radha Kandeth (Consultant Psychiatrist), Kevin Amazona (Clinical Lead), Vivian Wong (Senior Clinical Psychologist) and Diederick Meij (Head of Service) and Mini Luckhea (Assistant Director) from the NELFT CAMHS team.

Waltham Forest

Waltham Forest introduction

About Waltham Forest

- The London Borough of Waltham Forest is a London borough in East London, England. Its population is estimated to be 276,983 in 2019. The borough was formed in 1965 from the merger of the municipal boroughs of Leyton, Walthamstow and Chingford.
- Epping Forest is a remainder of the former Waltham Forest and forms the eastern and northern fringe of the borough. The River Lea lies to the west where its associated marshes and parkland form a green corridor which, along the reservoir-lined reaches, separates north and east London.
- The north and south of the borough, split by the North Circular Road, contrast markedly in terms of demographic and socio-economic indicators; with urban districts in the south having inner-city characteristics, and the more affluent suburban areas to the north having better access to open spaces, parks, and playing fields. Chingford in the north, Walthamstow in the middle, and Leyton in the south are the three major districts of the borough.
- Waltham Forest was one of the host boroughs of the London Olympics in 2012, with the Lee Valley Hockey and Tennis Centre and part of the Queen Elizabeth Olympic Park providing an ongoing legacy in the UK and London.

Draft

Waltham Forest introduction

Waltham Forest CAMHS services and pathways

Service / pathway name	Provider
CAMHS triage	NELFT community
CAMHS primary care support	NELFT community
CAMHS complex extra support service	NELFT community
CAMHS Neurodev and LD	NELFT community
CAMHS Whitefields LD schools clinic	NELFT community
CAMHS emotional pathway	NELFT community
CAMHS behavioural pathway	NELFT community
CAMHS Eating disorder	NELFT
Early intervention in psychosis	NELFT
Interact Crisis Service	NELFT

Service / pathway name	Provider
NHS Go: information	NHS E
Kooth online counselling open to all children and young people	Kooth
Youth Offending Service	Local authority
Youth Justice CAMHS worker and LAC consultant	ELFT
CYP substance misuse	CGL
Place2Talk schools drop in	Place2Be
Early Help provision (Harmful sexual behaviour)	

** NELFT contact data received for Waltham Forest did not include separate pathway / team names for Triage or Brief Intervention and Schools pathways are referenced only for Whitefields.*

Draft

Mapping Waltham Forest services against the Thrive Framework

The Thrive Framework

Maturity level 3. The Thrive Framework has a language that is starting to support the move away from some needs being considered as solely as a mental health services problem to solve.

Team Name	2018/19 Contacts	2019/20 Contacts	2020/21 Contacts (YTD)	2 - Giving advice	3 - Giving help	4 - Giving more help	5 - Giving risk support	Non-Thrive
ADHD-WF- ADHD Clinic	532	463	429			100%		
CAMHS-WF- Alliance Extra Support Service	5	12	111				100%	
CAMHS-WF Primary Care Team	249	572	2,852	20%	80%			
COUNS-WF- Fast Track	46							
INT-WF- INTERACT	1,179	583	252			20%	80%	
SMSC-WF- 722 - Waltham Forest	281							
T3-WF- CAMHS Emotional Difficulty	2,419	4,617	8,533			100%		
T3-WF-CAMHS Behavioural Pathway	130	275	371			100%		
T3-WF-Tier 3 CAMHS Neuro Pathway	3,622	4,838	5,976			100%		
TT-WF-CAMHS Access Team	1,432	2,254	3,561		50%	50%		
WHITF-WF- CAMHS WHITEFIELDS CLINIC	89	91	86			100%		

Draft

Waltham Forest – workforce

The locality team has a clinical workforce of **57.8 WTEs**. Under a third of the workforce is made up of Psychologists, Therapists and Nurses at Band 7 and Band 8a, with a medical workforce of 9.4 WTEs. Overall there are **1.28 clinical WTEs per thousand population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads, was £5,329K, which equates to **£118.55 per child or £3,633 per referral.**

Role Type / Grade	WTEs
Consultant	4.0
SAS Doctor	3.6
Specialist Registrar	1.8
Clinical - 8c	0.7
Clinical - 8b	3.0
Clinical - 8a	6.0
Clinical - 7	11.6
Clinical - 6	19.0
Clinical - 5	3.0
Clinical - 4	3.0
Clinical - 3	2.0
Total	57.8

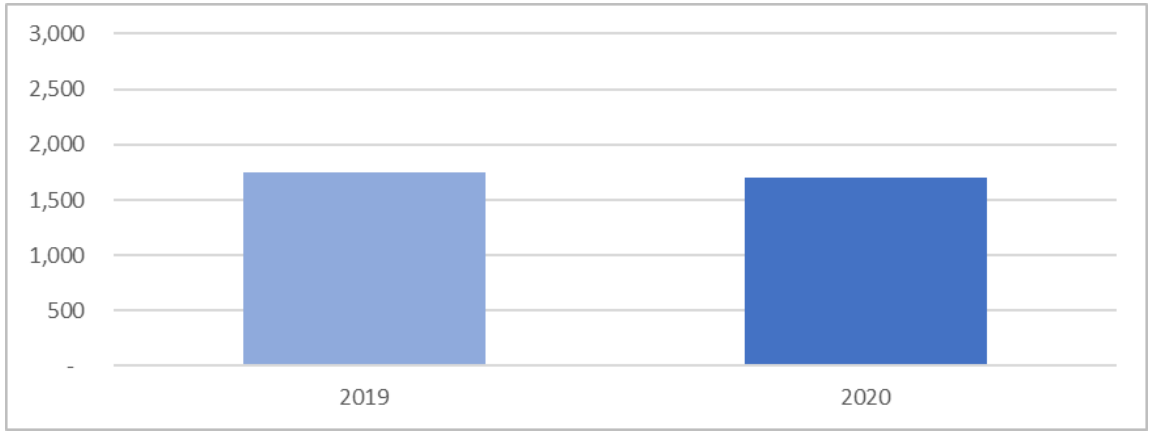
Source: NELFT local data with manual amends via NELFT feedback

Draft

Waltham Forest – referrals and caseload

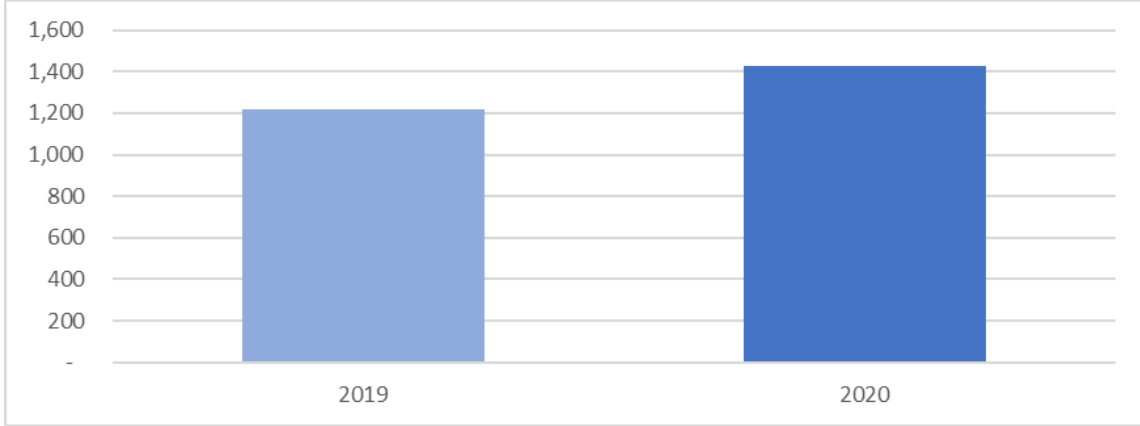
Numbers of new referrals fell across most pathways between 2019 and 2020, although the Primary Care Team and Emotional Difficulty pathway saw an increase. Whilst new referrals fell by 2% overall, average caseload increased by 17%, with much of the increase with the Neuro Pathway and Primary Care Team.

New Referrals



Team / Pathway	2019	2020	Change	Trend
ADHD-WF- ADHD Clinic	4	3	-25%	
CAMHS-WF- Alliance Extra Support Service	-	1		
CAMHS-WF Primary Care Team	19	238	1153%	
INT-WF- INTERACT	185	114	-38%	
T3-WF- CAMHS Emotional Difficulty	181	204	13%	
T3-WF-CAMHS Behavioural Pathway	5	5	0%	
T3-WF-Tier 3 CAMHS Neuro Pathway	212	122	-42%	
TT-WF-CAMHS Access Team	1,136	1,018	-10%	
WHITF-WF- CAMHS WHITEFIELDS CLINIC	2	-	-100%	
Grand Total	**1,744**	**1,705**	**-2%**	

Average Live Caseload



Team / Pathway	2019	2020	Change	Trend
ADHD-WF- ADHD Clinic	150	131	-13%	
CAMHS-WF- Alliance Extra Support Service	2	3	33%	
CAMHS-WF Primary Care Team	27	106	299%	
INT-WF- INTERACT	31	14	-54%	
T3-WF- CAMHS Emotional Difficulty	242	325	34%	
T3-WF-CAMHS Behavioural Pathway	14	15	9%	
T3-WF-Tier 3 CAMHS Neuro Pathway	528	594	13%	
TT-WF-CAMHS Access Team	186	209	13%	
WHITF-WF- CAMHS WHITEFIELDS CLINIC	38	32	-17%	
Grand Total	**1,216**	**1,428**	**17%**	

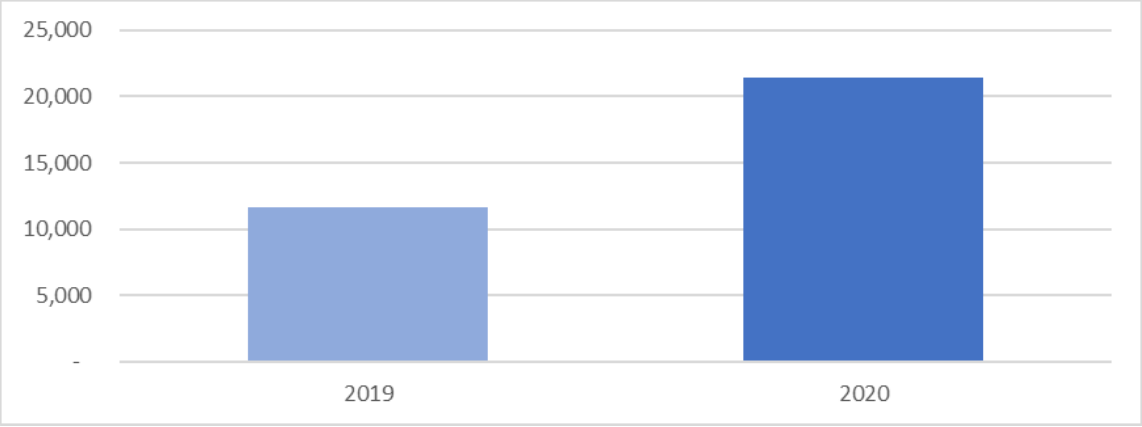
Source: NELFT local data

Draft

Waltham Forest - contacts

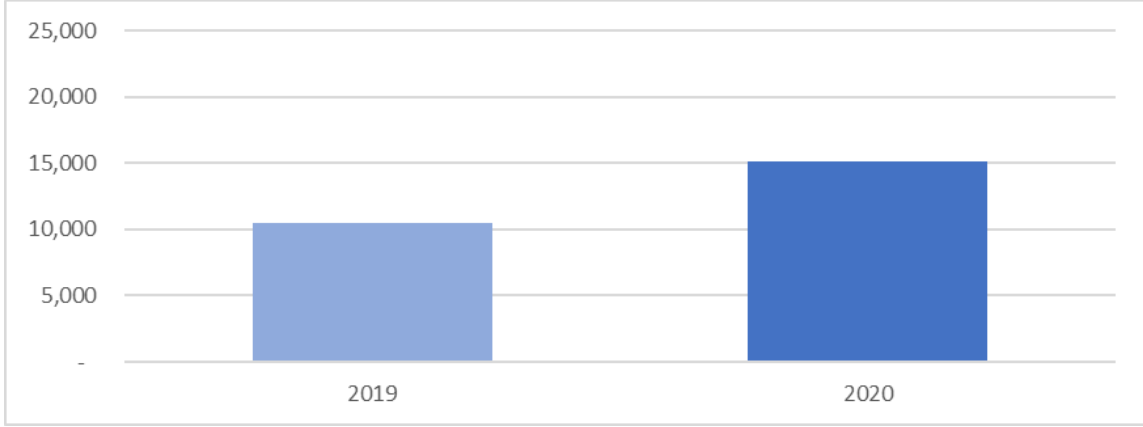
From 2019 to 2020 contact numbers increased by 84% and contact hours increased by 44% across all pathways. The Emotional Difficulty pathway saw the biggest increase in activity (4.5k contacts and 2.5k hours), followed by the Primary Care Team (2.3k contacts and 1.3k hours).

Contacts



Team / Pathway	2019	2020	Change	Trend
ADHD-WF- ADHD Clinic	471	463	-2%	
CAMHS-WF- Alliance Extra Support Service	14	17	21%	
CAMHS-WF Primary Care Team	214	2,560	1096%	
INT-WF- INTERACT	911	254	-72%	
T3-WF- CAMHS Emotional Difficulty	3,557	8,160	129%	
T3-WF-CAMHS Behavioural Pathway	238	425	79%	
T3-WF-Tier 3 CAMHS Neuro Pathway	4,108	6,390	56%	
TT-WF-CAMHS Access Team	2,028	3,094	53%	
WHITF-WF- CAMHS WHITEFIELDS CLINIC	104	94	-10%	
Grand Total	**11,645**	**21,457**	**84%**	

Contact Hours



Team / Pathway	2019	2020	Change	Trend
ADHD-WF- ADHD Clinic	387	326	-16%	
CAMHS-WF- Alliance Extra Support Service	10	13	27%	
CAMHS-WF Primary Care Team	171	1,492	774%	
INT-WF- INTERACT	993	321	-68%	
T3-WF- CAMHS Emotional Difficulty	3,378	5,888	74%	
T3-WF-CAMHS Behavioural Pathway	218	277	27%	
T3-WF-Tier 3 CAMHS Neuro Pathway	3,842	4,915	28%	
TT-WF-CAMHS Access Team	1,443	1,804	25%	
WHITF-WF- CAMHS WHITEFIELDS CLINIC	64	47	-26%	
Grand Total	**10,507**	**15,083**	**44%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

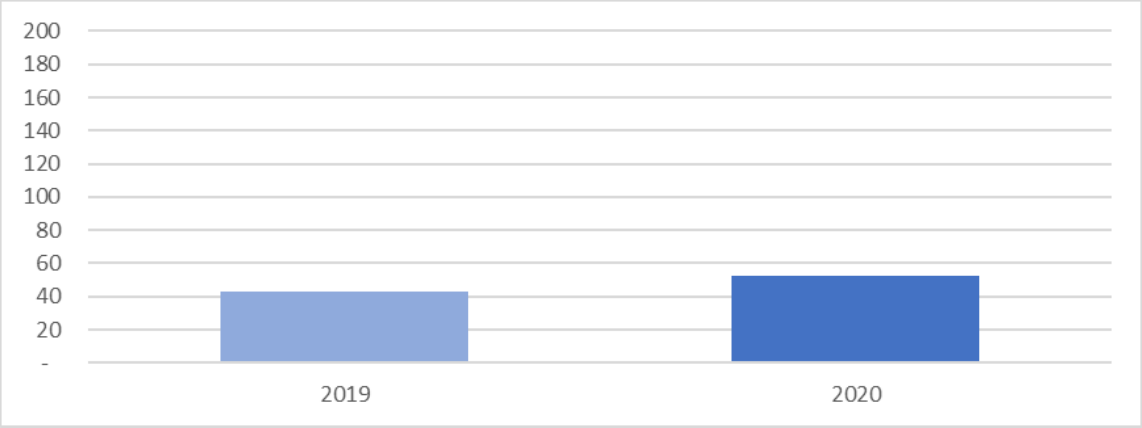
Source: NELFT local data

Draft

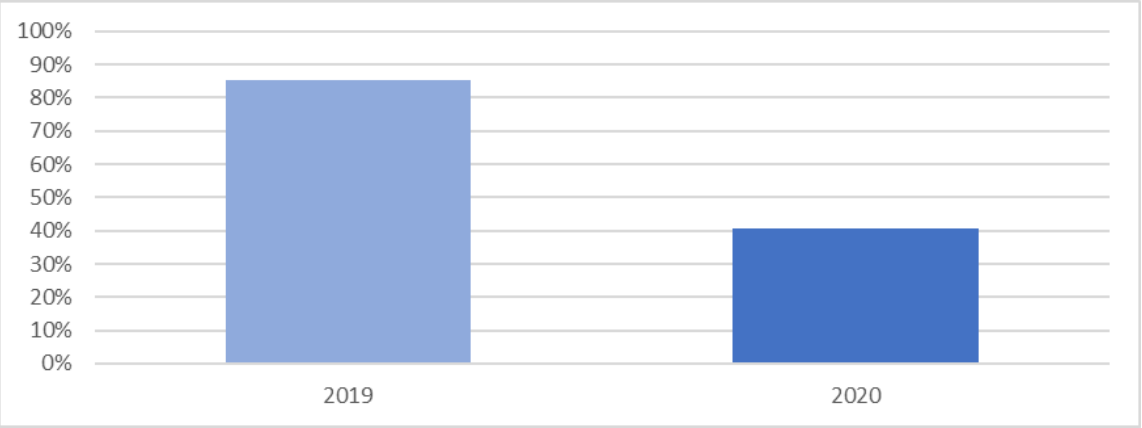
Waltham Forest – monthly time per case & contact type

The average contact time per case increased by 22% from 2019 to 2020, which was driven by the 30% increase in Emotional Difficulty as well as the 119% increase in the Primary Care Team. All pathways except Interact saw a large reduction in the proportion of time spent in Face-to-Face contacts.

Contact Minutes per Case per Month



Proportion of Face-to-Face Contact Time



Team / Pathway	2019	2020	Change	Trend
ADHD-WF- ADHD Clinic	13	12	-3%	
CAMHS-WF- Alliance Extra Support Service	26	24	-5%	
CAMHS-WF Primary Care Team	32	70	119%	
INT-WF- INTERACT	158	111	-30%	
T3-WF- CAMHS Emotional Difficulty	70	91	30%	
T3-WF-CAMHS Behavioural Pathway	80	93	16%	
T3-WF-Tier 3 CAMHS Neuro Pathway	36	41	14%	
TT-WF-CAMHS Access Team	39	43	11%	
WHITF-WF- CAMHS WHITEFIELDS CLINIC	9	8	-12%	
Overall Average	**43**	**53**	**22%**	

Team / Pathway	2019	2020	Change	Trend
ADHD-WF- ADHD Clinic	98%	74%	-24%	
CAMHS-WF- Alliance Extra Support Service	63%	23%	-64%	
CAMHS-WF Primary Care Team	89%	37%	-58%	
INT-WF- INTERACT	91%	93%	2%	
T3-WF- CAMHS Emotional Difficulty	90%	37%	-58%	
T3-WF-CAMHS Behavioural Pathway	93%	43%	-54%	
T3-WF-Tier 3 CAMHS Neuro Pathway	87%	46%	-47%	
TT-WF-CAMHS Access Team	62%	26%	-58%	
WHITF-WF- CAMHS WHITEFIELDS CLINIC	94%	15%	-84%	
Overall Average	**85%**	**41%**	**-52%**	

** Contact time includes all contact time: direct, indirect, face-to-face and non-face-to-face*

Source: NELFT local data

Waltham Forest assessment against Thrive principles

Draft

Attain

Principle	Description
Common Language	Thrive is used within the CAMHS service but is not routinely used beyond with partners. The CAMHS services are described according to the Thrive framework.
Needs-Led	There is a needs-based approach within the CAMHS service.
Shared Decision Making	Partnership working exists with CYP, primary care, parents and schools to coproduce service improvements.
Proactive Prevention	The primary care MH team (live from 2020) can provide interventions including CBT for mild to moderate anxiety and group workshops. The community assets (including voluntary services) to provide non-specialist support are limited.
Partnership Working	The Thrive framework is reported to be enabling discussions away from issues being solely one CAMHS issue to resolve. The CAMHS board have undertaken work to bring together public health, CAMHS and education. There is more work to do with social care to enable better collaboration. There are embedded workers in education and YOS team. Other partners include GPs (variability dependent on PCN), crisis service, acute hospital and police and Kooth
Outcome Informed	There is a clear understanding by the team of the importance of data. The team use data to inform decisions. Data quality is improving. Power BI has been introduced to provide intelligence and has enabled a view of the flow of users through the system. The managers have a live view of assessment wait times and the movement of CYP through subsequent pathways. A dashboard has not yet been developed but is desired by the CAMHS team.
Reducing Stigma	Engagement and peer support workers work to reduce stigma and encourage access. Digital technology has enabled access to some young people. There are people who do not have access to the internet and some do not want to access digitally. Gangs are hard to reach. Access to some CYP is not possible in COVID because adults are present that can inhibit access
Accessibility	CAMHS access is initially via a primary care MH team. This has no lower threshold.

Waltham Forest Strengths and challenges

Draft

Attain

Strengths

Leadership

- A clinical leadership model where each service area is led by a partnership of psychiatrist and nurse has enabled increased buy in and support for change

Workforce

- With enhanced tier 3 model, the job planning now relates to pathway stages with clear requirements on capacity to be provided by each psychiatrist.
- New MHST in post but not fully trained (9 month process),

Pathway

- Newly established Tier 2 primary MH team (established Oct 2019) with no access criteria. The upper threshold amended to getting more help. This team includes MHSTs (deliver CBT for mild to moderate anxiety). This has created a smoother transition from getting advice to getting more help.
- CAMHS triage now includes early intervention this has used the primary care team and in the future the MHST team to support some CYP getting help.
- Pathway streamlining undertaken to reduce waiting times and referral form refined for routine cases and core pathways to ensure efficient assessment e.g Neuro developmental pathway reduced wait for assessment from 2 years to 6 months due to partnership work across all agencies to get referrals providing all the required background data.
- Pilot for referral to treatment referrals of 4 weeks for routine and 5 days for urgent referrals.

Digital and IT

- The performance team have supported the team to use RIO to understand activity levels and CYP user progression along pathways. Currently this analysis is not automated and the development of dashboards will be useful.

Partnership

- Coproduction with CYP especially reaching schools and public health workers and using peer support workers to engage CYP.

Challenges

Capacity

- Historically had small team however additional investment to increase community support at tier 3 and tier 2 (getting more help and getting help) support ; including in the PCT & MHST are sufficient to meet pre- Covid demand. Challenge now relates to post-Covid needs ; increased acuity (getting more help & risk support,
- There is no LD/LAC CAMHS commissioned service,
- There is a lack of ASD post diagnostic support.
- Risk support capacity and inpatient bed access.
- Perinatal team is not funded to the level required to meet national target.

Pathway

- History of no “getting help” provision.

Partnership

- Service and system issues within education and social care (lack of availability of residential care placements which exacerbates pressure on inpatient specialist beds) .
- Previous directives are now creating difficulties in enabling social care and CAMHS to collaborate more.
- Poorly developed voluntary sector with a capacity below that of nearby boroughs, this means less “getting advice” and “getting help” options are limited.
- LAC some primary care support is provided but there are gaps to getting help /and getting more help.

Workforce

- Recruitment of specialist level staff (have continued CPD in CAMHS). Need to develop more options for training and developmental pathways for staff .
- Perinatal service (covers 4 boroughs) is not funded to deliver national access target.
- LD service has resource gaps across partner organisations.

Waltham Forest response to COVID-19

Draft

Attain

Service changes

- The team have turned to a digital offer. All main services are now offered virtually. Case reviews using videos were introduced with positive benefits. Parents / guardians and CYP reported feeling more comfortable remaining in their own home.
- Group workshops were converted to online videos
- Telephone still an important tool to access for example gang members.
- Investment in community services has now been added to meet pre covid profile. There is a chall.

Demand changes

- The demand created by Covid was not in any scenario modelled. The challenge post-Covid is the increased volume and greater acuity of cases (getting more help and risk support levels)
- Initially there was a false suppression in referrals.
- Demand has risen steadily to above previous levels.
- The acuity has increased. Between 50 – 100% of cases need extra support due to the acuity. This change sustained to November (awaiting data refresh)
- Eating disorders increased from 1 – 2 / year to 1 / month.
- Psychotherapy demand (individual and family CBT) has increased by 50%
- New presentation not seen before of neurodiverse young females not known to service.
- Many CYP attending ED needing crisis support were not known to service.
- CYP heightened anxiety because their support circles of peers, family, teachers, mentors, services could not be accessed or were themselves no calm (friends and family)

The content arises from an interview with Lynne McBride (Assistant Director) and Sam Ilaiee (Head of Service) from the NELFT CAMHS team.

Newham

Newham introduction

About Newham

- The London Borough of Newham is a London borough created in 1965 by the London Government Act 1963. It covers an area previously administered by the Essex county boroughs of West Ham and East Ham, authorities that were both abolished by the same act. The name Newham reflects its creation and combines the compass points of the old borough names. Situated on the borders of inner and outer East London, Newham has a population of 353,134, which is the third highest of the London boroughs and also makes it the 20th most populous district in England.

- It is 5 miles (8 km) east of the City of London, north of the River Thames. Newham was one of the six host boroughs for the 2012 Summer Olympics and contains most of the Olympic Park including the London Stadium. The local authority is Newham London Borough Council.

Thrive maturity 1 – 2
Trauma and difficult experiences are used as a shared language

Draft

Newham services and pathways

Service / pathway name	Provider
Chlid and Family Consultation Services (CFCS) – access	
CAMHS Triage	ELFT community
CAMHS Brief intervention	ELFT community
CAMHS Psychotherapy	ELFT community
CAMHS Neurodev and LD	ELFT community
CAMHS Paediatric liaison	ELFT community
CAMHS Eating disorder	ELFT
CAMHS Looked after children link with SC	ELFT community
CAMHS families first	ELFT community
Early intervention in psychosis	ELFT
Headstart: emotional well being and MH support in schools	HeadStart*
Bounceback online	HeadStart*
Peer parenting classes	Headstart*
HeadStart Creatice Arts and Sports Activities	HeadStart*
Edge of care	LB of Newham
CAMHS embedded clinicians into social care	ELFT community
NHS Go: information	NHSE
Kooth online counselling open to all children and young people	Kooth

*HeadStart are LA funded, embeded CAMHS workers

Draft

Assessment of Newham against The Thrive Framework principles

Attain

Principle	Description
Common Language	The iThrive Framework is an aspiration. It is not used yet as a common language. In lieu of the iThrive framework a trauma-focussed language is used to help understand need.
Needs-Led	The system has moved away from a diagnosis-centric model. The approach is needs-led which is helping to facilitate the involvement of a wider set of community assets to support children and young people. For example, for children displaying risky behaviours it is ok for other people to talk to a young person about self harm.
Shared Decision Making design	Coproduction is used within CAMHS and Headstart. Coproduction uses voice of children, young people and families. All cases are reviewed by the CAMHS MDT to agree the care plan. The service user and carers receive a care plan letter (following the Hackney team approach) that uses a conversational style to set out the story of the person and proposed steps to support them
Proactive Prevention	The wider determinants of health and well being are reviewed to provide support before accessing CAMHS. Investments have been made into teams to support mental health. These include community health champions, young people health champions. There is a gap for primary school age children. The local public health team are working to on a comprehensive offer. The Lottery funded Headstart (community and schools-based team) and Befriending services are provided via the Local Authority. Little preventative care for primary school age yet many now require residential care to access support
Partnership Working	Newham has a well-established model of embedded CAMHS roles within partner organisations. The Children's MH Partnership board is now in place to provide strategic leadership and support for partnership working. Examples of partnership working includes embedded CAMHS support within social care, special schools, troubled families team and youth offending team. Important to address parental mental health and addressing the family unit, multi agency collective has recently begun to work to provide interventions for cases the CAMHS have insufficient capacity to support.
Outcome Informed	Outcome measures are well established and the recording of them is reported as good. The data from Kooth does flow to the MHSDS, however the count towards access is small. Difficult to monitor outcome measures for CYP who step up / down between partners.
Reducing Stigma	Producing films about CAMHS to reduce concerns and preconceptions. The films include interviews with the local clinical team. Pop up Saturday clinics, interest led groups that help CYP access mentors and develop social networks e.g sports, football, music, These are published on the website. Hard to reach groups are being targeted via schools and voluntary organisations. Community Health champions also have a mental health remit; soon to be introduced are Young People Health champions. Building links between physical and mental health e.g. weight management services at the front end to consciously build links
Accessibility	Single point of access for children is open 7 days per week via the website The CAMHS team have a twice daily case review and a review of all open cases every 3 months Increased use of digital access has raised concern that inequalities may impact on [digital] access. A higher risk SPA is to be developed as a multi-agency approach. A "padlet" digital pinboard has been used to collate support offers available to CYP in the borough,

Draft

Newham – workforce

The locality team has a clinical workforce of **67.4 WTEs**. Over half the workforce is made up of Psychologists and Therapists at Band 7 and Band 8a, with a medical workforce of 9.5 WTEs. Overall there are **1.1 clinical WTEs per thousand population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads is £5,893K, which equates to **£96.34 per child or £3,681 per referral.**

Role Type / Grade	WTEs
Consultant	4.7
Specialty Doctor	1.8
Specialist Registrar	3.0
Clinical - 8d	1.0
Clinical - 8c	2.1
Clinical - 8b	3.4
Clinical - 8a	20.0
Clinical - 7	17.0
Clinical - 6	2.5
Clinical - 5	11.0
Unspecified	1.0
Total	67.4

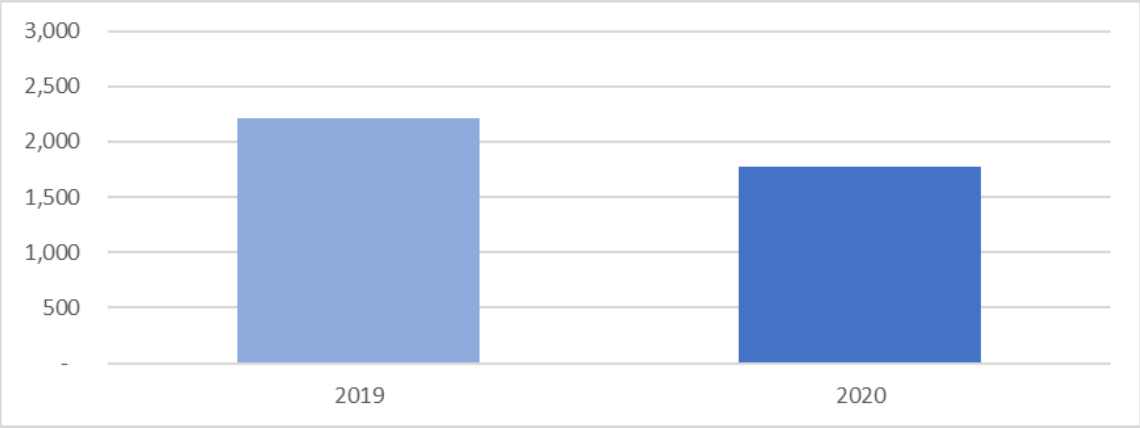
Source: ELFT local data

Draft

Newham – referrals and caseload

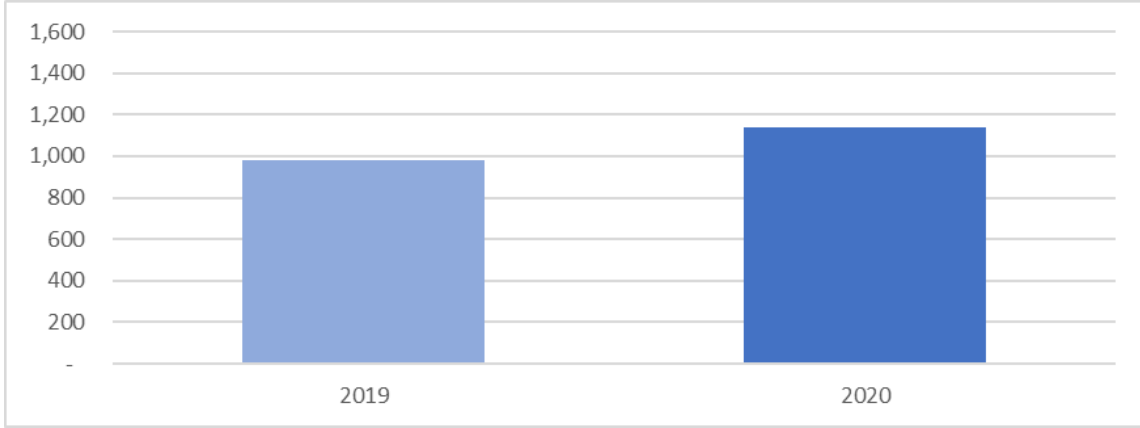
Numbers of new referrals fell across almost all pathways between 2019 and 2020, however caseloads increased significantly for a number of pathways. Overall caseload increased by 16%.

New Referrals



Team / Pathway	2019	2020	Change	Trend
NH CAMHS AMHT	26	14	-46%	
NH CAMHS AMHT EIS	10	13	30%	
NH CAMHS Best Start in Life	-	3		
NH CAMHS Crisis	120	184	53%	
NH CAMHS EB1	307	309	1%	
NH CAMHS EB2	277	263	-5%	
NH CAMHS Ed Outreach	11	6	-45%	
NH CAMHS Families First	13	9	-31%	
NH CAMHS LAC	56	48	-14%	
NH CAMHS NDT	202	138	-32%	
NH CAMHS PLT	36	17	-53%	
NH CAMHS Psychotherapy	26	24	-8%	
NH CAMHS Social Care	57	25	-56%	
NH CAMHS SPE	1,046	718	-31%	
NH CAMHS TOPS	21	6	-71%	
Grand Total	**2,208**	**1,777**	-20%	

Average Live Caseload



Team / Pathway	2019	2020	Change	Trend
NH CAMHS AMHT	27	38	40%	
NH CAMHS AMHT EIS	10	18	75%	
NH CAMHS Best Start in Life	-	2		
NH CAMHS Crisis	19	36	95%	
NH CAMHS EB1	233	278	20%	
NH CAMHS EB2	200	293	46%	
NH CAMHS Ed Outreach	13	6	-56%	
NH CAMHS Families First	5	7	30%	
NH CAMHS LAC	32	43	32%	
NH CAMHS NDT	159	202	27%	
NH CAMHS PLT	32	20	-38%	
NH CAMHS Psychotherapy	15	26	78%	
NH CAMHS Social Care	48	30	-38%	
NH CAMHS SPE	174	135	-23%	
NH CAMHS TOPS	13	6	-56%	
Grand Total	**980**	**1,137**	**16%**	

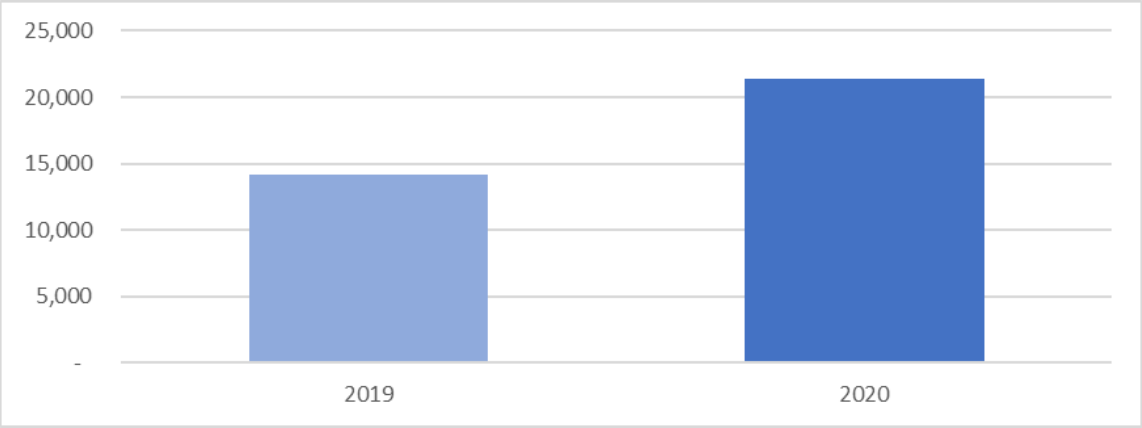
Source: ELFT local data

Draft

Newham - contacts

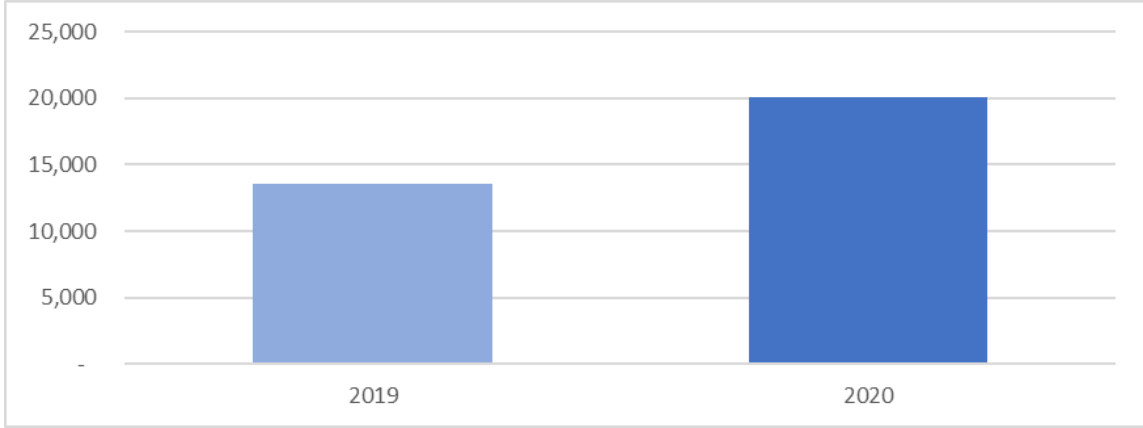
From 2019 to 2020 contact numbers and hours increased overall by 51% and 48% respectively. Approximately half the contact hours are with the Emotional & Behavioural pathways, which increased by over 50% overall.

Contacts



Team / Pathway	2019	2020	Change	Trend
NH CAMHS AMHT	809	1,723	113%	
NH CAMHS AMHT EIS	342	1,118	227%	
NH CAMHS Best Start in Life	-	22		
NH CAMHS Crisis	316	191	-40%	
NH CAMHS EB1	3,777	5,064	34%	
NH CAMHS EB2	2,917	5,818	99%	
NH CAMHS Ed Outreach	128	89	-30%	
NH CAMHS Families First	137	112	-18%	
NH CAMHS LAC	602	889	48%	
NH CAMHS NDT	1,829	2,845	56%	
NH CAMHS PLT	442	518	17%	
NH CAMHS Psychotherapy	351	1,013	189%	
NH CAMHS Social Care	578	309	-47%	
NH CAMHS SPE	1,654	1,581	-4%	
NH CAMHS TOPS	251	90	-64%	
Grand Total	**14,133**	**21,382**	**51%**	

Contact Hours



Team / Pathway	2019	2020	Change	Trend
NH CAMHS AMHT	804	1,761	119%	
NH CAMHS AMHT EIS	374	1,169	213%	
NH CAMHS Best Start in Life	-	32		
NH CAMHS Crisis	431	306	-29%	
NH CAMHS EB1	3,719	4,834	30%	
NH CAMHS EB2	2,799	5,289	89%	
NH CAMHS Ed Outreach	99	61	-39%	
NH CAMHS Families First	114	96	-16%	
NH CAMHS LAC	576	807	40%	
NH CAMHS NDT	1,906	2,723	43%	
NH CAMHS PLT	395	414	5%	
NH CAMHS Psychotherapy	326	861	164%	
NH CAMHS Social Care	583	284	-51%	
NH CAMHS SPE	1,265	1,358	7%	
NH CAMHS TOPS	169	61	-64%	
Grand Total	**13,561**	**20,055**	**48%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

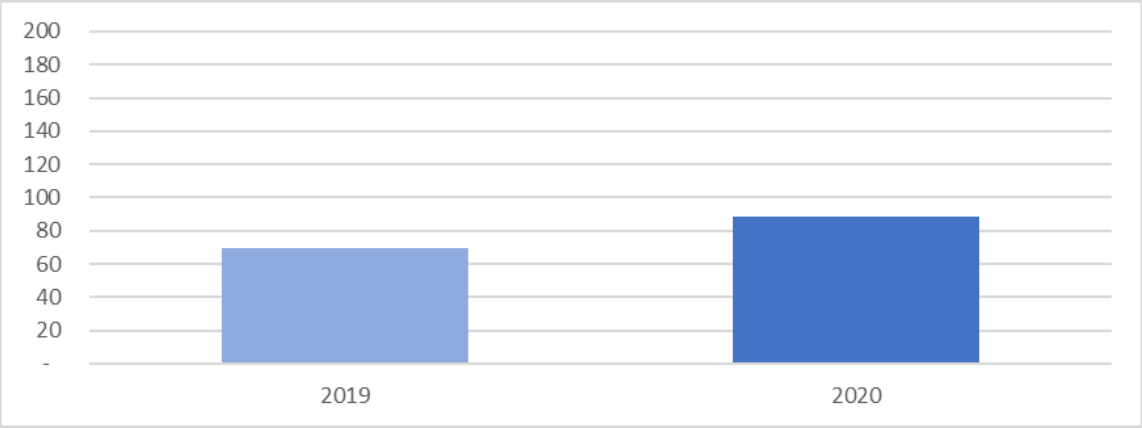
Source: ELFT local data

Draft

Newham – monthly time per case & contact type

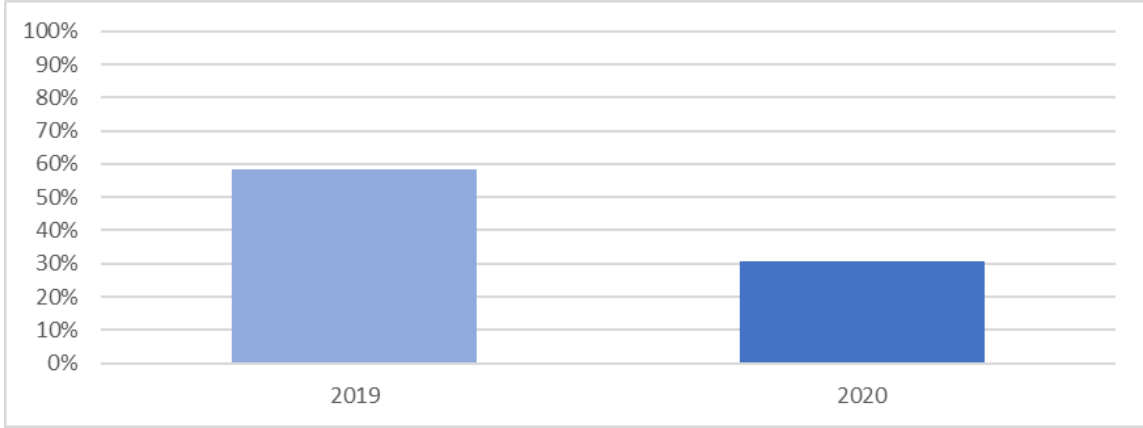
The average contact time per case per month increased by 27% from 2019 to 2020. Significant increases were in the Adolescent MH teams, PLT and Psychotherapy, with the Crisis team reducing by 64%. Except for Families First, all teams saw a drop in the face-to-face contact.

Contact Minutes per Case per Month



Team / Pathway	2019	2020	Change	Trend
NH CAMHS AMHT	148	232	56%	
NH CAMHS AMHT EIS	184	328	78%	
NH CAMHS Best Start in Life		108		
NH CAMHS Crisis	115	42	-64%	
NH CAMHS EB1	80	87	9%	
NH CAMHS EB2	70	90	29%	
NH CAMHS Ed Outreach	38	54	41%	
NH CAMHS Families First	112	73	-35%	
NH CAMHS LAC	89	94	6%	
NH CAMHS NDT	60	67	12%	
NH CAMHS PLT	61	104	70%	
NH CAMHS Psychotherapy	113	167	48%	
NH CAMHS Social Care	61	48	-22%	
NH CAMHS SPE	36	50	39%	
NH CAMHS TOPS	64	52	-19%	
Overall Average	**69**	**88**	**27%**	

Proportion of Face-to-Face Contact Time



Team / Pathway	2019	2020	Change	Trend
NH CAMHS AMHT	65%	27%	-58%	
NH CAMHS AMHT EIS	66%	24%	-63%	
NH CAMHS Best Start in Life		9%		
NH CAMHS Crisis	99%	85%	-14%	
NH CAMHS EB1	60%	30%	-50%	
NH CAMHS EB2	59%	31%	-48%	
NH CAMHS Ed Outreach	71%	56%	-21%	
NH CAMHS Families First	78%	79%	1%	
NH CAMHS LAC	41%	16%	-59%	
NH CAMHS NDT	61%	36%	-41%	
NH CAMHS PLT	60%	23%	-62%	
NH CAMHS Psychotherapy	85%	43%	-50%	
NH CAMHS Social Care	70%	39%	-43%	
NH CAMHS SPE	21%	15%	-29%	
NH CAMHS TOPS	59%	57%	-5%	
Overall Average	**58%**	**31%**	**-48%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

Source: ELFT local data

Draft

Newham Strengths and Challenges

Strengths

Access

- Award winning front door model Telephone triage .
- Daily duty cover to manage risks .

Pathway

- Workshop rolling programme to offer sessions on typical topics
- Increasing voluntary sector assets in Newham;
    - Aston Mansfield Community Involvement Unit
    - Fight for Peace (combines boxing and martial arts with education and personal development to realise the potential of young people in communities affected by crime, violence and social exclusion)
- Understanding the wider determinants of health and well being to provide support to people before needing to access CAMHS.

Partnership

- Local Authority funded Headstart (Lottery-funded) and befriending scheme (aims to increase social contact and reduce isolation) provide resource to build resilience and well being
- Future closer working with the Specialist Child and Young Person's Services for more alignment of physical and mental health
- Reducing barriers to integration.
- Building links between physical services to mental health e.g. weight management services .
- Embedded model is well established providing positive behavioural support into schools and support to social care staff.
- Voluntary sector has increased it's offer; Fight for Peace and Mansfield

Workforce

- Persistence to follow up and follow through to engage and support hard to reach, vulnerable people with complex situations.
- Different workforce models are being used that include small self led bubbles of band 8 staff a team of band 7's and 6's to support promotion and the inclusion of allied health professionals such as pharmacy and creative therapy roles.

Challenges

System

- Managing complex patients 'simply' who require input from many services.
- Reducing duplication and gaps in provision by the multiple agencies.
- Newham has the highest access target across NEL and funded similar to Waltham Forest who have a lower access target

Digital

- Sharing information between organisations particularly those working across schools and mental health.
- Website due for revamp.
- Not all CYP want to use video tech.
- Duplication of data inputting work by professionals working across health and education e.g. navigating appointments and recording outcomes within these.
- Expand and make better use of the Kooth service with increased awareness raising.

Workforce

- Duplication of administration and diary management. An outcomes administrator has now been employed to support the CAMHs workforce.
- Recruiting staff is difficult. Particular pinch points include medical staff.

Pathways

- Undefined tier 2 services (MHST is still a work in progress). Little support for under 5s.
- Staff managing the children and families triage are exhausted.
- Transition support is a concern.
- Addressing family unit as well as CYP to reduce impact of parental MH challenges.

Capacity and demand

- Kooth has been well received but it is considered to be under utilised potentially due to low awareness.
- Insufficient capacity within the triage team to undertake group treatment, although there is a rolling programme of 90 min sessions on common themes to provide some advice.
- Numbers of children presenting with social issues.
- Providing sufficient capacity for MH training for community health programmes.

Newham response to COVID-19

Draft

Attain

Service changes

- Primary care ADHD support stepped down.
- Flow routine cases into MDT panel to establish what can support an be provided to best meet need.
- The LA-funded befriending service provides chat services that focus on children's loneliness.
- Focus CAMHS resources on cases needing to get risk support. Other cases are now (since March 2021) reviewed by a multi agency collective to consider what support is available from the various community assets. However, this does need new ways of working and resources to manage new process
- Redesign of the consultation room with Perspex dividers and separate access and egress for service users and clinicians has now enabled COVID-safe face to face interaction.
- Digital appointments are now available by 'phone.

Marie Trueman-Able Head of commissioning and Transformation – Newham CCG. Philip Williams – Strategic lead for CYP Partnership (integrated role) Matthew Richardson – CAMHS commissioner (previously at Tower Hamlets CCG)

Demand changes

- Increases in eating disorders.
- 100% increase in crisis service demand between March 2019 and March 2020.
- Key presentations in crisis have included:
  - People with ASD.
  - Self harm incidence has increased with more violent acts
- Suicides have increased .
- Children of increasingly younger age (Younger teenagers and under 10s) displaying anxiety.
- Increased levels of anxiety and cases of OCD that are proving much harder to treat.
- Presentation cohorts are broad but there is still a concern that not all who need MH support can access services that have shifted on-line.
- Better attendance of family therapy sessions using digital platforms.

Tower Hamlets

Tower Hamlets introduction

About Tower Hamlets

- The London Borough of Tower Hamlets is located in East London. It was formed in 1965 from the merger of the former metropolitan boroughs of Stepney, Poplar and Bethnal Green. The new authority's name was taken from an alternative title for the Tower Division; the area of south-east Middlesex (not coterminous with the current borough) which owed military service to the Tower of London.

- The borough lies adjacent to the east side of the City of London and on the north bank of the River Thames. It includes much of the redeveloped Docklands region of London, including West India Docks and Canary Wharf. Many of the tallest buildings in London occupy the centre of the Isle of Dogs in the south of the borough. A part of the Queen Elizabeth Olympic Park is in Tower Hamlets. The borough has a population of 272,890,which includes one of the highest Muslim populations in the country and has an established British Bangladeshi business and residential community. Tower Hamlets has the highest proportion of Muslims in England outnumbering Christians, and has more than forty mosques and Islamic centres, including the East London Mosque, Britain's biggest mosque. Brick Lane's restaurants, neighbouring street market and shops provide the largest range of Bengali cuisine, woodwork, carpets and clothes in Europe.

- A 2017 study by Trust for London and New Policy Institute found that Tower Hamlets has the highest rate of poverty, child poverty, unemployment, and pay inequality of any London borough. However, it has the lowest gap for educational outcomes at secondary level. The local authority is Tower Hamlets London Borough Council

Draft

Tower Hamlets services and pathways

Service / pathway name	Provider
Provide tier 2 IAPT and step up / step down resource	Step Forward and Docklands
Youth space to inspire CYP includes mentoring	Spotlight
CAMHS triage	ELFT Community
CAMHS brief intervention	ELFT Community
CAMHS Neurodev and LD	ELFT Community and Barts
CAMHS Emotional and Behavioural pathway	ELFT Community
CAMHS Paediatric Liaison Team (acute based)	ELFT Community
Early intervention in Psychosis	ELFT
Eating disorder	ELFT
Crisis Service	ELFT
CAMHS MH schools link	ELFT Community
CAMHS embedded to social care	ELFT Community
Awareness campaign including on line	The Mix
Better beginnings Parent and infant well being coordinator	VCS and LBTH
Schools health service Compass Wellbeing CIC and LBTH	Compass & LBTH
Kooth online counselling open to all children and young people	Kooth
Mindfulness training into schools	LBTH

Assessment of Tower Hamlets services against Thrive principles

Draft

Attain

Principle	Description
Common Language	The Thrive Framework is used and has a maturity level of 2 / 3. Although within integrated fora the language if thresholds is used, transformation plans do use the Thrive framework. The project piloting the use of 4 week referral to treatment targets is using The Thrive Framework,
Needs-Led	There is a needs-led approach that is developing in the borough
Shared Decision Making	People Participation work is well developed in TH and across INEL
Proactive Prevention	Tower Hamlets Early Detection and Early intervention services work together to identify and support CYP at high risk of developing psychosis. The local authority provide teams addressing health and wellbeing in CYP. Step Forward (and Docklands) work as a key MH partner in schools (Pilot involving 4 schools) prior to specialist CAMHS. Proactive prevention offer also includes MHST (Tower Hamlets is a Trailblazer site). The different proactive prevention offers are hard to navigate and requires pulling together and maintaining. The CAMHS team have expanded self-help resources and education.
Partnership Working	There is good collaborative working between the commissioner and provider and strong partnership working with the third sector e.g. Step Forward, Docklands and Spotlight. Tower Hamlets has a good level of voluntary resources. There is a number of embedded CAMHS clinicians: paediatric liaison team within the Royal Marsden, nurse within the Youth Offending Team and a clinician supporting special schools. Th Navigating these may be problematic to those who do not know about them. The richness of the level of groups offers real potential to work together to provide reduce stigma, improve access and support. However there is a risk that CYP can fall between social care and CAMHS
Outcome Informed	Outcome measures are used although these data are not used more widely to test and improve ways of working.
Reducing Stigma	MHST provide training to staff and raise awareness amongst school children to reduce stigma and raise awareness. Spotlight with their work within a youth centre are a catalyst to reduce stigma. GPs do still see CYP who do not want to access MH services. Tower Hamlets is a very impoverished area and there are significant numbers of people without easy digital access. There are pockets of hard to reach communities for example some Chinese and some African originating groups.
Accessibility	CAMHS have a single point of access. A CYP under 18 to access to services including GP and other services requires. Tower Hamlets is a Trailblazer site testing 4 week referral to treatment target for routine cases and 7 days for urgent cases. A 24/7 crisis line is also available. Self referral is poor

Draft

Tower Hamlets – workforce

The locality team has a clinical workforce of **57.4 WTEs**. Over half the workforce is made up of Psychologists, Therapists and Nurses at Band 7 and Band 8a, with a medical workforce of 4.8 WTEs. Overall there are **1.35 clinical WTEs per thousand population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads, is £5,406K, which equates to **£126.68 per child or £3,184 per referral.**

Role Type / Grade	WTEs
Consultant	4.0
Specialist Registrar	0.8
Clinical - 8d	0.3
Clinical - 8c	1.8
Clinical - 8b	5.8
Clinical - 8a	15.4
Clinical - 7	17.3
Clinical - 5	10.0
Clinical - 4	2.0
Total	**57.4**

** Tower Hamlets' figures exclude the Patient Liaison Team due to data quality*

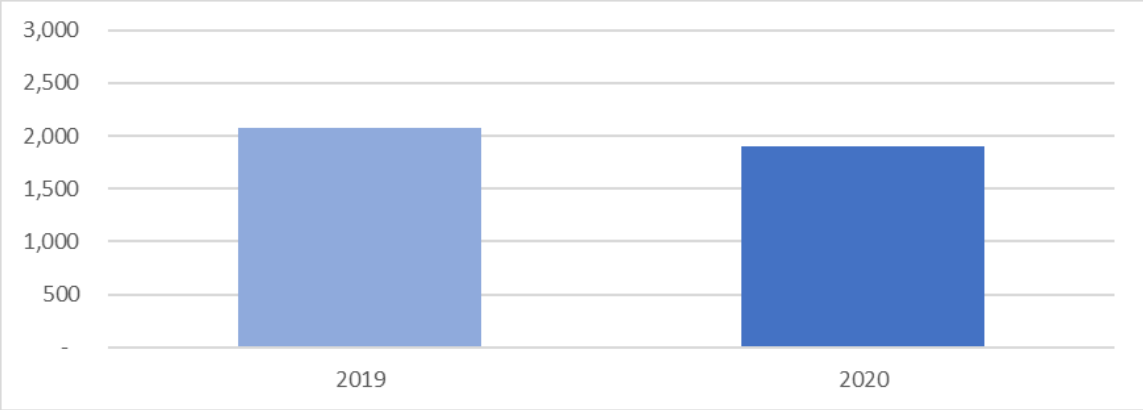
Source: ELFT local data

Draft

Tower Hamlets – referrals and caseload

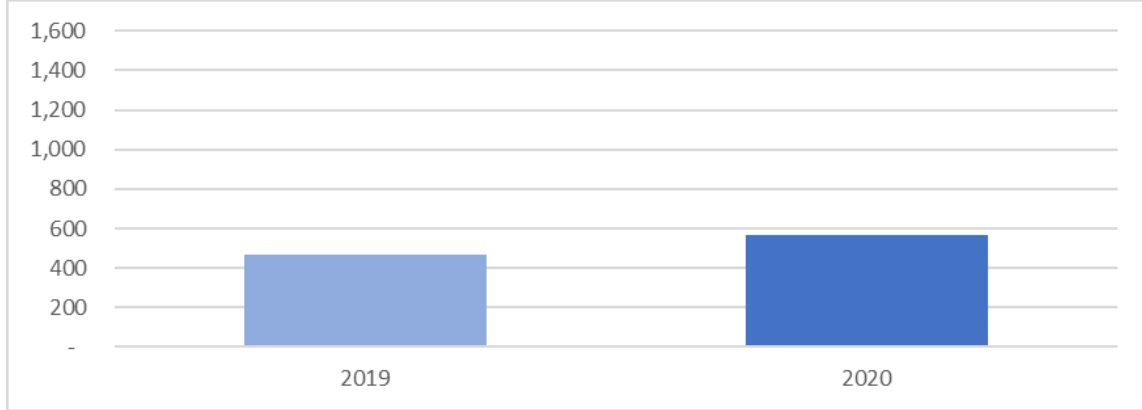
Numbers of new referrals decreased overall by 9% between 2019 and 2020. The only significant increases where in the Crisis and the MHST pathways. Overall caseload increased by 22%, the bulk of which are attributed to the MHST pathway.

New Referrals



Team / Pathway	2019	2020	Change	Trend
TH CAMHS AMHT	22	23	5%	
TH CAMHS ASD/LD	136	121	-11%	
TH CAMHS Crisis	129	198	53%	
TH CAMHS EB CD	653	489	-25%	
TH CAMHS LBTH	102	83	-19%	
TH CAMHS MHST	34	187	450%	
TH CAMHS SPE	1,004	779	-22%	
TH CAMHS SPE Brief Intervention	-	16		
Grand Total	**2,080**	**1,896**	**-9%**	

Average Live Caseload



Team / Pathway	2019	2020	Change	Trend
TH CAMHS AMHT	7	12	63%	
TH CAMHS ASD/LD	38	52	37%	
TH CAMHS Crisis	8	17	112%	
TH CAMHS EB CD	269	275	2%	
TH CAMHS LBTH	61	77	26%	
TH CAMHS MHST	8	65	674%	
TH CAMHS SPE	76	70	-8%	
TH CAMHS SPE Brief Intervention	-	3		
Grand Total	**467**	**570**	**22%**	

** TH CAMHS PLT referrals and activity have been excluded*

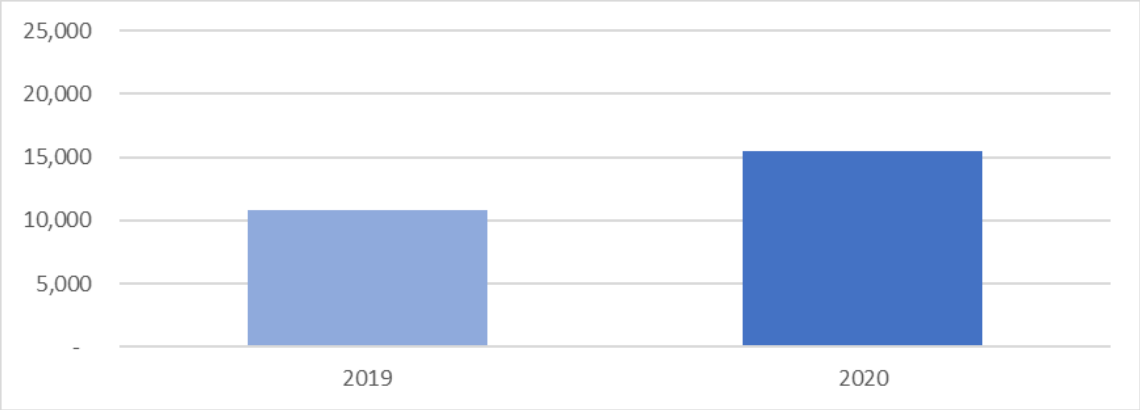
Source: ELFT local data

Draft

Tower Hamlets - contacts

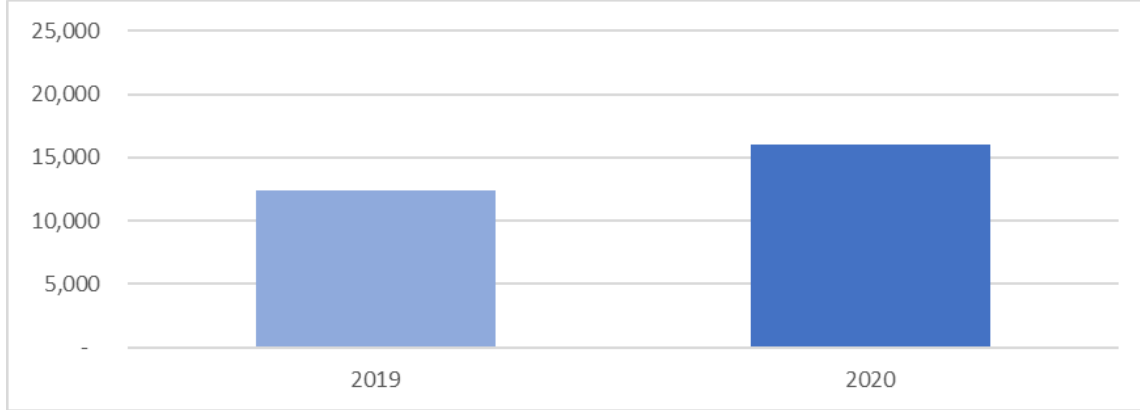
From 2019 to 2020 contact numbers increased overall by 44% and total contact hours increased by 30%. Over half of all contacts and contact hours sit with the Emotional & Behavioural pathway. However, the MHST and SPE pathways saw significant increases in contact hours.

Contacts



Team / Pathway	2019	2020	Change	Trend
TH CAMHS AMHT	306	651	113%	
TH CAMHS ASD/LD	1,263	1,698	34%	
TH CAMHS Crisis	245	458	87%	
TH CAMHS EB CD	6,805	8,363	23%	
TH CAMHS LBTH	699	779	11%	
TH CAMHS MHST	125	925	640%	
TH CAMHS SPE	1,326	2,547	92%	
TH CAMHS SPE Brief Intervention	-	65		
Grand Total	**10,769**	**15,486**	**44%**	

Contact Hours



Team / Pathway	2019	2020	Change	Trend
TH CAMHS AMHT	331	605	82%	
TH CAMHS ASD/LD	1,458	1,596	9%	
TH CAMHS Crisis	321	503	57%	
TH CAMHS EB CD	7,377	8,340	13%	
TH CAMHS LBTH	796	785	-1%	
TH CAMHS MHST	115	804	597%	
TH CAMHS SPE	1,950	3,323	70%	
TH CAMHS SPE Brief Intervention	-	90		
Grand Total	**12,348**	**16,046**	**30%**	

* *Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

** *TH CAMHS PLT referrals and activity have been excluded*

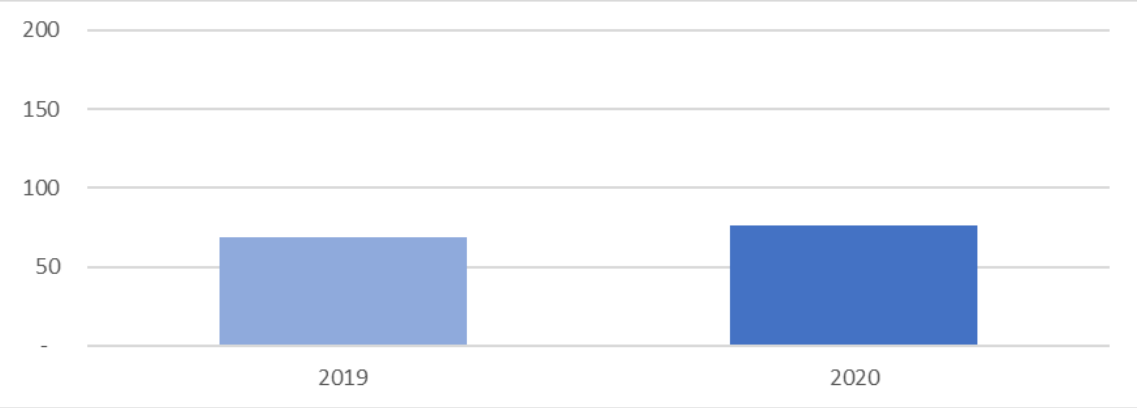
Source: ELFT local data

Draft

Tower Hamlets – monthly time per case & contact type

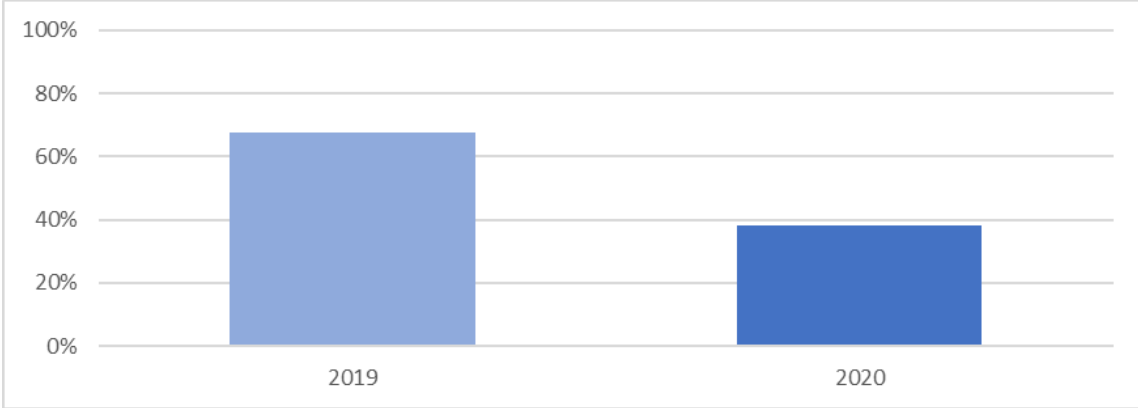
The average contact time per case per month increased by 12% from 2019 to 2020. However, there was significant variation with a number of the pathways seeing reductions. All pathways saw a reduction in the proportion of time spent in Face-to-Face contacts.

Contact Minutes per Case per Month



Team / Pathway	2019	2020	Change	Trend
TH CAMHS AMHT	116	130	12%	
TH CAMHS ASD/LD	64	51	-20%	
TH CAMHS Crisis	102	76	-26%	
TH CAMHS EB CD	69	76	10%	
TH CAMHS LBTH	65	51	-22%	
TH CAMHS MHST	69	62	-10%	
TH CAMHS SPE	64	119	85%	
TH CAMHS SPE Brief Intervention		138		
Overall Average	**68**	**77**	**12%**	

Proportion of Face-to-Face Contact Time



Team / Pathway	2019	2020	Change	Trend
TH CAMHS AMHT	76%	45%	-41%	
TH CAMHS ASD/LD	74%	48%	-36%	
TH CAMHS Crisis	99%	82%	-17%	
TH CAMHS EB CD	76%	43%	-44%	
TH CAMHS LBTH	81%	51%	-37%	
TH CAMHS MHST	91%	55%	-40%	
TH CAMHS SPE	17%	8%	-56%	
TH CAMHS SPE Brief Intervention		2%		
Overall Average	**68%**	**38%**	**-44%**	

* *Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

** *TH CAMHS PLT referrals and activity have been excluded*

Source: ELFT local data

Tower Hamlets Strengths and challenges

Draft

Attain

Strengths

Partnership

- Step Forward and Docklands work as key MH partners in schools (Pilot involving 4 schools) and support step up and step down transition. If a GP referral is not suitable for CAMHS, the GP will be recommended to refer to Step Forward.
- MHSTs in place to help access and undertake preventative interventions
- The area benefits from over 250 different groups. There is an opportunity to improve how different voluntary groups and statutory services work together.
- Patnership with LB Tower Hamlets – there is substantial investment from the Local Authority and joint working which benefits young people in TH
- Flexible and agile team.

Coproduction

- Local CYP ambassadors are supporting engagement and coproduction (highlighted by NHS England)

Pathway

- Duty critical response team set up to respond to urgent / emergency cases. If CYP in crisis creates a multi-agency response

Workforce

- There is a wider set of professionals that include AHPs and extended nursing roles

Digital

- Opportunity to build on the learnings from Covid around telemedicine, teletherapy and communicating other agencies and support services

Challenges

Digital

- Shared care records have been developed that cover primary care (EMIS), paediatric team encounters, ED, hospital discharge summaries and psycho social MDTs. The RIO system is reported as not being linked. Children receiving social care support)open to social care) are not visible to NHS-funded services.
- THEIS record activity and outcomes but double entry required as system not compatible with RIO.
- The lack of information sharing causes issues for the lead professional (e.g. GP) supporting the CYP as they step down from MH interventions.
- Lack of data around service delivery.

Pathways

- The barriers to access Eating disorder advice and help for families are being picked up in a local authority collaboration that will use digital services
- Vol sector agencies need support to capture MHMDS data
- Issues in establishing lead professional when a CYP steps down from specialist support
- Children who do not meet threshold to access CAMHS services
- The smooth shifting of CYP between Getting Help and Getting More Help still requires more work and focus
- Covid has highlighted the stretched resources within the neurodevelopmental pathway.

Partnerships

- Looked after children; need to improve the integrated working; risk CYP can "bounce" between services
- Early intervention; children can fall between the gaps between the tier 2 providers
- Social care funding issues create increased risk for CYP particularly: packages of care below prescribed and high staff turnover
- Working through safeguarding concerns with social care for inpatients requiring medication.

Tower Hamlets Response to COVID-19

Draft

Attain

Service changes

- Moved to agile working prior to lockdown and provided equipment to support working away from the office.
- Office made Covid-safe reducing capacity from 60 to 25.
- Developed an IT champion to support staff better use digital technology.
- Redesigned face to face clinics to be "Covid-proof" with separate staff and patient entrance / egress and Perspex screens.
- Created a duty response team to manage urgent / emergency cases. Monday to Friday 0900 – 1700. This will increase to 7 day working. Team includes consultant psychiatrist, junior doctor, senior clinician and 2 x duty clinicians.
- Improved management of information to schools and families to avoid bombardment.
- Use of school forum spaces to get feedback on offer. This highlighted issues being faced that included school-staff anxiety, child-bereavement, need for the right resource to support parents, school avoidance and domestic violence issues.
- Step forward and CAMHS reviewed risk management approach to ensure most risky families and individuals were targeted.
- Neurodevelopmental assessment and pathway moved online. Healios, since Jan 2021 have been commissioned to assess (AdAS) for appropriate CYP.
- Reviewed guidelines for who can be seen F2F for neurodevelopmental pathway to increase the numbers of CYP seen.

Demand changes

- An increase in referrals has been since October 2020 this includes an increase of CYP in crisis.
- The inpatient / tier 4 services have discharged at an earlier point and required community support to prevent future crisis events
- Anecdotally there have been increases in
  - Anxiety and disturbed behaviours
  - Eating disorders with an increase in eating disorder in boys
  - Normally 'contained' autistic children going into crisis
  - CYP in crisis is estimate to have increased by over a third
  - Increase in the complexity of cases
  - Physically and emotionally (resilience) deconditioned CYP
  - Increase psychotic and self-harming behaviour from CYP with underlying difficulties managing behaviours
  - Increase in online exploitation

The content arises from an interview with Hanspeter Dorner (Associate Clinical Director) and Bill Williams (General Manager)

City and Hackney

City and Hackney introduction

About City and Hackney

- The London Borough of Hackney is an inner London borough. The historical and administrative heart of Hackney is Mare Street, which lies 5 miles (8 km) north-east of Charing Cross. The borough is named after Hackney, its principal district. Southern and eastern parts of the borough are popularly regarded as being part of east London, with the northwest belonging to north London.
- The London Plan issued by the Greater London Authority assigns whole boroughs to sub-regions for statutory monitoring, engagement and resource allocation purposes has since 2011 assigned Hackney to the 'East' sub-region. The modern borough was formed in 1965 by the merger of the Metropolitan Borough of Hackney with the much smaller Metropolitan Boroughs of Stoke Newington and Shoreditch.
- Hackney is bounded by Islington to the west, Haringey to the north, Waltham Forest to the north-east, Newham to the east, Tower Hamlets to the south-east and the City of London to the south-west. Hackney was one of the host boroughs of the London Olympics in 2012, with several of the Queen Elizabeth Olympic Park venues falling within its boundaries.

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City & Hackney services and pathways

Service / pathway name	Provider
Access is via "any front door"	All
First steps Homerton (Getting help and Guidance)	Homerton UH
CAMHS triage	ELFT community
CAMHS brief intervention	ELFT Community
CAMHS disability	Homerton UH
CAMHS Neurodev	ELFT community
CAMHS Behavioural pathway	ELFT community
CAMHS Emotional pathway	ELFT Community
CAMHS Eating disorder	ELFT
CAMHS perinatal service	ELFT Community
CAMHS MH schools link	ELFT Community
CAMHS paediatric liaison service	ELFT Community
CAMHS crisis service	ELFT
Offcentre (Transition 18-25 proviision of CAMHS)	OffCentre
Well Family Plus (Family Action)	Family action
Young Hackney (LBH)	London Borough of Hackney
Children and Families clinical services (LBH)	London Borough of Hackney
Growing Minds (African, Caribbean and mixed heritage children)	London Borough of Hackney and VCE
Wellbeing and Mental Health in schools (Hackney Learning Trust)	
Kooth online counselling open to all children and young people	Kooth
Digital mild to moderate on line service	Helios

Providers in City and Hackney

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First Steps Community CAMHS:

- **Provider: Homerton University Hospital**
- 0 – 18 year service
- Getting help and Guidance
- No lower threshold
- Interventions include CYP mild to moderate issues for up to 6 sessions
- Provide primary schools offer for individuals (direct) and groups (indirect

Community CAMHS

- **Providers; East London NHS Foundation Trust**
- 0 – 18 years
- Getting more help and risk management
- Service for CYP with moderate, persistent, complex or severe mental health difficulties.
- Children under 16 need consent of a legally responsible parent or guardian.

Disability CAMHS

- **Provider: Homerton University Hospital & ELFT**
- 5 – 18 years

A service for CYP and families Profound and moderate difficulties in addition to MH. They have increased mortality due to complexity and risk.

- Disabilities and emotional, behavioural or mental health concerns.
- Learning or intellectual disabilities.
- Attention deficit hyperactivity disorders (ADHD) or autism spectrum disorders (ASD).
- Based at Hackney Ark, our team includes psychologists, psychiatrists, psychotherapists, play specialists and family therapists.

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City and Hackney borough **strengths**

Attain

Access

- Duty system provides 7 day, 24 hour access for CYP needing risk support. This service has required additional B7 level hours that have now been commissioned.(Crisis)
- First Steps meets its target offer of 5 week RTT.
- Along the child development pathway mental health and disability support is physically present. This helps reduce stigma and promote access.
- High levels of collaboration around commissioning. There are no thresholds so everyone should get seen.
- High quality and professional input, working with local communities: Orthodox Jewish community, African-heritage communities and the Turkish communities.
- In 20/21 the CCG commissioned support to develop an SPA for ELFT and HUH which is planned to launch in Autumn 2021

Partnership working

- Local leads established to facilitate strong user participation consulting on leaflets and films (First Steps).
- Front line staff across CAMHS services historically good links with peers (inc. health visitors).
- The Under 5 autism/ADHD support is a fully integrated service: paediatricians, OT physio, paeds community. Includes joint clinics, joint workshops , joint interventions.
- Comprehensive schools programme: previously WHAMS now mental health support teams.

Workforce

- There is a consistent workforce in place with low turnover. Until 9 months ago recruitment was not an issue within the Borough.
- The most common outcome from First-steps workshops is to step down to the universal offer / community support.
- First Steps is supported by four child wellbeing practitioners Retained trained practitioners.
- SilverCloud digital platform to support staff.

Resources

- Resources for a recovery plan is going out to tender.
- Workshop programme in place to support CYP (First Steps). Following interventions most common outcome is to step down to primary care / universal offer (First Steps)

Clinical Leadership

- Strong senior management team; shared vision

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City and Hackney borough **challenges**

Access

- Mental Health services are less well known across some Asian including Banglaldeshi communities.
- No wrong door is currently not as efficient as intended and can result in the CYP with the wrong service (project just agreed to create on system wide SPA). Audit shows 20% of first-time referrals go to the wrong place but are then redirected.

Capacity and demand

- Demand peaks are very challenging if staff absences occur.
- The local authority recently rescoped the threshold of one of their services which appears to have led to an increase in CYP presenting to CAMHS.
- Perception that a lack of system accountability in threshold and commissioning decisions contributed to this

Digital

- CAMHS digital systems are not fully integrated. These services cover First Steps, Disability-CAMHS and community CAMHS teams.
- Cyber attack on social care has prevented access to social care records (this was via a separate log-in. No interoperability in place).

Workforce

- Transition for CYP with LD is problematic; reference to high drop out at yr 8 and increased depression, anxiety and suicide for this cohort.
- Difficulty getting neurodevelopmental pathway resources. Demand now exceeds capacity.
- Retaining highly qualified CAMHs clinicians.

Demographics

- Multiple tiers of generational deprivation seen within the borough.

Pathways

- Waiting time targets breached.
- Step up and step down integration, need a better interface between tiers 2 and 3. Triage meetings shift cases rather than focus on need.
- No trusted assessment process.
- Navigation of neurodevelopmental pathway is very difficult and with increased demand a backlog has arisen. Used waiting list initiatives to remove but this has shifted demand to treatment .
- Children; once over 5 child transition to CAMHS services. Improved intelligence sharing between Commissioners of Child Health and CAMHS could help planning.

Leadership

- Duplication and extra meetings are required in area due to issues with digital communication and interoperability.
- Systemic change is difficult because CAMHS Alliance does not have clear authority or decision making process .
- there could be better sharing of good practice and what is working well across the ICS.

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Assessment of First Steps against Thrive principles

Principle	Description
Common Language	The Thrive framework is reported to be used across the community providers
Needs-Led	Use of the Thrive Framework encourages a needs led approach.
Shared Decision Making	Strong user-participation. Evidence of co-creation of services to best fit culturally appropriate service eg drop-ins in a mosque, African Saturday school
Proactive Prevention	The service provides an early intervention service
Partnership Working	There is good partnership work across 6 neighbourhoods and the services within; GP practices, children's services, children's groups, schools, health and voluntary sector. Involved in community for under 5s who need more help. CAMHs report that there is good working with schools and the local education authority. There has been closer working with social care but a cyber attack recently has set back access to records.
Outcome Informed	Outcomes are measured.
Reducing Stigma	Significant amount of work with Hackney communities to encourage access. Language barriers still exist for some Eastern European families.
Accessibility	No threshold to access service. Self referrals into the service access point. This is managed by a daily duty system to manage risk. See CYP who are not open to other services.

Draft

Assessment of City and Hackney Community CAMHS against Thrive principles

Principle	Description
Common Language	The Thrive Framework although not explicitly used was understood and the delivery of the Thrive Framework principles could be explained
Needs-Led	The CAMHS service works to a goals-based care plan
Shared Decision Making	Strong service user participation activities
Proactive Prevention	First steps provide proactive prevention activities .
Partnership Working	There is strong evidence of partnership at the working. A CAMHS partnership is in place but would benefit from a review of its decision making authority and process. The CAMHS services continue to work with schools
Outcome Informed	Outcome measures are used although these data are not used more widely to test and improve ways of working.
Reducing Stigma	There has been extensive work to reduce stigma across the different populations in Tower Hamlets. This include orthodox Jewish, Turkish and Afro-Caribbean groups. Groups have different ways of conceptualising mental health issues. Language can be a barrier.
Accessibility	Hackney currently operates a no-wrong-door model.

Assessment of City and Hackney CAMHS-disability service against Thrive principles

Draft

Attain

Principle	Description
Common Language	Thrive does not fit children with profound learning and mental health issues.
Needs-Led	Service users are mainly needing risk support. Many resources are diagnostic driven e.g Early Bird, Early Bird Plus, Cygnet. These are accredited packages that require evidence of a diagnostic step to maintain accreditation. Schools are diagnosis-driven and required to access specialist LD schools
Shared Decision Making	The CYP is often unable to give feedback and therefore use parent-based approach
Proactive Prevention	Proactive service support for families through the transition leads to reduced complexities later on. Additional resources are required down stream to achieve this.
Partnership Working	Good working relationships exist across pediatricians, OT, PT, paediatric community team. Support is accessible along the child development from the mental health and disability support teams. Integrated joint clinics joint workshops are also used to support parents
Outcome Informed	CORC is used. Information is fed back to the services on a monthly and bi-monthly basis which informs decision making and identifies where support is needed
Reducing Stigma	Stigma is not an issue for access.
Accessibility	Referrals are received mainly from clinicians along the child development pathway(including AHPs along this pathway) and also from schools, other health care professionals, parents can self refer (children known within the ARK),

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City & Hackney – workforce

The locality team has a clinical workforce of **59 WTEs**. Almost half the workforce is made up of Psychologists, Therapists and Nurses at Band 7 and Band 8a, with a medical workforce of 9 WTEs. Overall there are **1.4 clinical WTEs per thousand population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads is £5,206K, which equates to **£122.95 per child or £2,909 per referral**.

Role Type / Grade	WTEs
Consultant	5.3
Junior Doctor	3.7
Clinical - 8d	1.0
Clinical - 8c	2.9
Clinical - 8b	4.4
Clinical - 8a	14.7
Clinical - 7	13.0
Clinical - 6	5.0
Clinical - 5	8.0
Unspecified	1.0
Total	59.0

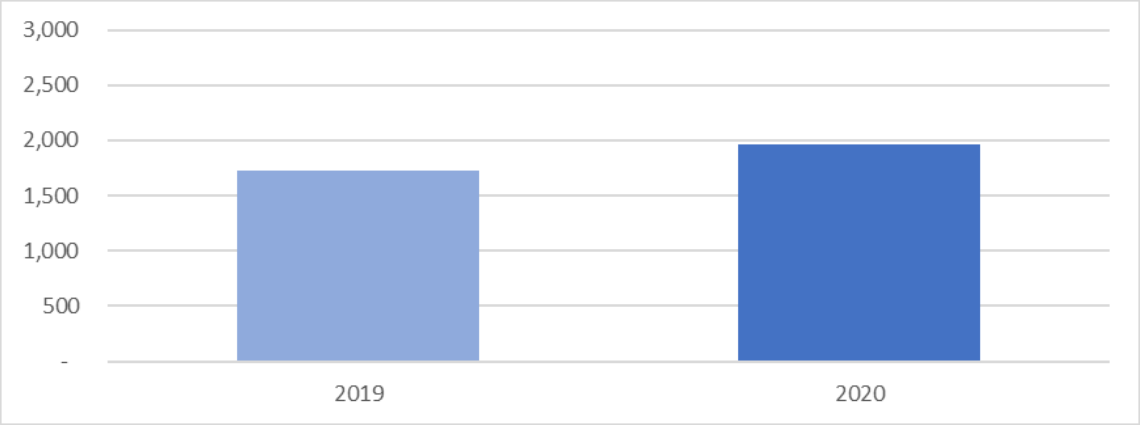
Source: ELFT local data

Draft

City and Hackney – referrals and caseload

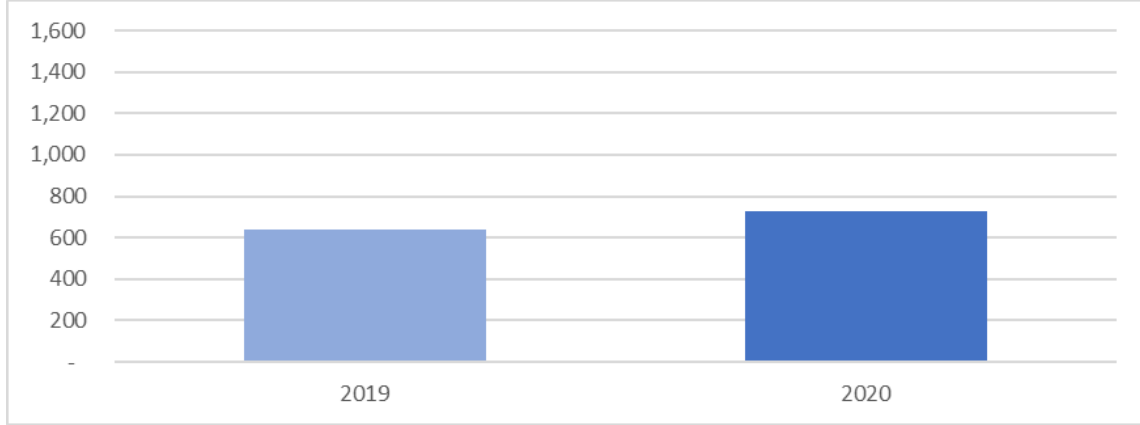
Numbers of new referrals fell across a number of pathways between 2019 and 2020, however Crisis and MHST rose significantly, accounting for an overall increase of 13%. Overall caseloads rose by 14% with the Neurodev pathway increasing along with Crisis and MHST.

New Referrals



Team / Pathway	2019	2020	Change	Trend
CH CAMHS AMHT	33	33	0%	
CH CAMHS AMHT EIS	7	5	-29%	
CH CAMHS Conduct Disorder	120	95	-21%	
CH CAMHS Crisis	87	170	95%	
CH CAMHS CWIS	-	47		
CH CAMHS EBS	279	249	-11%	
CH CAMHS MHST	1	241	24000%	
CH CAMHS NDT	213	210	-1%	
CH CAMHS PERINATAL	33	14	-58%	
CH CAMHS PLT	99	59	-40%	
CH CAMHS SPE	855	837	-2%	
Grand Total	**1,727**	**1,960**	13%	

Average Live Caseload



Team / Pathway	2019	2020	Change	Trend
CH CAMHS AMHT	23	29	26%	
CH CAMHS AMHT EIS	8	7	-7%	
CH CAMHS Conduct Disorder	38	32	-15%	
CH CAMHS Crisis	10	31	222%	
CH CAMHS CWIS	-	7		
CH CAMHS EBS	273	257	-6%	
CH CAMHS MHST	1	65	6936%	
CH CAMHS NDT	95	119	25%	
CH CAMHS PERINATAL	20	20	0%	
CH CAMHS PLT	28	31	8%	
CH CAMHS SPE	144	132	-9%	
Grand Total	**639**	**728**	**14%**	

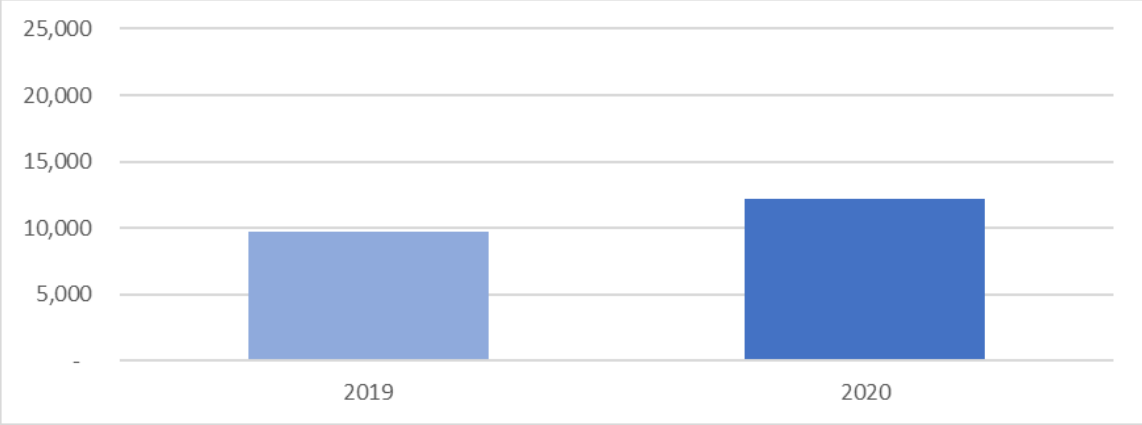
Source: ELFT local data

Draft

City and Hackney - contacts

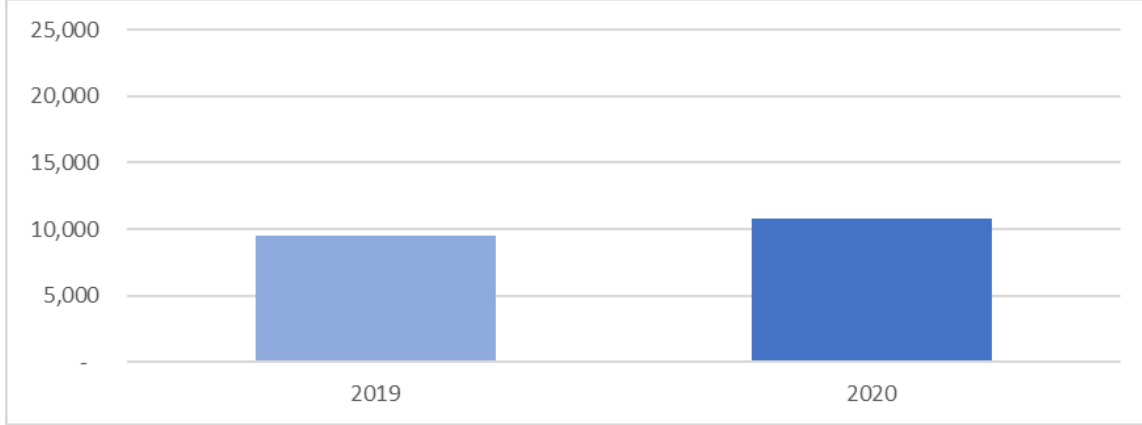
From 2019 to 2020 contact numbers rose by 26% and total contact hours rose by 14%. The highest relative increases in contact hours are with the Adolescent MH Team and the SPE pathway. The SPE pathway has had a 10% reduction in contacts but a 51% increase in contact hours.

Contacts



Team / Pathway	2019	2020	Change	Trend
CH CAMHS AMHT	562	935	66%	
CH CAMHS AMHT EIS	183	295	61%	
CH CAMHS Conduct Disorder	1,506	1,813	20%	
CH CAMHS Crisis	123	171	39%	
CH CAMHS CWIS	-	61		
CH CAMHS EBS	4,476	4,158	-7%	
CH CAMHS MHST	-	1,076		
CH CAMHS NDT	1,705	2,559	50%	
CH CAMHS PERINATAL	190	245	29%	
CH CAMHS PLT	150	201	34%	
CH CAMHS SPE	795	718	-10%	
Grand Total	**9,690**	**12,232**	**26%**	

Contact Hours



Team / Pathway	2019	2020	Change	Trend
CH CAMHS AMHT	559	830	49%	
CH CAMHS AMHT EIS	159	210	32%	
CH CAMHS Conduct Disorder	1,548	1,520	-2%	
CH CAMHS Crisis	169	197	16%	
CH CAMHS CWIS	-	42		
CH CAMHS EBS	4,338	3,680	-15%	
CH CAMHS MHST	-	797		
CH CAMHS NDT	1,855	2,328	26%	
CH CAMHS PERINATAL	149	176	19%	
CH CAMHS PLT	105	146	39%	
CH CAMHS SPE	583	878	51%	
Grand Total	**9,463**	**10,805**	**14%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

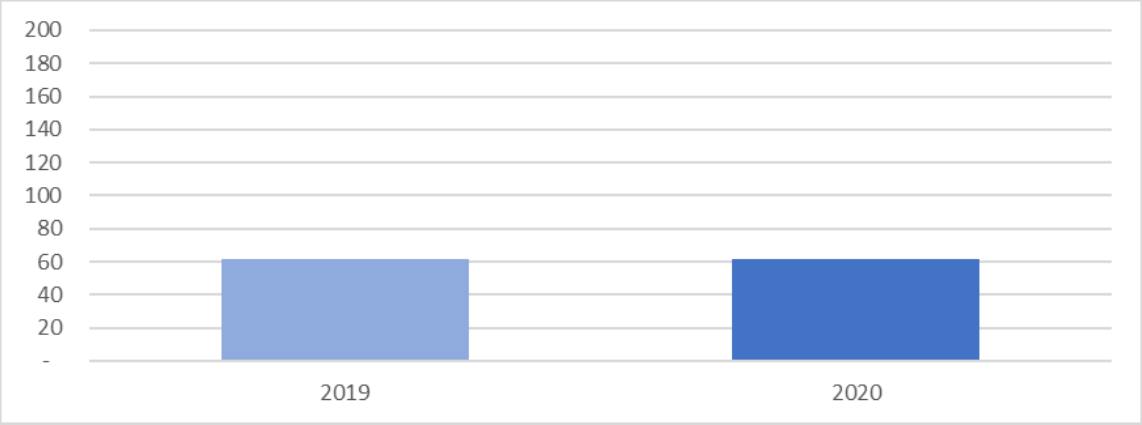
Source: ELFT local data

Draft

City and Hackney – monthly time per case & contact type

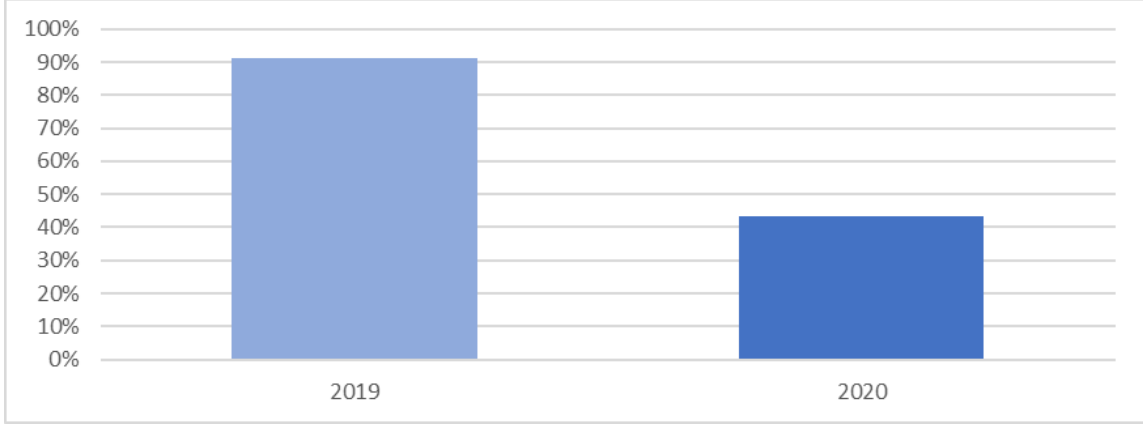
The average contact time per case per month remained constant from 2019 to 2020. Whilst there was a significant reduction in the Crisis pathway, the SPE pathway more than doubled. All pathways saw a reduction in the proportion of time spent in Face-to-Face contacts.

Contact Minutes per Case per Month



Team / Pathway	2019	2020	Change	Trend
CH CAMHS AMHT	121	144	18%	
CH CAMHS AMHT EIS	106	150	41%	
CH CAMHS Conduct Disorder	103	119	16%	
CH CAMHS Crisis	88	32	-64%	
CH CAMHS CWIS		30		
CH CAMHS EBS	79	72	-10%	
CH CAMHS MHST	-	62		
CH CAMHS NDT	49	49	0%	
CH CAMHS PERINATAL	38	45	19%	
CH CAMHS PLT	18	24	29%	
CH CAMHS SPE	20	33	65%	
Overall Average	**61**	**61**	**0%**	

Proportion of Face-to-Face Contact Time



Team / Pathway	2019	2020	Change	Trend
CH CAMHS AMHT	85%	45%	-47%	
CH CAMHS AMHT EIS	92%	36%	-61%	
CH CAMHS Conduct Disorder	94%	39%	-58%	
CH CAMHS Crisis	99%	86%	-13%	
CH CAMHS CWIS		52%		
CH CAMHS EBS	93%	51%	-45%	
CH CAMHS MHST		46%		
CH CAMHS NDT	92%	39%	-57%	
CH CAMHS PERINATAL	95%	34%	-65%	
CH CAMHS PLT	92%	55%	-40%	
CH CAMHS SPE	74%	19%	-74%	
Overall Average	**91%**	**43%**	**-52%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

Source: ELFT local data

City and Hackney Response to COVID-19

Draft

Attain

Service changes

- Created Covid secure rooms to maintain face to face presence.
- Moved to virtual working and use of digital platforms e.g. Attend Anywhere (LD-CAMHS) for digital consultations .
- Multi-agency meetings moved on line. This has had a two fold positive impact. Firstly an increase in the numbers of multi agency meetings to support CYP and secondly improvement in attendance.
- Transformation in schools has been sped up because the pandemic has increased the awareness of mental health.
- Front door team now managing triage and initial treatment where relevant because waiting times are extending as demand has risen.
- LD-CAMHS team realigned resources to manage increased demand. Stopped doing new referrals for child autism / ADHS assessment and parenting interventions.
- LD-CAMHS created a duty system with a clinical member of the team on site every day to manage the referrals where there was significant risk.
- On call introduced to be responsive to families and people with risks and deal with these on a day to day basis.

Demand changes

- CAMHS community demand dropped at first now it is estimated to be 50% higher.
- CAMHS community have more open cases with anxiety around schools closing and reopening.
- Cohort of referrals where the CYP situation is "fraught and unpleasant", for these complex referrals unclear what is the most appropriate mental health intervention.
- In the Covid first wave, schools and social care packages stopped therefore LD-CAMHS CYP lost routine, their communication aids and life markers. As a result saw a huge rise in challenging behaviour and family breakdown. The staff are still dealing with this. Pre Covid saw 1 – 2 / month. In Covid this rose to 30 / month (issues included family breakdown, child in despair, parents near suicide). These cases take half a day per week per case. Normally one person one case.
- COVID pandemic increased the complexity and risks of presenting referrals for the CAMHS disability service.

The content arises from an interview with Roger Davies (C&H Psychological Therapies Lead), Merrisha Gordon (General Manager), Sharon Davies (Assoc. Clinical Director) and Ruth Kossof (Homerton UH)

Attain

Improving health and wellbeing

ICS Crisis and specialist eating disorder services

NELFT crisis service "Interact"

Draft

Mapping of Interact services against the Thrive Framework

iThrive Maturity level 2 within the system. The common language used between services is one of assessment, formulation and treatment. Interact offer mainly assessment and formulation.

Team Name	2018/19 Contacts	2019/20 Contacts	2020/21 Contacts (YTD)	2 - Giving advice	3 - Giving help	4 - Giving more help	5 - Giving risk support	Non-Thrive
INT-BD- INTERACT	766	618	432			20%	80%	
INT-HV- INTERACT	1,411	565	444			20%	80%	
INT-RB- INTERACT	856	582	458			20%	80%	
INT-WF- INTERACT	1,179	583	252			20%	80%	

Assessment of Interact against Thrive principles

Draft

Attain

Principle	Description
Common Language	The iThrive Framework is not used as a common language. Currently, the language of assessment, formulation and treatment is used,. The interact team offer assessment and formulation and some intervention. There is not a clear and agreed understanding around the threshold for crisis.
Needs-Led	The Interact team solely work where there is a need for urgent risk support.
Shared Decision Making	
Proactive Prevention	To improve proactive prevention there needs to be more joined-up offers able to step up and parity across boroughs in terms of community assets . Across Barking, Havering and Redbridge there are staff employed to undertake awareness raising (education and prevention work.
Partnership Working	The crisis team work closely with the CAMHS community team, Brookside (inpatient facility), the home treatment team, the NECL patient flow team and the acute trusts and in particular the emergency department.
Outcome Informed	There are a variety of outcome measures used most are not designed for use in crisis situations . There is a psychologist within the team.
Reducing Stigma	Families do not always want MH involvement. Staff do not always understand when to involve mental health services. There remains education opportunities to improve the understanding of mental health and crisis management.
Accessibility	Three access routes: 1. referral from hospital psychiatric liaison team (provide 2 hr response time to Barts WhipCross and 4 hrs to Kind George and Queens) 2. 5 day follow up support for person discharged from ED with indication of MH issues (where a CYP is known to CAMHS they will pick up the case) and 3 ED diversion; referral to avoid ED admission via a phone line between 9 and 5 M-F Assessment is completed over the phone and follow up made either same day from ED team or next day.

Draft

NELFT Interact – workforce

The Crisis team has a clinical workforce of **8.6 WTEs**. The workforce is made up of 8 WTE Nurses and 0.6 WTE of a Bank Psychologist. Overall there are **4.6 clinical WTEs per 100k population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads, is £1,158K or **£6.13 per child** (5-17).

Role Type / Grade	WTEs
Consultant	1.0
Clinical - 8a	0.6
Clinical - 7	1.0
Clinical - 6	5.0
Clinical - 5	1.0
Total	8.6

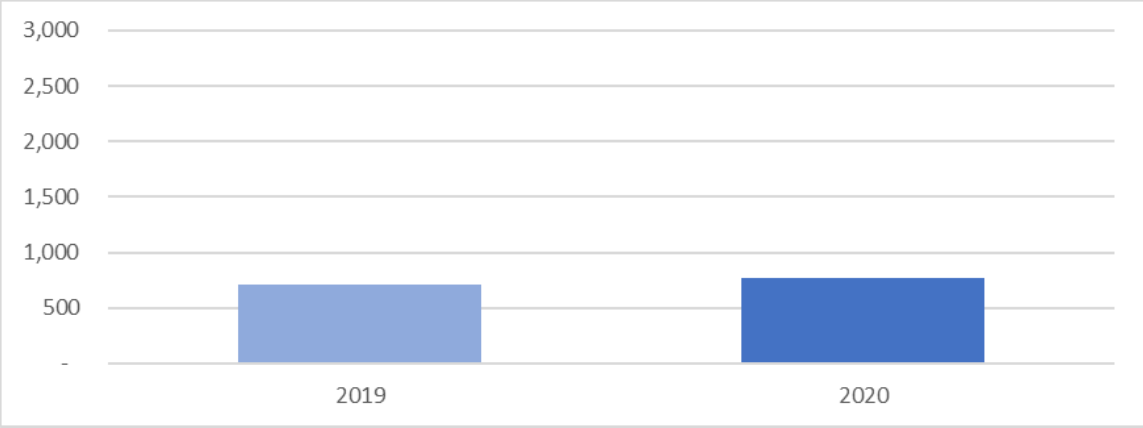
Source: NELFT local data, with manual adjustment via feedback from Melody Williams

Draft

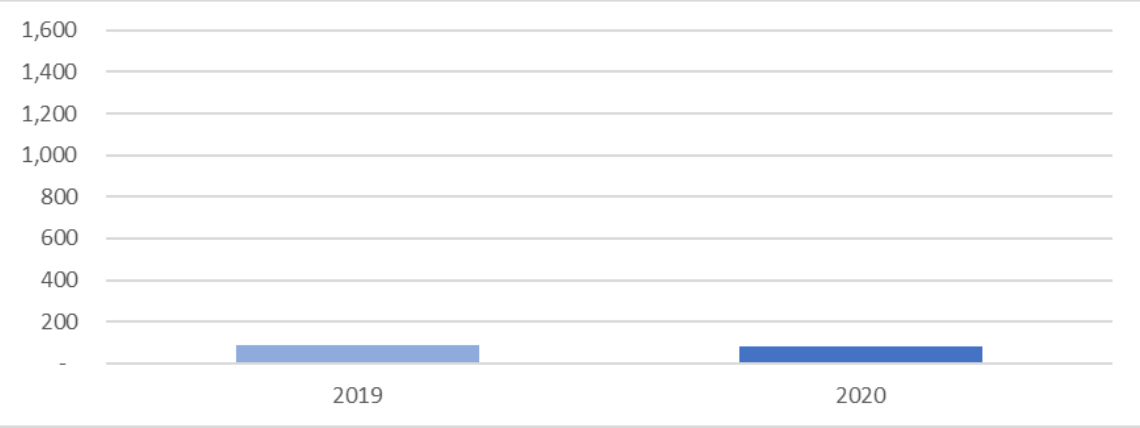
NELFT Interact – referrals and caseload

Between 2019 and 2020, referral numbers increased by 9% overall, although average caseload numbers fell by 6%. There were big variances between Redbridge and Waltham Forest, with the former seeing a significant increase in referrals and caseload, whereas demand appears to fall for Waltham Forest.

New Referrals



Average Live Caseload



Location	2019	2020	Change	Trend
Barking & Dagenham	163	143	-12%	
Havering	160	161	1%	
Redbridge	200	352	76%	
Waltham Forest	185	115	-38%	
Grand Total	**708**	**771**	9%	

Location	2019	2020	Change	Trend
Barking & Dagenham	25	25	3%	
Havering	29	24	-17%	
Redbridge	14	21	48%	
Waltham Forest	17	9	-49%	
Grand Total	**84**	**79**	-6%	

Source: NELFT local data

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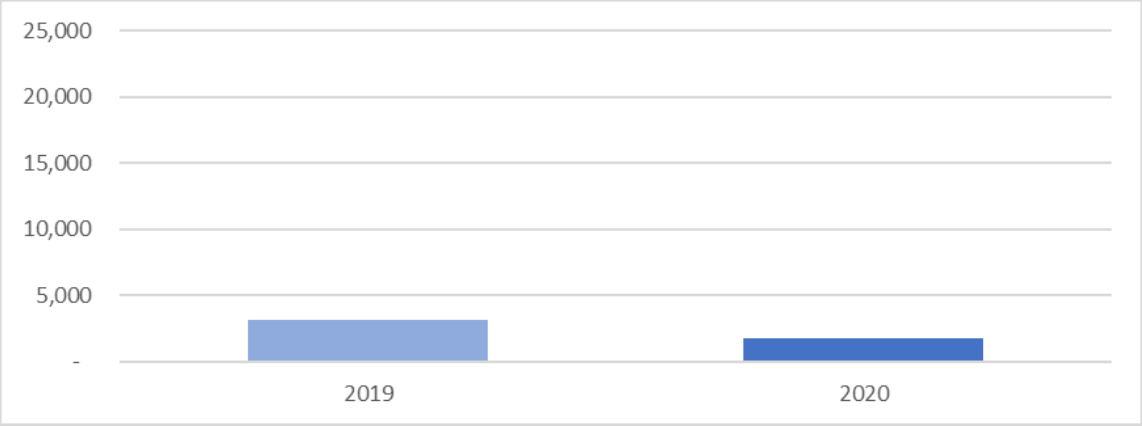
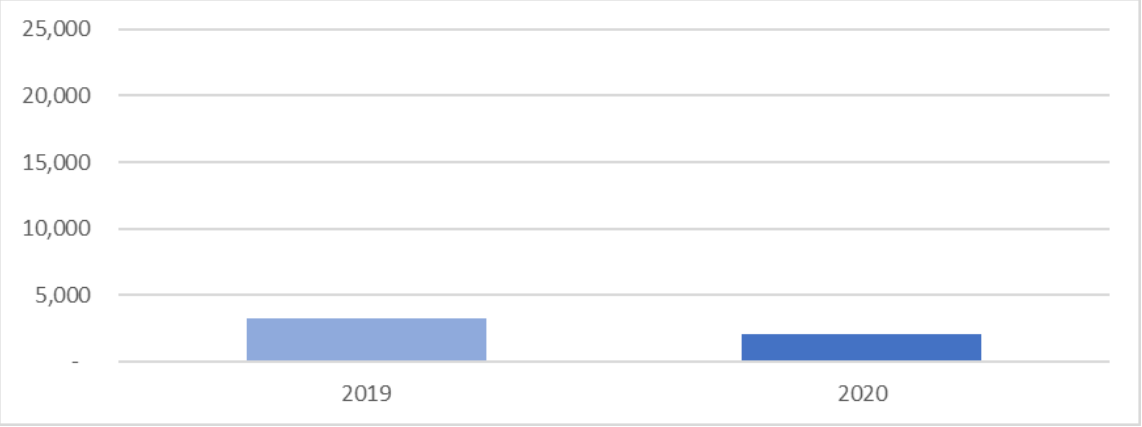
NELFT Interact - contacts

From 2019 to 2020 both numbers of contacts and contact hours fell significantly. Waltham Forest saw the most dramatic drop, with 71% fewer contacts and 67% fewer contact hours.

Contacts



Contact Hours



Location	2019	2020	Change	Trend
Barking & Dagenham	670	476	-29%	
Havering	809	420	-48%	
Redbridge	766	602	-21%	
Waltham Forest	925	271	-71%	
Grand Total	**3,170**	**1,769**	**-44%**	

Location	2019	2020	Change	Trend
Barking & Dagenham	662	510	-23%	
Havering	793	528	-33%	
Redbridge	793	707	-11%	
Waltham Forest	1,003	334	-67%	
Grand Total	**3,251**	**2,078**	**-36%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

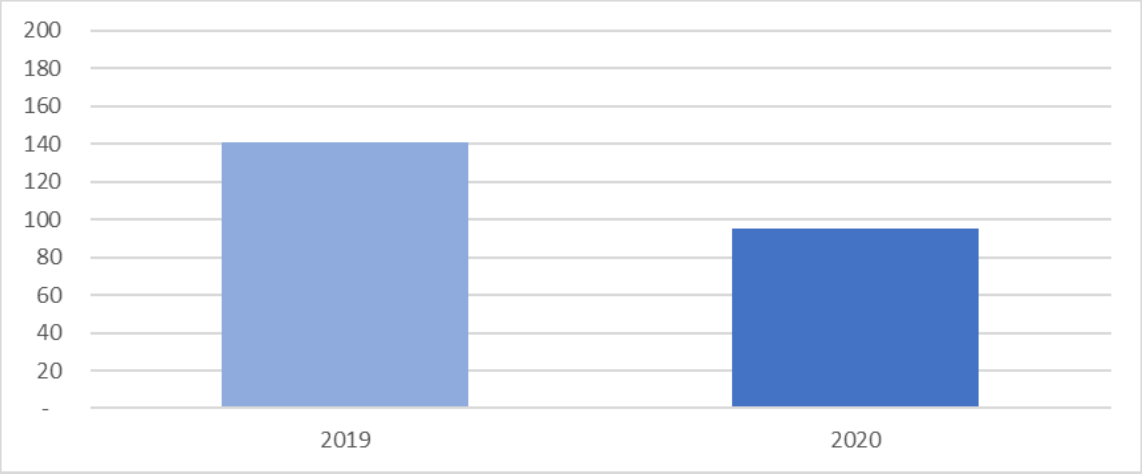
Source: NELFT local data

Draft

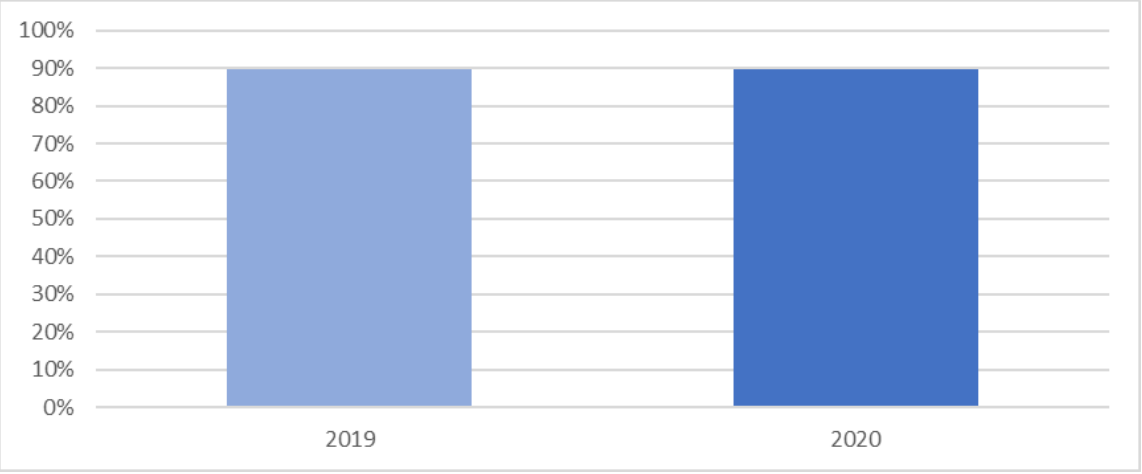
NELFT Interact – monthly time per case & contact type

The average number of contact minutes per case per month fell consistently across all locations, with Redbridge having the largest drop between 2019 and 2020. Time spent in face-to-face contacts remained consistently high at around 90% across all locations.

Contact Minutes per Case per Month



Proportion of Face-to-Face Contact Time



Location	2019	2020	Change	Trend
Barking & Dagenham	135	101	-25%	
Havering	139	111	-20%	
Redbridge	137	83	-40%	
Waltham Forest	150	98	-35%	
Overall Average	**141**	**95**	**-32%**	

Location	2019	2020	Change	Trend
Barking & Dagenham	88%	89%	1%	
Havering	88%	89%	1%	
Redbridge	91%	90%	-1%	
Waltham Forest	91%	90%	-1%	
Overall Average	**90%**	**90%**	**0%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

Source: NELFT local data

NELFT Interact Strengths and Challenges

Draft

Attain

Strengths

Pathway

- Risk management model includes the social, emotional, physical and mental health aspects
- Interact provides consistency and safe containment of a CYP at risk.
- Positive patient experience.

Leadership

- Reactive and calm.
- Team flexibility to ensure patient care is at an optimum.

Digital

- Hospital system can see a flag for when CYP is being supported by community mental health services. Aim to extend to ambulance trust to reduce hospital ambulation.

Challenges

Partnership working

- The Interact team are not involved in the locality case reviews because they cannot support attending 4 different localities although they have a standing invitation.
- Support for getting help in the community has limitations.
- Referrals now almost all from ED only. Almost no referrals from CAMHS.
- There is embedded getting more help in the CAMHs teams however there is not always support for "getting help" in the community.
- When a child is in crisis, family will often require support as well from Culture of registrar / middle grade not discharging leaving this to the liaison service.
- whole system.

Workforce

- Recruitment – for example nurses courses and placements have currently stopped. Working with acute Trusts to support rotation of paediatric nurse with mental health services.
- Looking at different and non traditional incorporating band 4 nurses and AHP roles including SALT.

Digital

- No digital platform.
- The team is behind in writing up their notes onto RIO. Dictating software may offer a way to reduce time to notes digitised.

Draft

Interact response to COVID-19

Service changes

- Interact maintained face to face service and its main focus on helping CYP who need risk support.
- As referrals reduced move resources from the crisis / acute pathway inpatient the unit. When demand increased staff redeployed back to interact.
- Maintained business as usual services and the response times even with the higher volumes of referral from the various ED's.
- Staff deployed into ED as majority of activity presented in ED
- Networks have diminished during the Covid pandemic increasing the demand and service pressures on mental health services.
- During COVID the call line extended 9 – 10pm M-F and 8 – 10 over weekend using psychiatric liaison.

The content arises from an interview with Nicola Upton (service Lead) NELFT Interact team.

Demand changes

- Two years ago the service saw an increase in ED attendances requiring support from the Crisis team that equalled the number of referrals from the CAMHs community team.
- At the commencement of lockdown there was a decline in all referrals.
- Subsequently there has been a large increase in ED referrals. There are now only small referral volumes from the CAMHS community team.
- During COVID cases have been held longer by Interact
- The children and young people (CYP) presenting in ED have more complex issues and include the following cohorts:
    - CYP with complex social difficulties. Many require family interventions. Many are known to service and over 50% need a safe guarding intervention.
    - Increasing ASD presentation.
    - Increasing presentation of eating disorders (50% unknown to service) .
    - Increased over doses with more requiring medical intervention.
    - Groups of children who are encouraging risky behaviour amongst their peers.
    - In Havering the majority if admitted CYP are black British
- Overall it appears the resilience of CYP has dropped in the last lockdown.

NELFT specialist eating disorder service

Assessment of NELFT Eating Disorder services against Thrive

Draft

Attain

Principle	Description
Common Language	The Thrive Framework is not used
Needs-Led	Treatment is NICE concordant FBT CBT and diagnosis specific.
Shared Decision Making	Service users involved in service changes e.g. changes to website and use of non face to face clinics. The service vales relationships with families and CYP and engages with them to agree care plans
Proactive Prevention	The servie work with schools and GPs to provide information, education to raise awareness.
Partnership Working	The service engages well with peers and involved in the healthy London Partnership as well as research teams, CAMHS, primary care schools, GPs and paediatric wards. The team also link with Barts health team
Outcome Informed	Outcome measures for eating disorders for over 14, and the use this at assessment and then every 3 months and at discharge on a needs basis (Recommended treatment – course of a year is approximately 20 sessions)
Reducing Stigma	A lack of awareness continues to exist in the community. There is opportunity for more awareness raising and education.
Accessibility	Access is by referral.

Draft

NELFT Eating Disorder – workforce

The Eating Disorder team covers Adults and Children. The indicative clinical WTEs covering children is **11.9 WTEs**. The workforce is made up of 9.6 WTE Psychologists, Dieticians, Nurses and support roles, plus 1 WTE Consultant Psychiatrist. Overall there are **5.1 clinical WTEs per 100k population of 5 – 17 year olds**. The indicative annual cost of the clinical posts, including non-pay and overheads is £752k, or **£3.98 per child** (5-17).

Role Type / Grade	WTEs
Consultant	0.6
Clinical - 8b	0.8
Clinical - 8a	0.7
Clinical - 7	5.5
Clinical - 6	1.0
Clinical - 4	1.0
Total	9.6

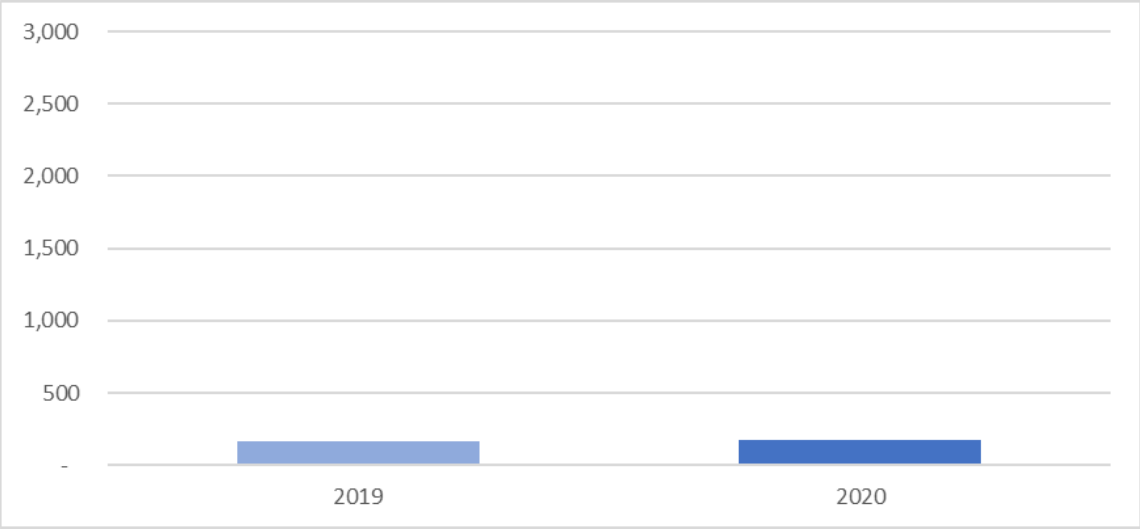
Source: NELFT local data. Costs for NELFT ED were supplied as indicative as they provide a combined adults and children's service.

Draft

NELFT Eating Disorder – referrals and caseload

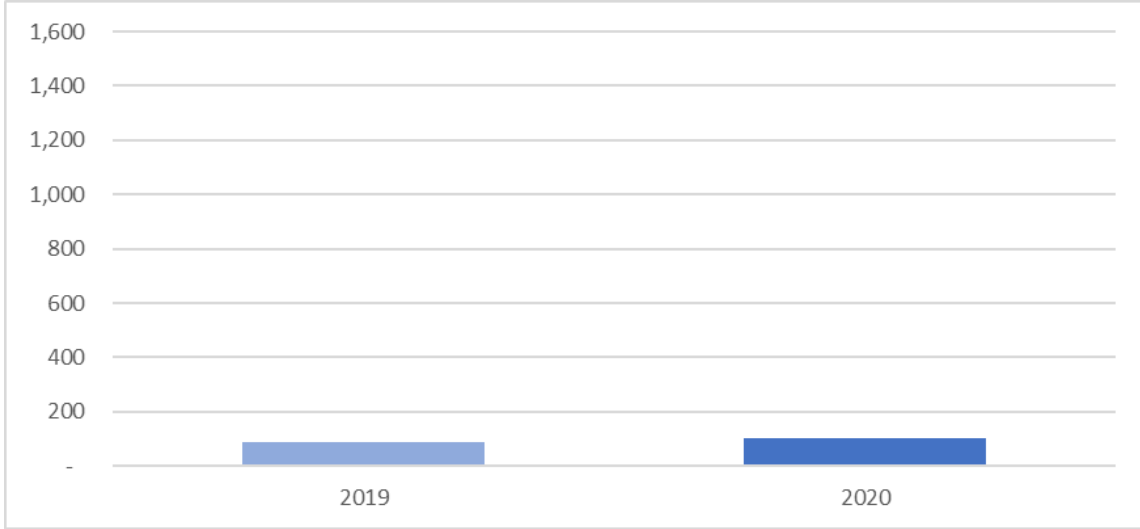
Between 2019 and 2020, referral numbers and average open caseload increased by 38% and 55% respectively.

Referrals



	2019	2020	Change	Trend
New Referrals	169	172	38%	

Average Open Caseload



	2019	2020	Change	Trend
Caseload	90	103	55%	

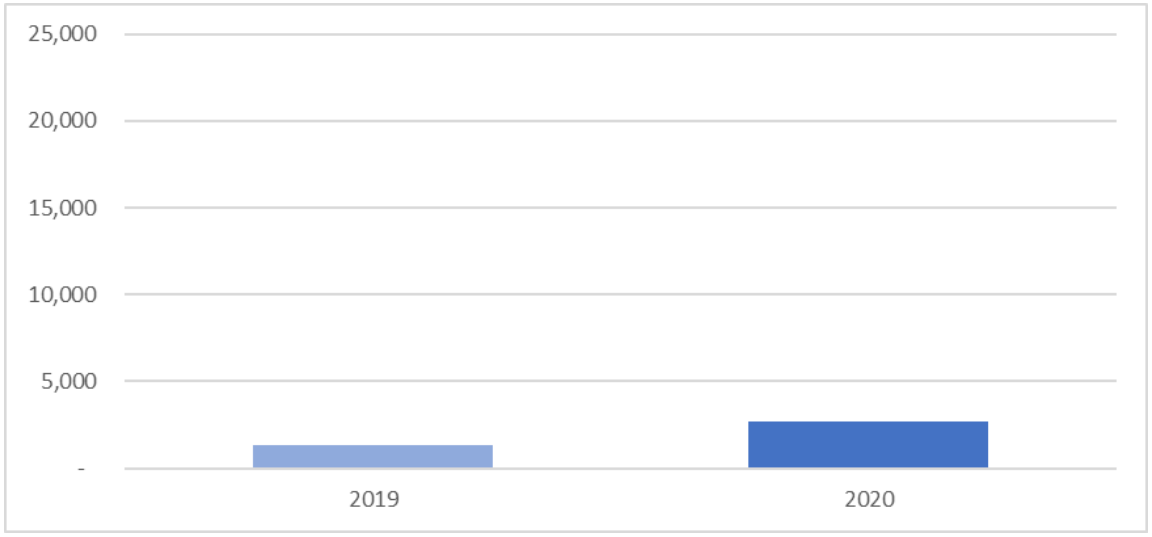
Source: NELFT local data, including manual amends following feedback.
Amends include new referral numbers, with caseload figures adjusted as per the proportional change to amended referral numbers.

Draft

NELFT Eating Disorder - contacts

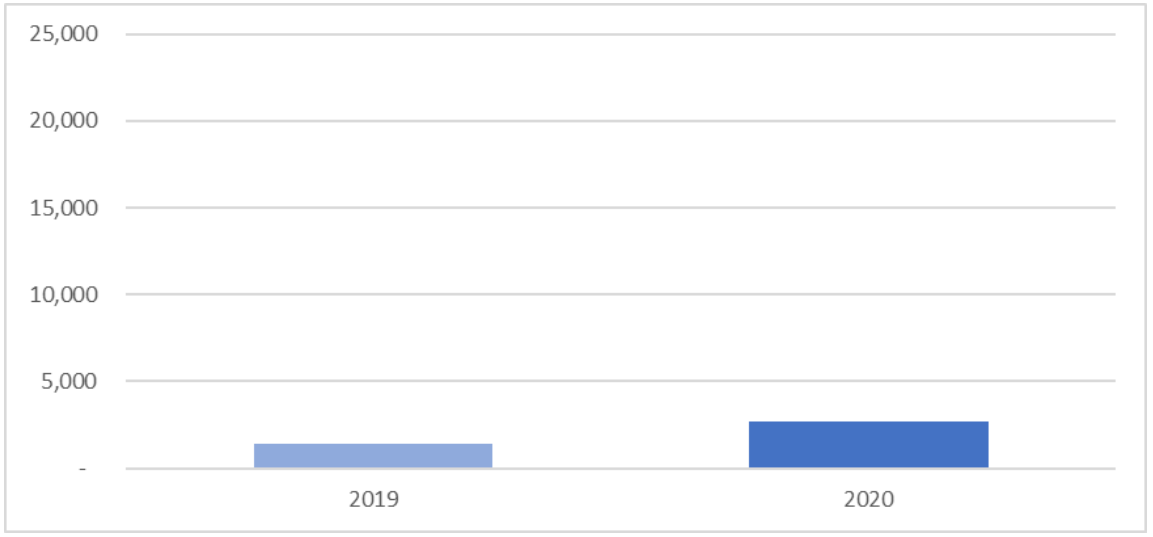
From 2019 to 2020 total both contact numbers and contact hours approximately doubled.

Contacts



	2019	2020	Change	Trend
Contacts	1,322	2,670	102%	

Contact Hours



	2019	2020	Change	Trend
Contact Hours	1,372	2,694	96%	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

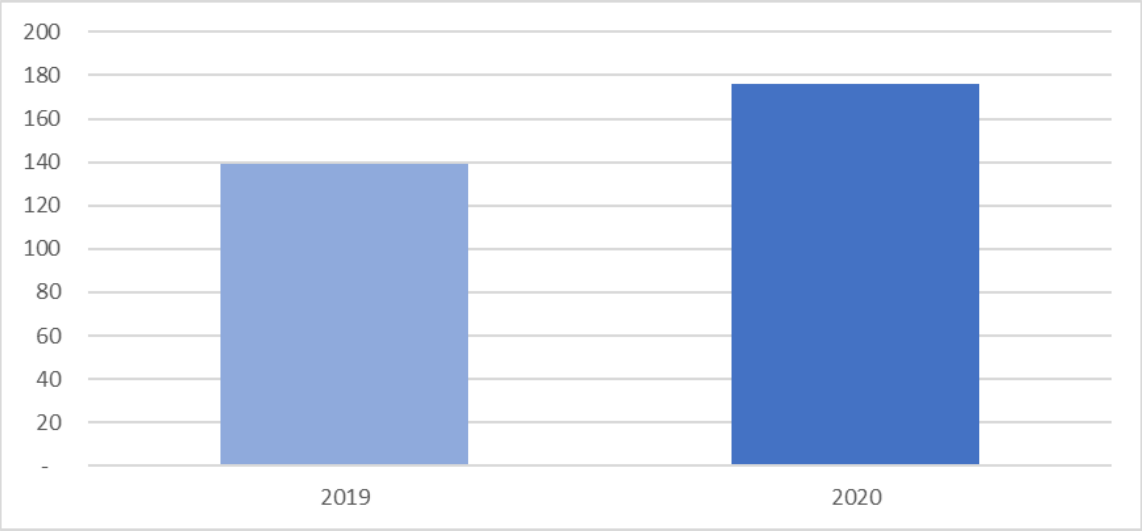
Source: NELFT local data

Draft

NELFT Eating Disorder – monthly time per case & contact type

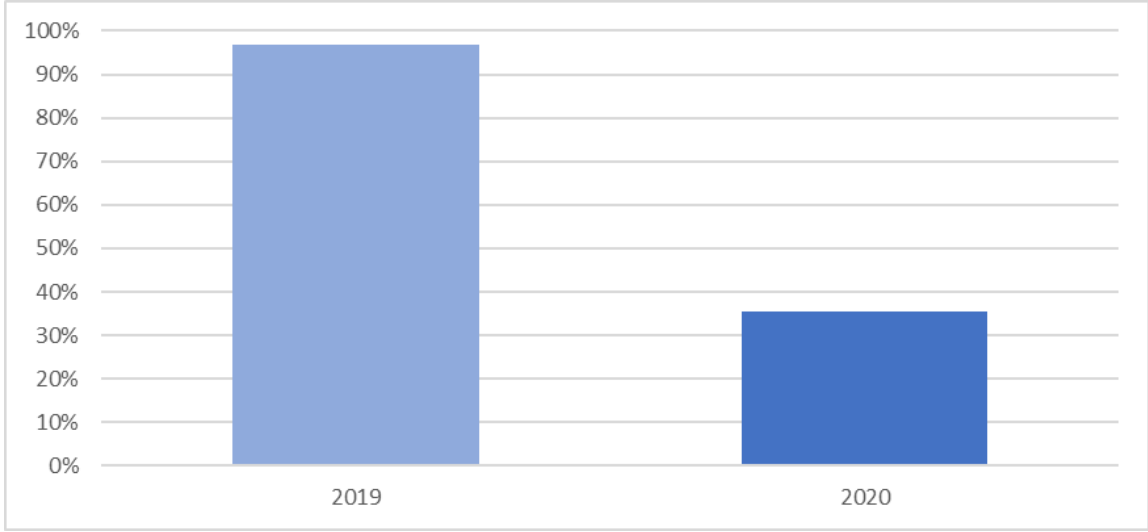
The average contact time per case increased by 37 minutes from 2019 to 2020.
The proportion of face-to-face contact time dropped from 97% to 36%.

Contact Minutes per Case per Month



	2019	2020	Change	Trend
Avg Contact Minutes per Case per Month	139	176	27%	

Proportion of Face-to-Face Contact Time



	2019	2020	Change	Trend
Proportion F2F contact time	97%	36%	-63%	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

Source: NELFT local data

NELFT Eating Disorder specialist service

Draft

Attain

Strengths

Leadership

- Well established and experienced eating disorder service
- Involved in Healthy London Partnership
- The team has been managed and deployed flexibly to best support the CYP referred
- Access to supervision and training even through COVID
- Emphasis on team well being
- Strong research links

Partnerships

- Good relationships with the paediatric inpatient unit
- Eating disorder community is small the team take an active role in this community and sharing ideas and learnings from this community

Access

- Access and assessment all patients due to complexity and risk that may be present.
- .

Challenges

Capacity

- Eating disorder inpatient facility constraints
- Funding gap (existing business case)

Pathway

- No intensive treatment pathway
- Improve the awareness and advice offer
- Balancing and signposting to lower level help

NELFT Eating Disorder Response to COVID-19

Draft

Service changes

- The service was part of a regular meeting sharing experiences and ideas to manage services through Covid.
- The service has had to professionally, personally and culturally find its feet in its response to COVD. Despite this it was quick to mobilise.
- In response to COVID, services that were all face to face for clinics and therapy to a mixed model where at risk patients are given face to face appointments .
- Increased high risk clinics from 2 / week to 3 / week (defined using national guidance)
- Doubled assessment slots in clinics
- Needed to work in a home liaison fashion (not commissioned to provide home liaison) for patients who would normally be admitted into an EDS inpatient bed but due to lack of beds have to be managed in the community.
- Consistently unable to meet access targets (1 week for urgent referrals and 4 weeks for routine).
- Weekly meeting to discuss with peers how to best deploy resources.

Demand changes

- During the COVID pandemic, the number of referrals increased and the acuity and risk-associated increased
- Increased number of clients not suitable for community treatments
- Delays in moving patients along their care pathway because home leave and return could not be easily facilitated due to risks in spreading COVID
- Service users have been deteriorating before treatment can start

The content arises from an interview with Rory Harnett (Head of Service) Jennifer Danby, Salma Suri (Consultant psychiatrist) and Kirsty Sheppard from the NELFT EDS team.

ELFT crisis service

Draft

Mapping of ELFT crisis services against Thrive

The Thrive Framework is not used

Team Name	2018/19 Contacts	2019/20 Contacts	2020/21 Contacts (YTD)	2 - Giving advice	3 - Giving help	4 - Giving more help	5 - Giving risk support	Non-Thrive
CH CAMHS Crisis	27	71	157			50%	50%	
NH CAMHS Crisis	1	31	23			50%	50%	
TH CAMHS Crisis	4	257	251			50%	50%	
TH CAMHS Crisis Community			151			50%	50%	

The crisis service is embedded with the physical emergency departments of Newham, Homerton UH and the Royal London. Staff are on site 0900 – 2100 / 7 days a week.

Referrals can be made by:

- The staff make contact with every referral. They create a collaborative safety and coping plan with the CYP. A flow up is arranged by community team if the CYP is discharge. If they remain an inpatient in the acute hospital the crisis team will maintain contact.
- If the CYP needs an inpatient stay within a specialist MH unit, they will arrange this in conjunction with psychiatry colleagues and the NEL bed management service.

NB: This data is for the Crisis team only, it does not include other crisis activity that might be captured by other teams

Assessment of ELFT crisis response against Thrive principles

Draft

Attain

Principle	Description
Common Language	Thrive is not a common language.
Needs-Led	CYP with complex need involvement from a wide array of support to enable effective discharge and meeting needs.
Shared Decision Making	CYP family safety and coping plans created collaboratively with them and their network. Form template content and design created by service user group. Service user involvement in all interview processes redesigning interview schedule and interview panels – good retention of good quality staff. Service user involvement in all interview processes redesigning interview schedule and interview panels.
Proactive Prevention	The crisis team do undertake some brief interventions where this is possible and necessary. However, the team has no base and are not funded for outreach work three fore this is limited.
Partnership Working	Work in partnership with the locality CAMHS teams to step down a CYP who has presented in ED with MH concerns.
Outcome Informed	Outcome measures have been amended to nationally recognised measures. KPIs are still in development.
Reducing Stigma	There is still stigma with families who do not want mental health services involved and amongst staff. Also there are preconceptions around CYP who are neuro diverse.
Accessibility	Access is based on needing crisis support. This can either be via a crisis phone line when the community team will support or on ED attendance and referral to the crisis team can be made.

Draft

ELFT Crisis – workforce

The Crisis team has a clinical workforce of **12.8 WTEs**. The workforce is made up of 12.3 WTE Nurses and Psychologists, overseen by a part-time consultant (currently vacant). Overall there are **8.8 clinical WTEs per 100k population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads, is £1,200K or **£8.21 per child** (5-17).

Role Type / Grade	WTEs
Consultant	0.5
Clinical - 8b	1.0
Clinical - 8a	1.0
Clinical - 7	9.3
Clinical - 5	1.0
Total	12.8

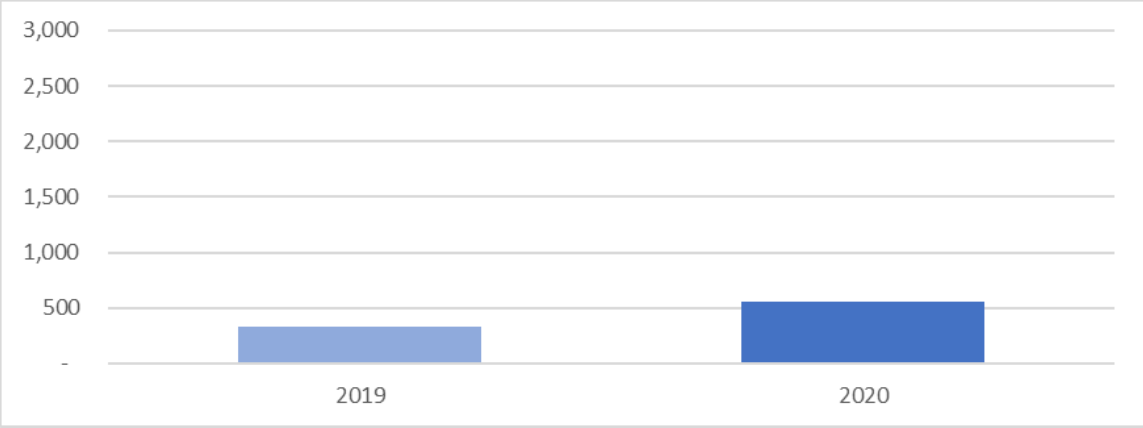
Source: NELFT local data

Draft

ELFT Crisis – referrals and caseload

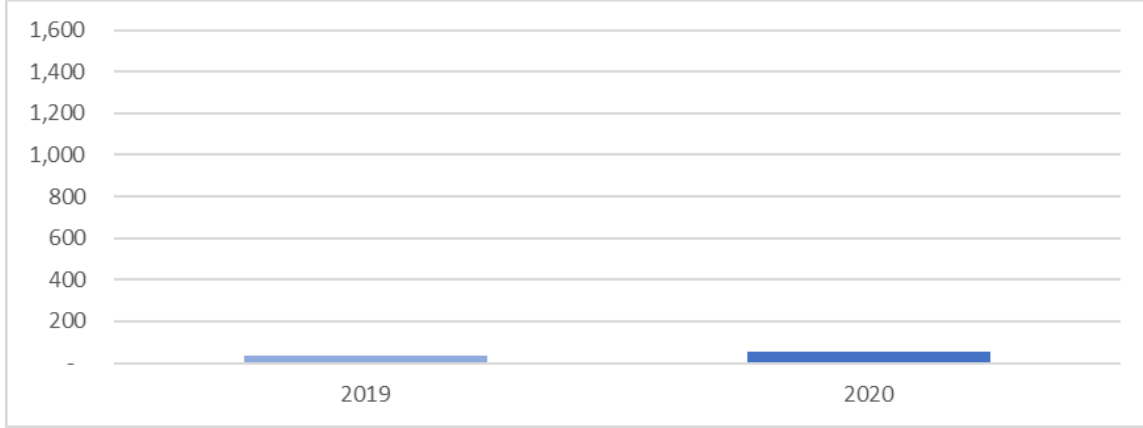
Between 2019 and 2020, referrals rose significantly across all three boroughs, with City & Hackney seeing a 95% increase. Average caseload approximately doubled for Newham and Tower Hamlets, and tripled for City & Hackney.

New Referrals



Location	2019	2020	Change	Trend
City & Hackney	87	170	95%	
Newham	120	184	53%	
Tower Hamlets	129	198	53%	
Grand Total	**336**	**552**	64%	

Average Live Caseload



Location	2019	2020	Change	Trend
City & Hackney	10	31	222%	
Newham	19	36	95%	
Tower Hamlets	8	17	112%	
Grand Total	**36**	**84**	132%	

** There are known data quality issues with Crisis referrals which are being rectified.*

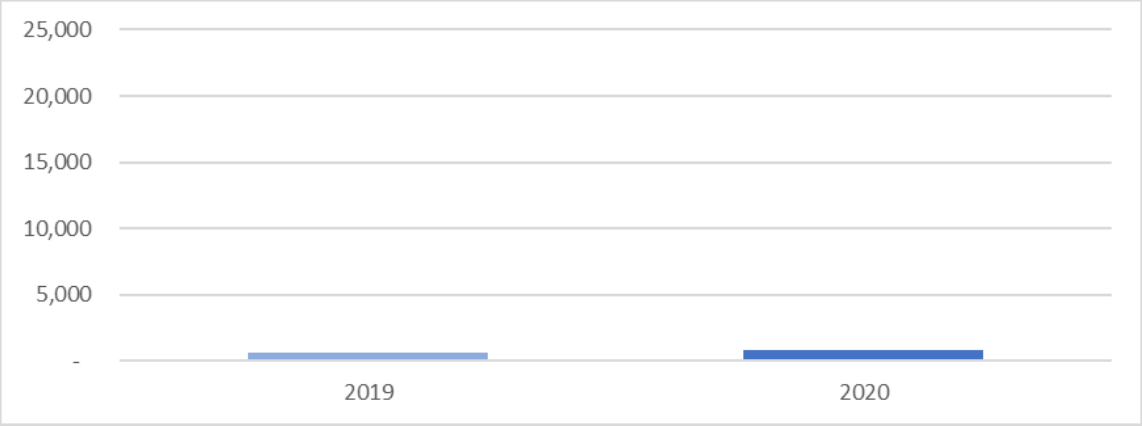
Source: ELFT local data

Draft

ELFT Crisis - contacts

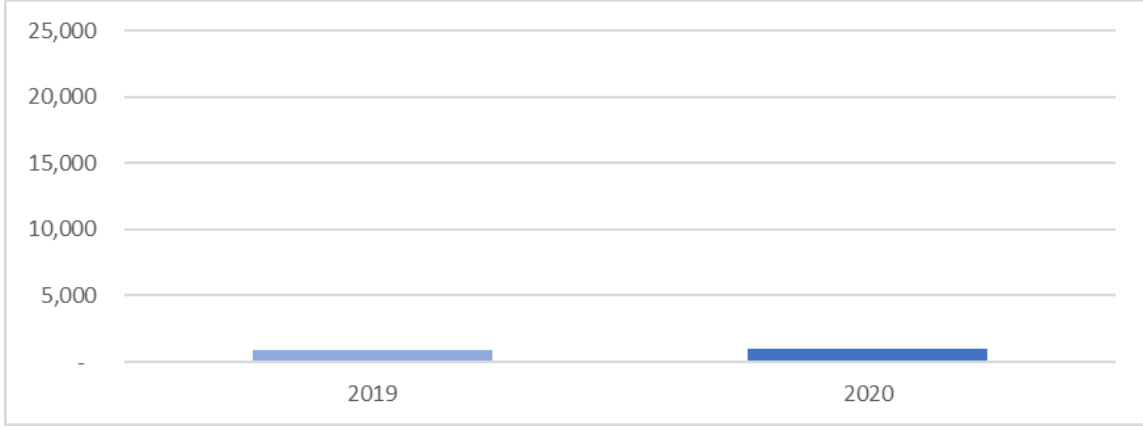
From 2019 to 2020 total contact numbers increased by 20% and contact hours increased by 9% across all locations. Tower Hamlets had the biggest increases, whereas Newham's contacts and contact hours fell.

Contacts



Location	2019	2020	Change	Trend
City & Hackney	123	171	39%	
Newham	316	191	-40%	
Tower Hamlets	245	458	87%	
Grand Total	**684**	**820**	**20%**	

Contact Hours



Location	2019	2020	Change	Trend
City & Hackney	169	197	16%	
Newham	431	306	-29%	
Tower Hamlets	321	503	57%	
Grand Total	**921**	**1,006**	**9%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

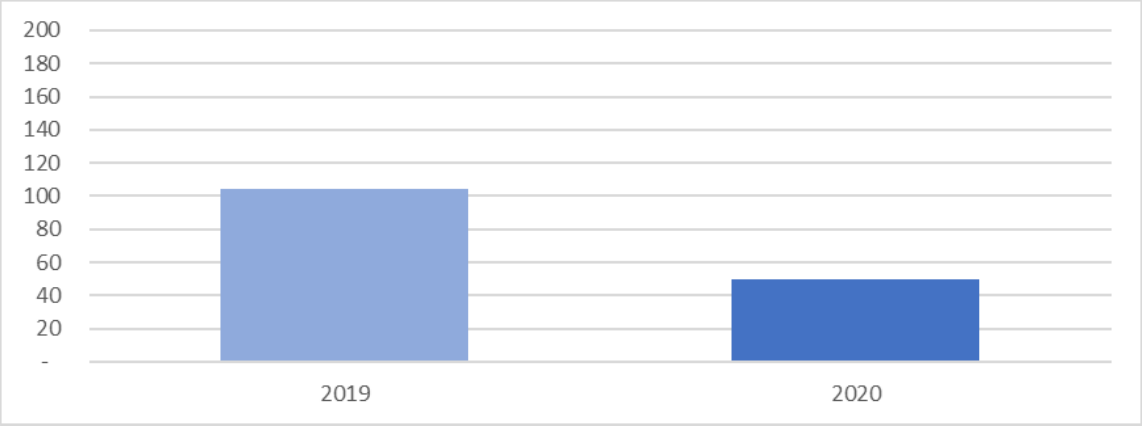
Source: ELFT local data

Draft

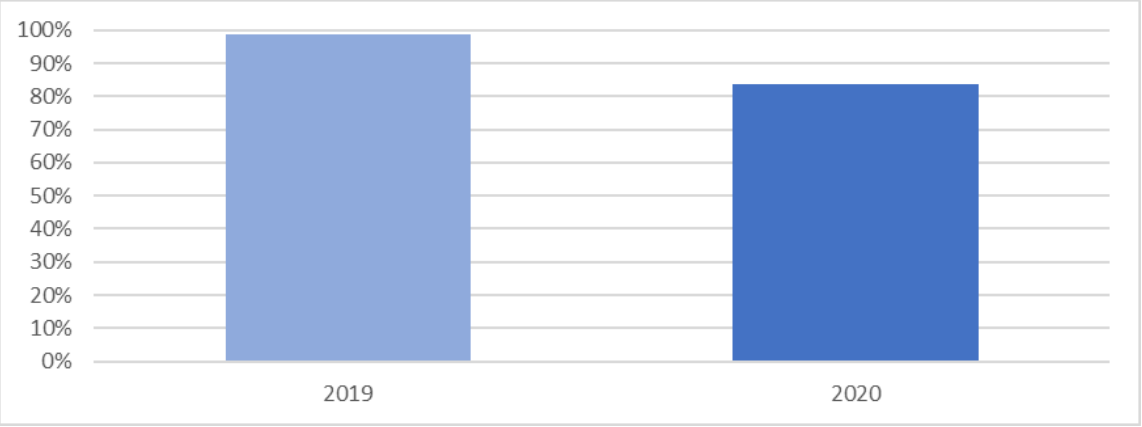
ELFT Crisis – monthly time per case & contact type

The average contact time per case decreased across all locations from 2019 to 2020, with City & Hackney's and Newham's falling by the most. The proportion of face-to-face contact time also fell by an average of 15%, dropping to 84% in 2020.

Contact Minutes per Case per Month



Proportion of Face-to-Face Contact Time



Location	2019	2020	Change	Trend
City & Hackney	88	32	-64%	
Newham	115	42	-64%	
Tower Hamlets	102	76	-26%	
Overall Average	**105**	**50**	**-52%**	

Location	2019	2020	Change	Trend
City & Hackney	99%	86%	-13%	
Newham	99%	85%	-14%	
Tower Hamlets	99%	82%	-17%	
Overall Average	**99%**	**84%**	**-15%**	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

Source: ELFT local data

ELFT crisis response Strengths and Challenges

Draft

Strengths

Capacity and demand

- There is always a person with CAMHS training on site at the hospitals. This could be the crisis team or trained middle grade doctors out of hours.

Leadership

- Great support from the Trust to set up new service.
- Flexibility to try new ways: planning to spilt one nurse across 3 x hospitals starting shift wherever there is a referral and then move as needed to provide cover. Given authority to try and track demand and activity.
- Aspiration to develop and expand the team.

Digital

- PANDO; a secure phone app through which conversations, photos and patient information can be shared (used widely in ELFT)
- Video MDT meetings to facilitate discharge to be more likely to get all agencies / professionals involved.

Challenges

Access

- For CYP in the community, they can call a crisis line and speak to a crisis call handler. The relevant CAMHS team will be contacted to respond (within 60 min) , if the CYP has or likely to harm themselves or others; police and an ambulance will be called.
- Developing access via 111. No SOP in place yet but have begun to expand service to midnight 7 days a week.
- If a CYP arrives at the hospital outside the CYP MH crisis team they will be seen by an all-age mental health practitioner.
- Issues with inpatient tier-4 bed capacity.

Pathways

- The crisis team are not funded for outreach.
- Addressing issues before they are at crisis.
- After MH crisis episode; social care support is difficult to access. CAMHS crisis employed a Social Care worker in Newham embedded in the team until March 2022, with a 50 /50 cost split.

Digital

- The team is paper-based because they are mobile with no permanent base.
- Shared care record exists but is not comprehensive. Importantly it does not include progress notes.
- Acute EPR log ins provided but need refresh every month.

Workforce

- There is a risk of exhaustion and burn out.
- The team is small and 1 member being on long term sick has affected capacity significantly

ELFT crisis response to COVID-19

Draft

Service changes

- The service is very new (Pilot Nov 2018)and when COVID happened it was just at the of pilot period as the service became permanent from 1 April 2020.
- The service was still in the process of refining model and getting staff recruited as Covid hit.
- Additional funding made available to improve the service by
    1. Increasing hours
    2. Changing banding and
    3. Introducing the crisis line call back service
- Hospitals wanted diverts from ED with mental health support to reduce unnecessary attendance due to COVID risk. Very few CYP were suitable (either violent, risk self harm or need medical intervention). With the hub far away the CYP were fed up and far from home. Now the team prefer to see them where they are which can reduce total journeys

The content arises from an interview with Ruth Woolhouse and interview with Marie Trueman-abel, Philip Williams and Matthew Richardson.

Demand changes

- Service has seen a consistent doubling of referral numbers
- Dip at first lockdown for week or 2 then picked up since.
- Breakdown seeing:
    - People who have not been seen by CAMHS or other services previously and presenting with significant problems
    - More children with 1st episode psychosis who had symptoms bubbling no one knew about or there was sufficient support to manage
    - More neurodiverse children gone into crisis due to regular support – this cohort have horrible time in ED.
    - Children with eating disorders can get ill if their restart to feeding is not carefully managed – COVID has increased this risk
    - More violent methods of self harm – horrible injuries from jumping from heights, ligatures, throwing from trains. Previously more over-doses.
    - Demographics got younger youngest child 8 – mean age 15. Before youngest 11 -12 mean 16-17
    - Increasing number of boys. Overall girls still are the largest group
    - Disproportionate number of trans children being seen
    - Increase in presentation of children with British Asian heritage: British Indian, British Pakistani, British Bangladeshi
    - Lots of minority ethnic backgrounds have cited racism and social exclusion as factor for their presentation
    - In Hackney the ultra orthodox (20% of population) have very small numbers presenting
    - Some anecdotal evidence that more black boys are being seen in crisis, other groups hard to reach on follow up – not great to pick up language barriers,

ELFT specialist eating disorder service

Draft

Assessment of ELFT Eating disorder services against Thrive principles

Attain

Principle	Description
Common Language	Thrive is not used.
Needs-Led	The holistic model used treats the CYP's eating disorder and underlying issues using a physical and mental health approach and involving wider agencies.
Shared Decision Making	The CYP referred discussed by MDT if taken forward, bloods, ECG and physical measures taken. CYP met for assessment. MDT discuss data and agree plan, this is fed back to the CYP and family.
Proactive Prevention	It is recognised there is more proactive work that can be undertaken. The service is engaging with the national charity BEAT to work in the patch.
Partnership Working	The service has close liaison with schools.
Outcome Informed	
Reducing Stigma	There remains a gap in understanding eating disorders in society. There are communities where less than expected referrals originate e.g. Somali. Also there can be a lack of understanding by some professionals because there are differences in how people present from some backgrounds for example the Bengalese community.
Accessibility	Referrals can be from professionals or self referred.

Draft

ELFT Eating Disorder – workforce

The Eating Disorder team has a clinical workforce of **10 WTEs**. The workforce is made up of 9 WTE Psychologists, Therapists and Nurses, plus a Consultant Psychiatrist. Overall there are **6.9 clinical WTEs per 100k population of 5 – 17 year olds**. The annual cost of the clinical posts, including non-pay and overheads is £917k, or **£6.27 per child** (5-17).

Role Type / Grade	WTEs
Consultant	1.0
Clinical - 8	2.1
Clinical - 7	3.0
Clinical - 6	1.0
Clinical - 5	1.0
Unspecified	2.0
Total	10.1

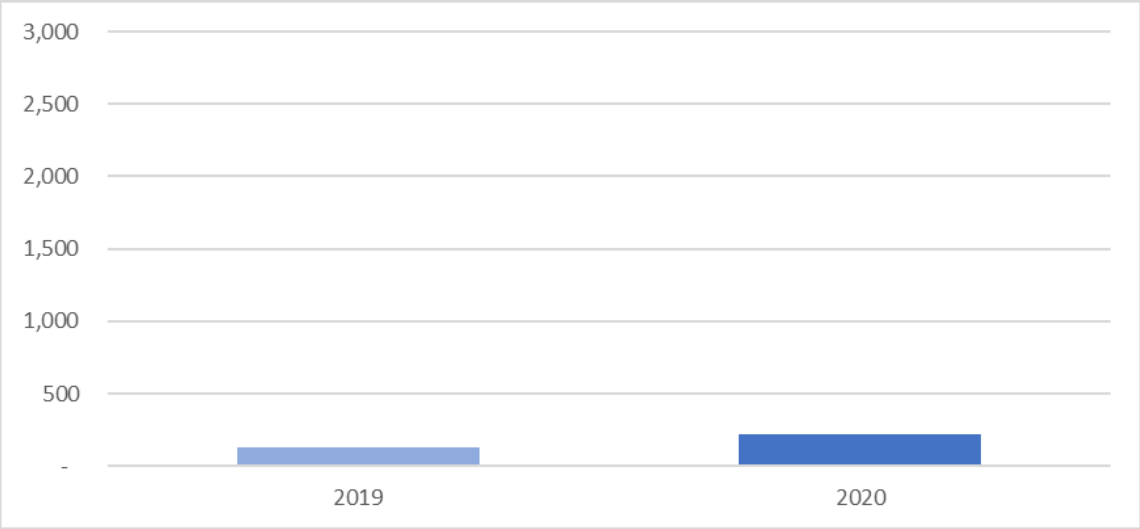
Source: NELFT local data

Draft

ELFT Eating Disorder – referrals and caseload

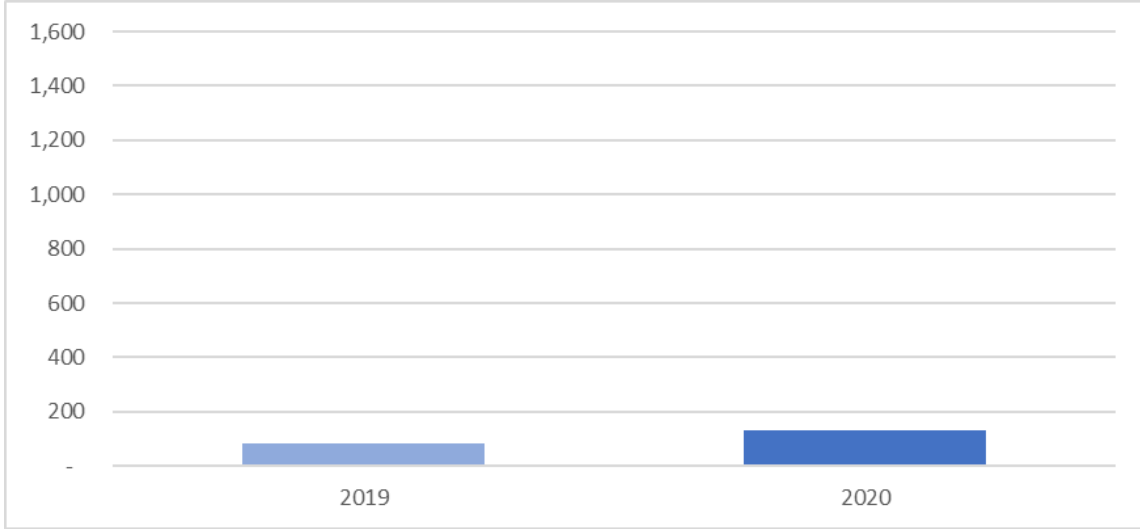
Between 2019 and 2020, average open caseload and new referral numbers increased by between 60 and 70%.

Referrals



	2019	2020	Change	Trend
New Referrals	130	220	69%	

Average Open Caseload



	2019	2020	Change	Trend
Caseload	83	133	60%	

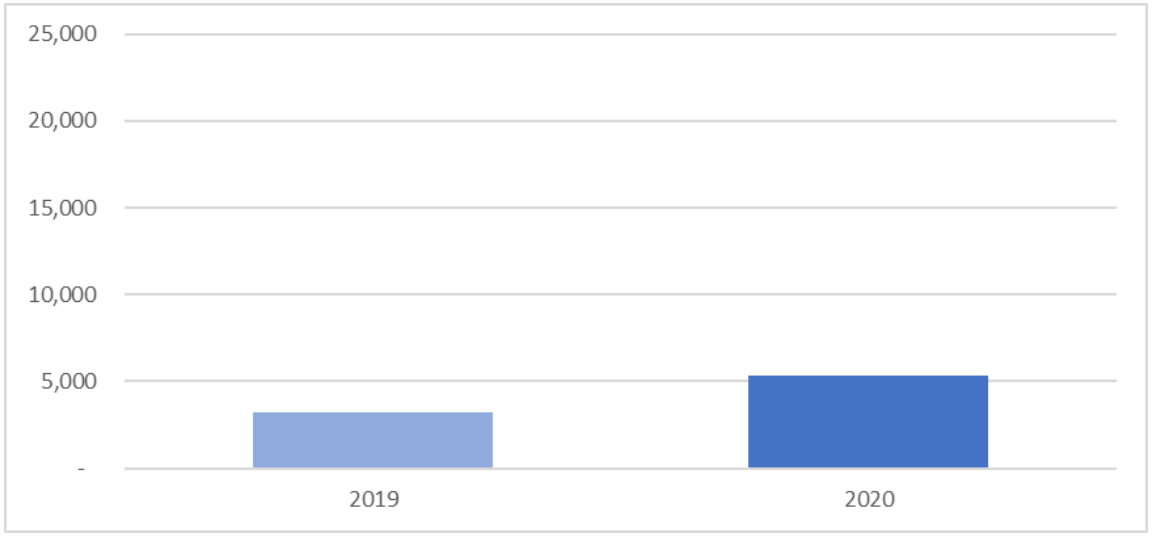
Source: ELFT local data

Draft

ELFT Eating Disorder - contacts

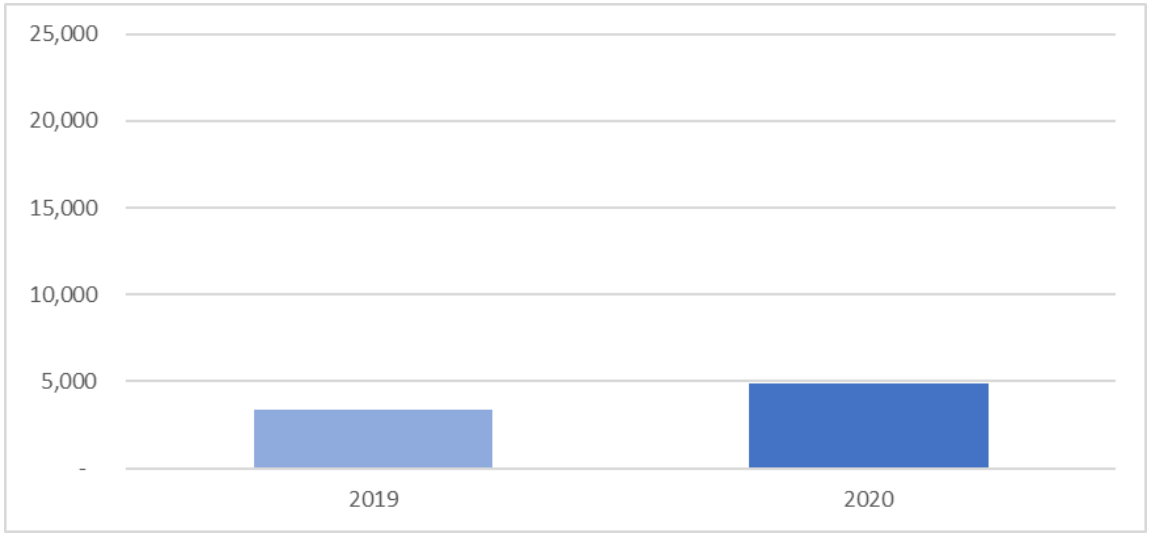
From 2019 to 2020 total contact numbers increased by 67% and contact hours increased by 46%.

Contacts



	2019	2020	Change	Trend
Contacts	3,211	5,350	67%	

Contact Hours



	2019	2020	Change	Trend
Contact Hours	3,361	4,900	46%	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

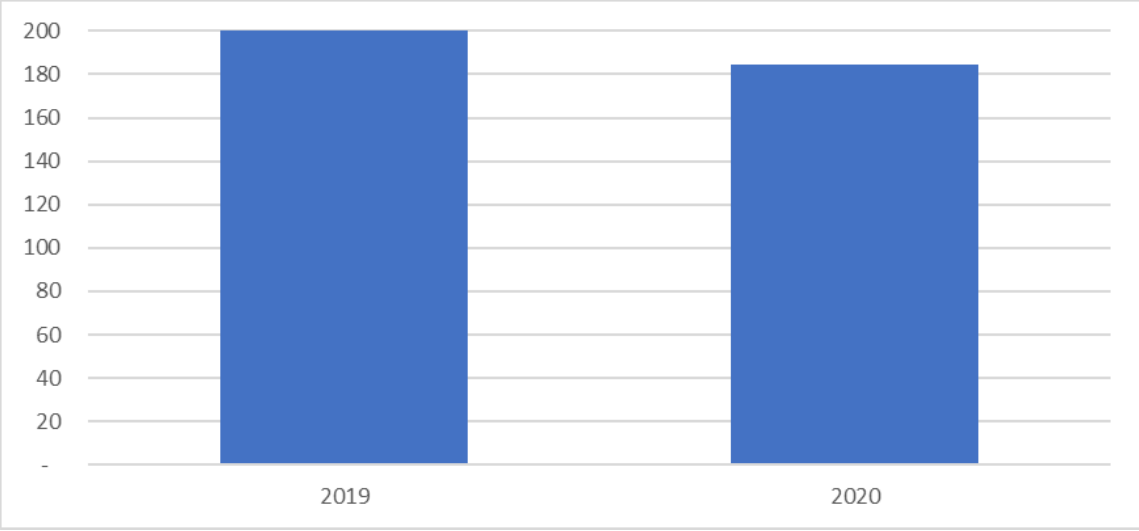
Source: ELFT local data

Draft

ELFT Eating Disorder – monthly time per case & contact type

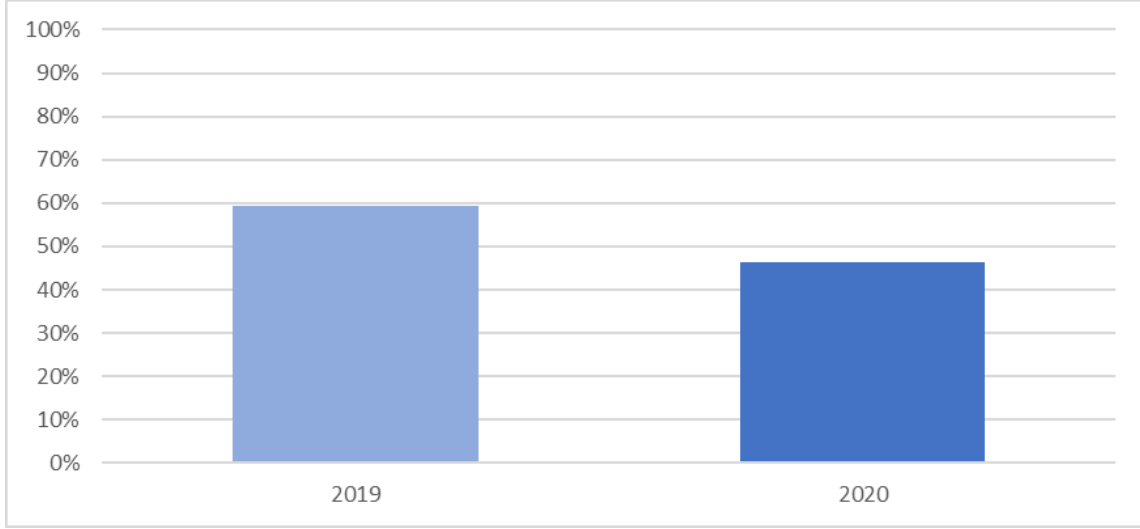
The average contact time per case decreased by 17 minutes from 2019 to 2020.
The proportion of face-to-face contact time decreased from 59% to 46%.

Contact Minutes per Case per Month



	2019	2020	Change	Trend
Avg Contact Minutes per Case per Month	202	185	-9%	

Proportion of Face-to-Face Contact Time



	2019	2020	Change	Trend
Proportion F2F contact time	59%	46%	-22%	

** Contact data includes all contact types: direct, indirect, face-to-face and non-face-to-face*

Source: ELFT local data

ELFT Eating Disorder specialist service

Draft

Strengths

Leadership

There is strong leadership present that ensures the resources are mobilised to deliver the best possible care. The leader is concerned for the well being of her team that is clearly working significantly more in 2020. The time to undertake leadership activity is possibly underestimated.

Partnership

- BEAT (eating disorder charity). Planning to work with BEAT in every locality and spot purchase the SOLACE programme (parent peer group programme).
- Close working with paediatric colleagues , schools / education, social care (MASH safeguarding).
- Able to use short paediatric admission to manage physical risk.

Pathway

- When the CYP is stable and functioning , the team use a holistic model of care based on Prof Janet Treasure model (SLAM) to treat associated comorbidities. This model involves physical and mental health. The team will work in an MDT alongside psychiatrists, dieticians paediatric nurses and mental health care practitioners.

Access

- Referrals via CAMHS works well particularly in Hackney.

Challenges

Capacity and demand

- The service is meeting access standards although demand is very challenging for the service capacity. This has been escalated to the providers risk register.

Workforce

- Very small team and the team remains under resources in nursing and psychiatry.
- Risk of burn out; noticed staff working extended hours.
- High staff turnover
- Issues recruiting into Newham.
- Duty phone line has been affected due to staff sickness.
- Delays in getting hours recognised e.g. increasing specialist eating disorder psychiatrist.
- Creating incentives for staff so they commit to the service.

Pathway

- Risk that a holistic model of care cannot be continued. This approach establishes the person-specific maintaining factors to help the CYP stay well.

ELFT Eating Disorder Response to COVID-19

Draft

Attain

Service changes

- The increase in demand has had an impact on the throughput of cases and the team's ability to contain and to manage a caseload.
- Regular and active caseload management including Red, Amber, Green and Blue ratings
- Introduced daily duty huddle
- Employed a paediatric nurse (but lost some staff)
- Moving to a digital platform has increased parents' accessing parent group to create worthwhile discussions and also helped students access services without anxiety of missing school.
- Hospital at home supported by children's community nursing team
- Developed an intensive pathway for eating disorders based on published literature and peer experiences. Early feedback illustrate benefits bit there are issues to address.

Demand changes

- Referrals have increased.
- Complexity and acuity of referrals have increased.
- The level of self harm has increased.
- The main presentation in Covid has changed. CYP are presenting late due to a fear to leave the house and travel. Therefore there can be a 10 month history of the disorder but a fear of not wanting to be admitted.
- There has been a need to support high risk patients in the community, this has been facilitated using the MARSIPAN checklist and approach used across all three hospitals in the path.
- Demand changes have further stretched limited resources ; the risk of high demand and stress on the team has been flagged and has been entered onto the ELFT corporate risk register.

The content arises from an interview with Erica Cini (Clinical psychiatrist)

Attain

Kooth

Overview of Kooth

About Kooth

- Kooth PLC is a digital mental health and wellbeing company working that aims to provide "*a welcoming space for digital mental health care, available to all*"
- Kooth provides services across each borough in NEL
- Kooth's services are in all London borough's except Ealing and Hounslow which are both currently tendering for digital mental health support
- The service model relies on service promotion by partners within a locality e.g. MHSTs, GPs to generate awareness and traffic onto it's platform
- Kooth provides free, anonymous advice and support for those waiting service support or those who do not access services for support
- Kooth can dial up and down the resources across the patch to meet demand
- https://www.kooth.com/

Kooth services

- Evidence-based tools and approach
- Services include:
- One to one advice via telephone or chat
- Professionally-moderated discussion boards
- Group webinars, staff training, events, workshops and school assemblies
- Daily journaling resource

Draft

Assessment of Kooth against Thrive principles

Principle	Description
Common Language	Across Kooth the maturity level is 3.
Needs-Led	Kooth meets the needing help category of The Thrive Framework.
Shared Decision Making	The Participation team through engagement identify what is working well on the site. Recently, self-care activities have stimulated seen to be accessed and generate conversation. These (prevention) activities are being increased. Podcasts (idea length 20 – 30 min) are a well used resource e.g. "Living as a queer young person in London) and podcasts talking about issues during self harm awareness week. Kooth uses coproduction accessing local groups and also Ambassadors (recently restarted Ambassador programme that was on hold due to Covid) to promote, listen and feedback.
Proactive Prevention	Kooth is an early prevention service. It provides evidence-based tools to support emotional regulation. CYP can access a Kooth Journal and a goal setting platform. These tools can be used with and without support and rate Kooth services
Partnership Working	Kooth engages with partners for the purpose of raising awareness about the Kooth "offer " and to refer CYP to if they need more specific advice or need help. It has links to social care, police (both the MET and the operational alliance – NE4 and hate crime division), Big issue (Wlatham Forest) and a street based gang prevention service. The Participation Team work with young People to ensure Kooth provides services that meet CYP needs and resources they want to access.
Outcome Informed	Outcome measures are measured by Kooth. The service is embarking on measuring and monitoring using The Thrive Framework. Within the team are researchers and data - scientists
Reducing Stigma	Digital enables access to some additional groups but can be a barrier . The Participation Team aim to ensure the Kooth approach builds confidence in CYP to access services and when they require specialist-services they can do so via Kooth, a door they are comfortable with. CYP involved in a gang culture are still a hard to reach
Accessibility	The service is anonymous and free to access. It provides support to people who do not meet criteria for CAMHS or specialist services. There is good access by BAME CYP. The service can access some hard to reach groups, although it is not a panacea. 80% of YP return to the platform

Kooth Strengths and Challenges

Draft

Strengths

Partnership and integration

- Strong partnership working to promote Kooth particularly in Barking Redbridge and Havering.
- Co production; at a Kooth-Ambassador-led event pre Covid, 70 + CYP attended an event to feedback about what will hep them to feel comfortable to access services.
- There is a mature contracting relationship between commissioners and Kooth. Kooth regional managers meet with commissioner every 3 months to discuss trends, impact, arising needs and what resources could possibly shift to meet those.
- Opportunities to expand collaboration on social media platforms using influencers to access different groups and raise the profile of MH

Workforce

- BACP counsellors

Resources

- Evidence-based self-care activities (prevention) activities have increased.
- Podcasts are a well used resource by CYP.

Challenges

Access

- The platform and counselling resources are only provided in English and Welsh. The Pakistani and Indian CYP communities coming onto the platform have no language barrier. The barrier is seen in Eastern European and Southern Europeans group.
- Opportunity for improvements to better meet the needs of SEN. There are CYP who cannot sign up for an account on their own.
- Reduce reliance on text-based material, increasing multi-media, enabling more text to speech
- Access from the following sources in order: schools / GPs / CAMHS / Google. Google is seen as an issue because it also surfaces many pages that are not helpful along with the relevant page.

Resources

- Relevance and currency; staying up to date with what is going on in each borough .

Kooth response to COVID-19

Draft

Attain

Service changes

- Kooth service model did not change although resources were 'flexed' across the system.

Demand changes

The following are topics that are trending across the Kooth platform:

- Anxiety and stress
- Increasing interest in eating disorder
- Increase in suicidal thoughts– seen across England too

On live NEL specific forums

- Rise in domestic violence at the pandemic that has stabilised
- Impact on lived in environment and the concerns of the advancing " gentrification bubble"
- Doing university work at home – accessing resources and a quiet, private space
- about ow to get own space
- Less talk on drugs and alcohol
- Across NEL a LGBTQ event held and has created a big discussion on Kooth platform on the processes of coming out and how this has changed during the pandemic

The content reflected from Kooth in this report are from Kooth team member Tristyn Eddings, referred to this project by Mark Scott

Attain

Improving health and wellbeing

9. Recommendations

Recommendations 1

Funding of CAMHS teams varies across the ICS. This is impacting access and care provision

The CAMHS community services are stretched and caseloads are increasing in all teams. The investment across NCL has significant variance that is not related to demand. The investment is impacting on access and care. In BHR where the investment per new referral across borough teams is the lowest and contacts shortest. In BHR concerns for staff wellbeing were voiced. As well as BHR having smaller CAMHS community teams, the interviews indicated that the BHR localities had less community assets to support lower-level need.

Recommendations

1. ICS-level review of total all age investment (commissioner (CCG and LA), Lottery and other sources) and how that funding has been deployed by providers to identify best strategies to increase access to resources for CYP.
2. Share the different workforce models being employed across the ICS
3. If additional finance is made available, the most expedient approach to provide increased resource is considered to invest in proactive prevention capacity (inc schools) that can also be used to step CYP down into.

Eating Disorder services are particularly pressurised. The demand for specialist eating disorder services has in increased between 2% and 69%. This concern was echoed within the Eating Disorder teams where the demand has put the Eating Disorder teams into a critical position. It was reported that there are concerns about staff well being and staff working excessive hours.

Recommendation

1. Urgently review investment and workforce within the eating disorder teams
2. Share learnings between the teams of how they responded to the Covid pandemic
3. Fund an Intensive Pathway for Eating Disorders for both NELFT and ELFT

Recommendations 2

Managing CYP in crisis

Referrals to the crisis teams have risen between 9% and 16%. The teams have responded to additional workload by reducing the contact time by almost a third between 2019 and 2020 to between 73 min (ELFT) and 95 min (NELFT). Acute providers all reported via a focus group that they typically have 2 – 3 CYP inpatients with mental health issues.

Recommendations

1. Acute Trusts should consider how a Young Person in emergency department / inpatient could be cared for in a separate side room facility to manage the risk to themselves and others
2. Increase the uptake of training across, nursing and security workforce in acute hospitals
3. Provide training on de-escalation to staff within acute providers
4. Review how staff in acute settings can rapidly access specific and personalised information (through digital systems/ tools) to help a YP in crisis and in their care de-escalate
5. Improve communication between crisis and acute teams for example using NHS SBAR tool to frame communication between MH and acute clinician
6. Develop stronger, more integrated links with community CAMHS and other agencies to reduce presentations in ED, including improved community CAMHS service signposting for acute staff

Recommendations 3

Staff Health and Well-being

Staff have been exposed to increase workload that contains increasingly more complex cases. All staff have been stretched and it is important that interventions for staff are available to prevent the risk of staff taking sick leave in response or leaving the industry

Recommendation:

1. Review available data (NHS staff survey) to understand the baseline for staff wellbeing for future comparison
2. Develop the Keeping Well NEL hub to ensure sustainability and promote the use of the hub amongst employees
3. Establish communication campaign to raise awareness of work-related issues and stresses, providing visible leadership, as well as enhanced and capable line management to support staff.

Communication

There is no common language used across the ICS or within a place to describe CYP need for mental health support. The Thrive Framework is at best used by the CAMHS community team and some partners. Eating Disorder teams and crisis teams do not use Thrive. A common language can help support job planning for clinicians and the involvement of other resources providing lower level support.

Recommendations

1. A common language is established across the ICS to enable a consistent and meaningful approach to describing services that can support children with emotional and mental health issues.
2. Share how Havering and Waltham Forest community teams have used The Thrive Framework to provide clarity for job planning
3. Agree and roll out a standard lexicon for labelling the different teams and the different pathways against which activity is recorded

Access

The pathway of a CYP from birth to adulthood is artificially fragmented. Access to services is complicated without a health and care single point of access for all children's services. Access for those in crisis needs to be simple, widely understood to support interventions to reduce attendance at hospital.

Recommendations

1. Review Front door models and establish consistency building on good practice e.g. Newham award winning service
2. Create a joint CYP commissioning strategy
3. Establish an ICS approach for CYP access to work in an integrated way that can be delivered at a Borough level
4. Promote the 24/7 crisis lines
5. Commission crisis teams 24/7 to deliver incentive home treatment type offer from ELFT
6. Establish model for social prescribing and a digital catalogue of support that is periodically refreshed and updated
7. Review and share the varied non-standard staffing models to inform local team workforce planning

Recommendations 4

Partnership

It is clear that where services are coproduced they can better address issues of stigma, promote access and meet a communities need. There is significant variation across localities of experience around coproduction

Recommendations

1. The Kooth contract is reviewed for commissioning at an ICS level. Kooth insights are shared to the teams on the ground as well as commissioners. Kooth coproduction and engagement resources are quantified to consider where Kooth can best lead coproduction to release locality team resources.
2. Recommendation: Create regular "summits" where insights, knowledge and support can be shared

Proactive prevention

Where proactive prevention resources are in place this can help manage demand into and out of the specialist CAMHS services. It is important to have an integrated approach in each Borough. Across the system a principle is that there is no wrong front door. In Hackney, there is a First Steps service that has no lower threshold of need, for the Getting advice and Getting help part of the system. The most common outcome of this service is step down to the universal offer. These services can also support stepping down from the CAMHS community teams. This can reduce the numbers of clients the CAMHS community services hold onto post intervention.

Recommendations

1. Consider the benefits and costs of commissioning mental health support in primary care. This should review the opportunity to access the Additional Roles Reimbursement Scheme. This scheme provides funding to PCNs for roles that include social prescribing link workers, physicians' associates, care coordinators, heath and wellbeing coaches, occupational therapists and mental health practitioners
2. Establish a social prescribing strategy for the ICS that ensures a richer source of community-based voluntary and third sector organisations able to provide support for mild mental health issues (See UCL and Anna Freud – led project)
3. Across schools including Academy schools establish an approach to identify all the resources that can work alongside and strengthen the interventions across all schools, for example school nurses
4. Establish the capacity to provide brief interventions within the community mental health teams
5. Consider the Barking and Dagenham team multi organisation approach for supporting routine referrals

Recommendations 5

Professional advice, support and information sharing

Improved access to specialist advice and care information about the CYP help provide a more personalised and effective approach

Recommendations

1. Review how specialist mental health advice can be provided to a GP in a timely manner to support a CYP with mental health needs to reduce referrals
2. Develop the integrated care records to include all providers with a focus on prioritised data sets that are useful for mental health support (e.g. notes as well as clinical letters) that can provide timely and useful information to support decision making
3. Evaluate the use of PANDO phone app for use across the ICS to enable mobile and secure communication and sharing of case –relevant information with teams and partner agencies to support CYP
4. Training on mental health care and first aid made available to all services accessed by CYP to reduce stigma, increase understanding and know what to do if they are involved in a CYP in crisis.
5. Introduce clinical dictation software for mental health teams

Pathways

There is significant work that has been improving pathways, SOPs and clinical guidelines across CYP mental health conditions to build upon. A focus on pathways can prevent duplication, reduce waste and release time to care. There are also areas that remain significant issues such as transition.

Recommendation:

1. Establish a trusted assessment model across the ICS to reduce duplication
2. Conduct a review across the ICS of digital approaches used to support CYP at all stages the neurodevelopmental pathway and their efficacy
3. Across the ICS, share CAMHS pathway quality improvement projects that have had positive outcomes in improving access and reducing waste.
4. Establish a shared care agreement approach that sets out the care plan, lead clinician, review points to support CYP in the community
5. Review the arrangements for transition considering the strengths and issues of other models such as the transition approach for physical long-term conditions

Attain

Improving health and wellbeing

Appendicies

Language

- The Thrive framework is not used consistently within a place and is not yet a common or consistent language. Community CAMHS and crisis services are all aware of The Thrive Framework and able to describe how they use it. Havering and Waltham Forest report the highest level of maturity (Level 3). Specialist Eating Disorder services do not use The Thrive Framework. Greater Manchester specialist eating disorder services are an example that has used The Thrive Framework to create a whole system partnership to support eating disorders.

Access

- Within NEL, there are examples of single points of access (SPA) for children's mental health services where these are not yet in place, they are planned. The introduction of a SPA has the potential to improve young people's access to mental health services. A review by Suffolk PH highlighted SPA across all children's services such as Nottingham and Liverpool are better able to support the holistic, social, emotional, physical and mental health needs of a child or young person (CYP). Localities using a more holistic view are able to involve wider partners in supporting children with lower levels of needs thereby allowing the specialist teams to focus on higher and more complex levels of need. Example of using a more holistic view include Barking and Dagenham.
- 24/7 crisis telephone lines are available across the ICS by ELFT and NELFT. The ELFT service is CYP specific 0900-2100, then all age outside of these hours, whereas NELFT is all age. Feedback from staff in acute providers is the phone line access does prevent some crisis. The development of ICS-wide dedicated 24/7 CYP mental health crisis support telephone line will be beneficial along with wider promotion of the crisis phone lines because currently feedback suggests that only existing service users are aware of this service.
- Every community team has established triage function to enable the timely identification and management of at-risk CYP. All of NEL have commissioned a 7 day crisis service.
- For some conditions and some CYP, digital tools have improved access to services and attendance. Specific examples include family therapy, aspects of the neurodevelopmental pathway and for specialist eating disorder clinics. All community providers during the Covid pandemic moved to a digital first approach. However digital access did cause some issues for example; safeguarding issues where adults will not allow CYP to talk to professionals alone, for some teenagers there is a culture of keeping cameras off and CYP within gangs. All services agree that moving forward a bended approach of digital and face to face contacts will be used.
- Some places reported that navigating digital resources and digital signposts to advice and help is difficult. These resources include system wide resources and also ones focused on local support within a place. There is recognition that providing a simple approach to navigating these resources and maintaining a resource catalogue will be helpful to improve the accessibility and use of these resources.
- The ELFT Crisis team brief response is now commissioned 24/7 from Summer 2021.

Insights/app

Needs led and personalised support

- All providers are working on a needs-basis. Exceptions are where a treatment requires a diagnosis for the quality control of that treatment and the requirement of a diagnosis to access support from education on the neurodevelopmental pathway,
- Assessment to establish need is undertaken by each service separately. No trusted assessment processes were reported across the ICS. Some service representatives felt that without a trusted assessment process there was duplication of work. Establishing trusted assessment processes across health and social care is expected to release time to care.
- Havering, Barking and Dagenham and Newham specifically described how they are developing and expanding approaches to consider all aspects of need (emotional, physical and mental health) to be able to best meet the needs of the CYP. The approaches include staff training as well as involving other agencies in the triage of routine referrals to find an approach that best meets the CYP need. Importantly, this changes the perception that every referral is for the mental health services to solve. The ELFT specialist eating disorder service also explicitly work to an holistic care model.

Proactive prevention

- Components of proactive prevention include raising awareness, providing training to non-mental health workers and providing emotional support and lower-level intervention for example CBT for mild to moderate anxiety. These elements are all within the scope of MHST workers. These roles are still in their infancy and the different places are at different stages in their implementation. Only data from Hackney reported significant MHST activity. ELFT are working to improve MHST mandatory reporting Hackney previously had Wellbeing and Mental Health in schools (WAMHS) which provided awareness and training to school staff.
- This review highlighted the importance of having a clearly-described and funded tier 2 offer. The benefits of this include having clear support to step up and step down a child or young person (CYP) and provides clarity to the job planning process for medical roles. A clear tier-2 offer is not present in all areas in all areas. Redbridge for example has no clear tier 2 provision.
- Many areas have incorporated brief interventions, where beneficial, as part of the triage and assessment work. The benefits of this is early access to an intervention for routine cases for a CYP. It is important to develop a system to use the available resources to support interventions. There is not a consistent definition of brief interventions and the provision is therefore variable. Barking and Dagenham, and Tower Hamlets are good examples of the provision of brief interventions.
- Kooth offer digital counselling, advice and sign-posting. There is opportunity for improving the awareness of the Kooth service within communities and also across professionals. There is opportunity for closer working between Kooth and other services for example providing support around coproduction, reduce any potential duplication of resource around advice and signposting and provide business intelligence to the operational clinical leaders of services. Intelligence may include insights into CYP on-line topics of discussion on the mediated-discussion boards.
- Primary care are ideally placed to provide proactive prevention support and lower-level interventions. However, there are currently no enhanced services covering children's mental health in the ICS to fund this. There is an opportunity to use the Additional Roles Reimbursement Scheme (ARRS) to provide additional capacity to provide primary care mental health support but sustainable funding will also need to be identified to progress, as there is 50% funding for ARRS roles.

Insights /app

Outcomes and impact

- The quality and use of Business intelligence across providers and commissioners can be improved. Waltham Forest community CAMHS team is an example where the NELFT performance team have supported the local management team to better understand their demand, activity and the progress of a CYP along a pathway. Development of a dashboard is currently underway for Waltham Forest CAMHS team . Better business intelligence will support operational clinical leads identify opportunities and lead transformation.
- Commissioners reported difficulties seeing up to date views on service delivery and some had developed their own tools. There has been good progress been made during the last year to provide data and illustrate surge planning using PowerBI. Kooth data appeared to be only seen by the commissioner yet there is benefit in providers having access to Kooth (and other) data to provide a wider perspective of need and current support.

Partnership working

- A GP focus group highlighted an opportunity to provide improved advice and guidance for GPs.
- The group described the need for timely access to expert advice that can guide GP-led care or confirm the referral route and information required.
- Embedded roles are used in many places to support integrated working. This is particularly the case to provide mental health input to looked after children as an embedded member of a social care team. There is variance in how embedded roles are used and there is significant input required from management structures to ensure they work well. One team reported difficulties in establishing an embedded role specifically around dotted reporting lines and communication. The NHS England Youth Offending Team have flagged the need to ensure embedded roles are sustainable and not reliant on a single mental health worker. Not all boroughs have local authority funded embedded roles.
- The third sector / voluntary sector can be a significant asset to support wellbeing, build resilience and improve awareness and access of proactive prevention approaches. This needs to be built on to make the most of community assets within their place. For example in Newham there have been developments to create a single point of referral to use the resources of the system better. Tower Hamlets and City and Hackney are two examples where there is a history of third sector / voluntary sector involvement. These have had positive impact on the engagement with communities within the place, for example in Tower Hamlets this has helped better understanding and access to the Orthodox Jewish community, Caribbean community and Turkish community. In Newham there has recently been work to expand such involvement. The BHR integrated care partnership has identified a paucity of third sector / voluntary sector resource. This will have an impact on the BHR locality teams.

Insights /app

Workforce development

- All teams expressed issues with recruitment and retention although this issue was significantly less in Tower Hamlets and City and Hackney. Medical roles with the specialist skills pose the greatest issues for teams. Each area has been developing different approaches to providing workforce capacity. This includes extending roles for example of nurses and AHPs and involving pharmacists, There is value in sharing the different approaches and also considering how scarce resources could be supported and deployed at a system level.
- Places that are unable to provide Inner London-allowance highlighted this as a barrier across to recruitment. For example the two different levels of outer and inner London Boroughs within the tight local geography, where Tower Hamlets and City & Hackney are inner and the other Boroughs are outer London, presents a real challenge.
- Both specialist eating disorder services have seen significant increase in demand. A business case existed before Covid for the NELFT-run service. It is recommended that a review is undertaken of the specialist eating disorder workforce to ensure these services can sustainably meet demand. However, there are some existing difficulties in recruiting.
- Concerns have been raised about the health and well being of the staff and their ability to sustain the current levels of work.
- A focus group formed from acute hospital nurses and medical members of the North Tames Paediatric Network identified the need for training for clinical and also ancillary staff e.g. security) particularly around de-escalation.

Pathways

- Waltham Forest were able to describe how quality improvement work has streamlined pathways to ensure the right information is provided on referral to support triage and assessment. This has reduced time to chase information releasing time to care.
- CYP are presenting with eating disorders in crisis, within acute hospitals and GPs. Demand is wholly outstripping capacity and an urgent look is required to establish a feasible, affordable and impactful way forward.
- There is variability in neurodevelopmental pathways across the ICS. Covid has had a variable impact on waiting times. Video consultations have been used on these pathways by all area Redbridge and Tower Hamlets appear to have progressed this furthest covering of the demand and pathway with virtual consultations than other areas. Sharing their work is recommended.
- When a CYP steps down from specialist mental health services GPs reported there can be a lack of awareness about the care plan and any escalation approach for that person. It is recommended in the care plan the lead practitioner for that CYP is identified and the plan is available for GPs and other services.
- Both specialist eating disorder teams are unable to provide an intensive pathway as set out in Addendum - Inpatient and Intensive Day Care Extension to the community eating disorder guidance published in 2019.
- Transition has been raised by all areas. There are significant concerns around a young person as they end their support from CYP-focused services and move to adult support. The approach taken for physical long term conditions is seen as a better approach.

Insights/app

Digital information

- Establishing digital share care records is key national strategy. The East London Patient Record (also known as the Health information Exchange) "portal" was referred to within many interviews. The NEL scheme covers all key providers that a CYP could have a touchpoint with across health and social care. The scope detailed on the East London Partnership did not include North East London Foundation Trust. A minority of community teams reported using the portal. Those that did use it reported that clinical letters were shared but not clinical notes. It was viewed that notes would provide a much more accurate and timely view of the care being provided to a CYP.
- Digital business structure is variable. There is no consistent approach to labelling pathways and resources within a community CAMHS team making cross comparison very difficult.
- Activity coding is variable. There did not appear to be standards for recording direct activity (individual and family) and indirect (training and workshops) activity.
- Crisis teams and acute hospital staff reported issues facing the crisis teams to access and update records. The ELFT crisis team has to access to multiple systems. NELFT team cannot access their clinical system within the hospital. Both teams report issues with accessing the different hospital systems. The teams are aware of the "portal" but it does not include notes. The situation results in delays processing notes. There is an opportunity for a technology-based solution with mobile equipment and medical dictation software.
- The ELFT crisis team reported they use the PANDO phone app, used across ELFT, to securely share patient information and for secure team messaging. This could be a useful tool across the ICS.

Learning from Covid

- All teams have been extremely flexible through Covid. Teams and resources have been reorganized and different protocols implemented to ensure they are urgent patients are identified and supported in a timely way. Teams have also adopted Covid safe-ways of working including remote working and making Covid-safe consultation room. Covid-safe consultation rooms has included creating separate entrances and egress into clinic rooms and placing perspex dividers between clinician and client. Teams have increased the use of video and telephone consultations. Although video consultations do not work for all for reasons outlined previously the teams are clear they want to maintain the following from the changes made:
    - Duty system to manage referrals
    - Improved approach to risk management
    - Video MDT case review meetings that enable more holistic reviews of patients with better attendance possible from key partner organisations
    - Video consultations for family therapy, some eating disorder appointments (reduce need to travel and reduce school interruption) and assessments where it is useful to see the CYP in their normal environment to be able to assess how they typically interact
    - For group workshops changed to using videos with a phone call follow up released time to care
    - Use of forums to collect views from e.g. schools, with minimum workforce input

Insights/app

Future demand

The long term impact of Covid is unclear but could be significant and wide ranging. The teams are all fully engaged with managing current demand and have not had bandwidth to consider what the future impact could be or what the future strategies for CAMHS services could look like. If the longer impact of Covid on mental health is not considered and approaches to address this the impact on CYP wellbeing and future mental health needs could be significant and CAMHS teams could return to 'firefighting' and see demand spiral. CAMHS, crisis and community teams and focus groups have highlighted:

- Resilience of CYPs' has dropped particularly after the third wave
- Increased levels of anxiety in CYP not known to service
- Reduction in the age of CYP who experience crisis
- Increase in adverse childhood experiences that, from Covid, could include bereavement, becoming a carer, family breakdown or domestic violence
- Increased complexity of presentation
- Increased numbers of group approach to self harm
- More violent examples of self harming
- Increase in digital exploitation

During the pandemic staff have responded to the additional need. However, this cannot be sustained and already some leadership teams are using the phrase "burn-out" to describe how some of their team are feeling. This needs to be considered in a funded establishment that in many instances carried vacancies. This report recommends the health and well being needs of staff are also considered.

Due to the pandemic there has been a rapid increase in demand for services and there has been a focus on surge planning as a result. There is significant learning from Covid-related service change and what differences were required to adapt to the change in demand. A good example has been the change from a what is perceived as an average referral, as there are multiple types of referrals and many ways of managing them (including digital, face to face, telephone, etc).

Appendix from here
The Thrive Framework

The Thrive Framework

The project has been asked to assess:

- The maturity of the use of The Thrive Framework
- How services map to 5 needs areas of The Thrive Framework
- Heuristic assessment of activity against the 5 needs areas for each service
    - E.g. Crisis support may be considered 75% getting risk support and 25% getting more help

5 levels of maturity

- 1. Initial: Exists within a project environment
  2. Foundational: Exists within one service
  3. System: Used across a patch
  4. Analytical: Ability to monitor or measure
  5. Innovative: Used within improvement and transformation plans

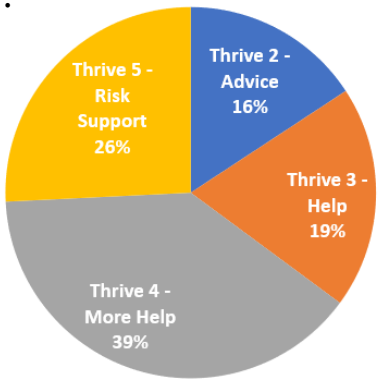
Methodology for analysis

Thrive Mappings

Each team or pathway used to record referrals and contacts, across all borough teams (inc. Crisis) has been mapped to the Thrive Framework, enabling the analysis and comparison of demand and activity at Thrive category level.

The mappings were established by the locality leads for each team, along with the two Crisis team leads.

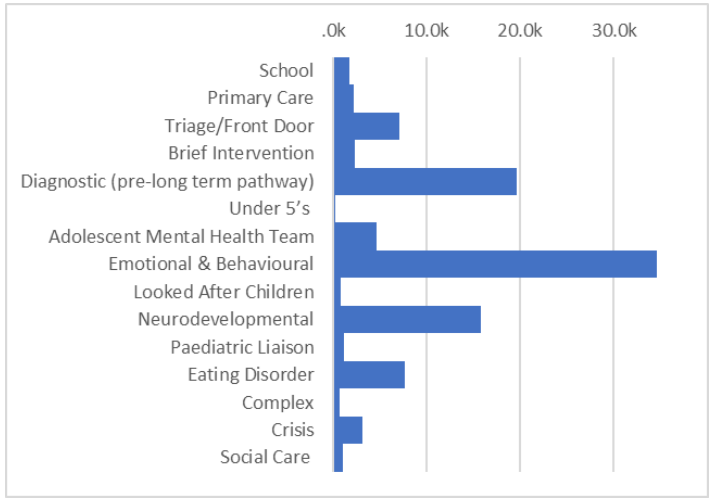
Eating Disorder services have not been mapped.



NEL new referrals in 2020 mapped to Thrive categories 2 - 5.

Pathway Mappings

With over 80 separate team or pathway names in use across the two main providers, it was important to be able to group these to enable comparisons, analysis and modelling at ICS and ICP level. Therefore the clinical leads also helped to establish a group of 11 pathways for NELFT, with Julia Yu (Head of Performance at ELFT) providing a standard mapping for ELFT.



NEL contact hours in 2020 mapped to 15 standard pathways.

Metrics calculated from data

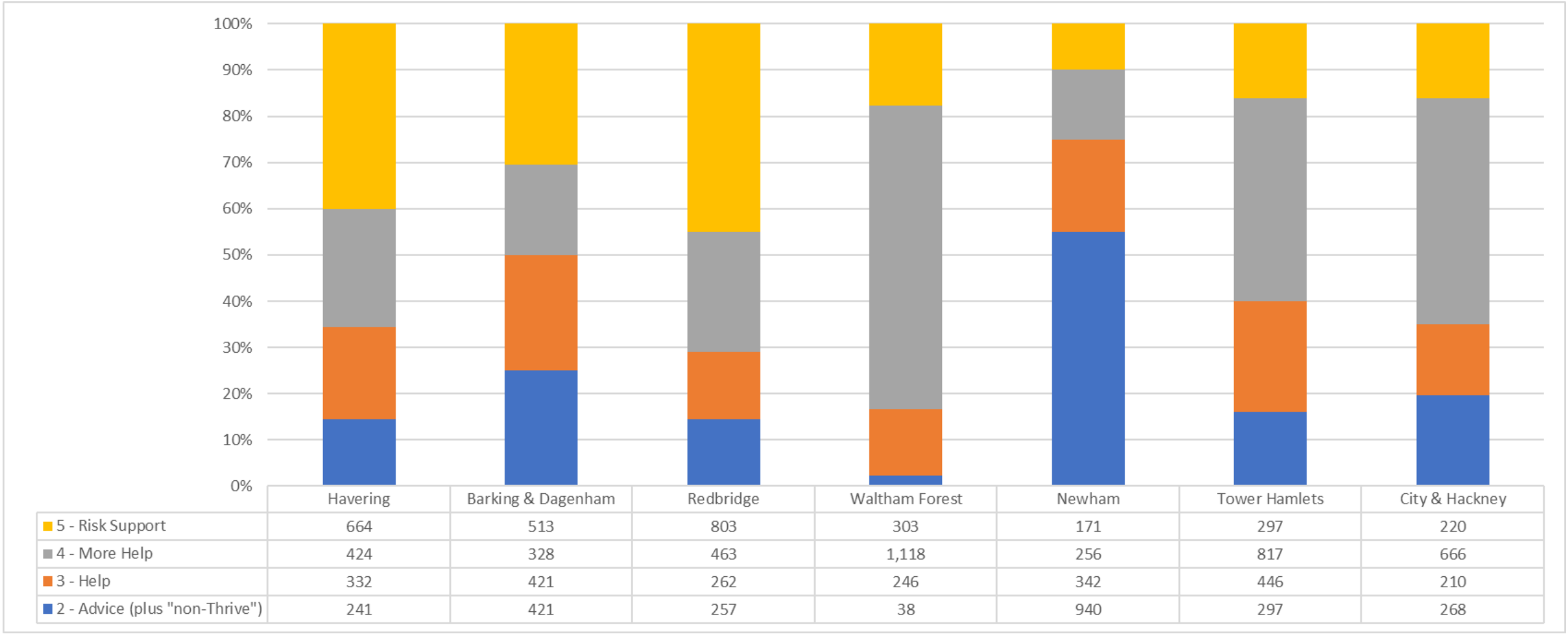
Detailed referrals, contacts and workforce data were provided by both ELFT and NELFT. From this data, the following metrics were calculated and used in this report:

Metric	Description
Cost of clinical staff per referral	Pay costs plus overheads by borough / service divided by the number of new referrals. This shows the relative "investment" by CAMHS team.
Cost of clinical staff per child population	Pay costs plus overheads by borough / service divided by the number of 5-17 year olds in the area. Another measure of relative investment.
Caseload	Using referral and discharge dates, the average number of "open" referrals were calculated per month.
Minutes per case per month	Contact time by month divided by caseload.
% face to face contact	Proportion of contact time recorded as face-to-face.

Demand by Thrive Category

Draft

The below shows the comparative split of demand (new referrals) across Thrive categories using 2020's new referrals data for each borough's CAMHS team. Crisis referrals are included at borough level. Eating Disorder referrals are excluded.



	Havering	Barking & Dagenham	Redbridge	Waltham Forest	Newham	Tower Hamlets	City & Hackney
5 - Risk Support	664	513	803	303	171	297	220
4 - More Help	424	328	463	1,118	256	817	666
3 - Help	332	421	262	246	342	446	210
2 - Advice (plus "non-Thrive")	241	421	257	38	940	297	268

Source: Local data from ELFT and NELFT

Approach to quantitative and qualitative data collection

NEL Children and Adolescent Mental Health Services – demand and capacity modelling and service mapping Plan on a Page (POP)

Date: 03.02.2021 Version: 1.0 Draft for discussion Updated by Michael Bewell

1. Purpose

To define the project scope, to form a basis for project management, and an assessment of overall success. The POP will act as a base document against which the Integrated Care System and Attain delivery team can assess progress, change management issues, and ongoing viability questions. The project initiation document forms the "contract" between the Attain delivery team and the SRO. Once signed off, changes will need to be agreed formally between both parties.

2. Project Description

Outline of the project

This project involves undertaking a system analysis across CAMHS providers and the seven North East London (NEL) boroughs. The aim is to create an overarching system view of the different types of CAMHS services by boroughs, how they map against the Thrive Framework (an integrated, person centric needs-led approach to delivering services to children, young people and their families), the current levels of demand and activity for the services and the identification of where there are service gaps in providing equitable access or overprovision now and in forecast.

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Guiding principles

The review will be underpinned by the following principles:

- The starting point is to replicate analysis undertaken in NCL ICS by Attain.
- Future scenarios for modelling will be clinically led
- The programme will ensure strong stakeholder engagement to develop a better understanding as to the current provision and root causes of variation
- Work alongside other commissioned work e.g. Mental Health JSNA

Objective

To provide a system wide strategic view of CAMHS provision by:

- Providing analysis of where service users access users and service user flows across NEL to consider if the services are in the right location
- Presenting capacity analysis against demand
- Providing a future view of the impact of scenarios that impact capacity and demand
- Supporting providers at a local level to understand blockages to providing equitable care
- Identify improvements to the current delivery models to improve access and reduce waiting times in local services.
- Providing intelligence at a strategic ICS level to support strategic aims
- Ensuring understanding and support of the recommendations

Scope

Inclusion: Geography: Includes Barking and Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest

Services – include CAMHS services across emotional wellbeing, community, specialist and crisis support services

Exclusions: Tier 4 inpatient services and forensic, schools / education-based initiatives. Non-CAMHS related services, transition services

Dependencies -

Population and prevalence data provided by JSNA project

Involvement of JSNA project in advance of Stage Gate 2 and 3

3. Approach

The project will focus on the largest care providers first to and aim to complete as complete a coverage as possible in the time allocated. The project will have 3 work streams:

- **Communication and engagement** – providers and commissioners will be identified via project board. Individuals will be contacted and "on boarded" to the project
- **Qualitative data input –** documentation on services and transformation will be requested and a structured interview will be held to understand service, strengths, opportunities, developments planned and occurring. Providers interviews can include manager, professional and clinical view points
- **Analytics and evidence base** – data collection, provider support and guidance and development of the geographical map of services by borough, systems dynamics map and presentation, service demand and capacity. The modelling approach will mirror that reported in the NCL final report.

These work streams will be interdependent at times.

4. Governance Arrangements

SRO: Dorian Cole and Sara Wilson

Day to day contact will be via Mark Scott

Project progress report – biweekly

Project group meeting

Risks and issues will be recorded with mitigations in the project documentation. Significant risks will be escalated as appropriate through the weekly report and project group

5. Communication Plan

Stakeholders will be identified by the SRO/Project Manager, and contact details provided. Communication and engagement will happen on three levels:

Key stakeholders that will help define the outputs and be part of the "sign off" process

In addition to the SRO noted above, this includes clinical and operational management leads and also senior clinical and strategy leads for relevant organisations agreed with the SRO. Attain will meet directly with these people to ensure they have opportunity to contribute and are included in the ongoing presentation and feedback sessions. (Steering Group members)

BI/finance

Attain will work closely with BI/finance colleagues to collate the demand data.

Staff with an interest in the programme

This includes staff that work within the CAMHS services, and these teams will receive high level information from the commissioners about the work commissioned. Attain will be led by the SRO to determine the level of communication and engagement from those teams at this stage. Clearly once the pathway has been developed the CCG and the CAMHS Programme Board would need to undertake a wider consultation/engagement exercise before implementing any significant changes to any working arrangements.

6. Timescales and Phases

The programme will be split into 4 Gateway approval points. The purpose of each gate way is provided below

Gate 1:Agree final structure, data definitions and data inputs / qualitative questions 19 Feb
Gate 2:Confirm analysis and scenarios , Thrive framework assessment by service and key messages arising from interviews are complete and any remedial work 5 March
Gate 3 Conclusions and recommendations ready for stakeholder review 26 March
Gate 4 Report updated with stakeholder review comments for publication 9 April

Note; Gate 3 is expected to align with the JSNA and be at the end of March

7. Outputs

	Key deliverables	Format
1	Production of robust activity plans at Borough and ICS wide levels to support service planning.	Excel
2	Scenario modelling of agrees models	Excel PowerPoint
3	Mapping of CAMHS services against The Thrive framework, across ICS and by Borough to understand warranted and unwarranted variation in service provision against current and future projected demand.	PowerPoint
43	Final Report outlining findings of system wide demand and capacity analysis and recommendations for where the system should prioritise CAMHS mental health service transformation, including recommended models of care for priority CAMHS services.	PowerPoint

8. Risk Management

Risk	RAG	Mitigation Action
Stakeholders not available in timeframes required		Early communication about project 1:1 appointments allows project to target key role
Data not available		Data sharing agreements and engagement in ICS informatics group and provider BI teams
Data not comparable		Agree data definitions

9. Assurance

Attain will use their internal quality assurance process to ensure the outputs are of the quality Attain customers should expect. Specific quality standards will be agreed between Attain and the programme SRO at each stage of the programme.

External assurance on the clinical elements of the pathway will be sought through the client's agreed leads and the use of stage gates.

Key Lines of Enquiry 1

Theme	Questions to answer	Source	Comments / risks
Demographics	Where is the greatest CAMHS need or changes in demand seen – highlight areas of increase and high need	Prevalence data	At borough level
	How do current resources map onto levels of mental health prevalence? Identify area of over / under provision	Present prevalence Staffing levels x area	At borough level
	How is demand expected to change in the future (likely scenarios)	Scenarios – request in engagement. Request through other meetings? How big is the "jump" in demand	
	Scenario impact – capacity changes: new ways of working	Include current Covid scenario and future facing HEE data on new workforce coming on line?	
Service	Is service capacity meeting current demand. What will be impact if demand changes as modelled in scenarios	Assessment of referrals and first appointment capacity Proportion assessed and discharged? What is current delivery and workforce model?	
	Current service model	Strategies and engagement	Relate to service model (single point of contact) and qualitative input from engagement
	Are services easily accessible and needs dependent not diagnosis dependent		Can parents call up.
	Are there clear processes to change service model is response to service demand	Qualitative input from engagement	
	How well is the current system working	SWOT in engagement	

Key Lines of Enquiry 2

Theme	Questions to answer	Source	Comments / risks
Thrive	How well is The Thrive framework being used in the area	Background reding and confirm in engagement: 5 level maturity model form each 7 boroughs	
	What is the level of resource provision against the Thrive framework categories	Engagement. Other sources?	Any duplication / excessive spend / spend gaps in any areas
Strategies	How do existing strategies address future needs	Review of existing LTP and other transformation strategies	
	What gaps are there in existing strategies		
	What does the project recommend		Examples: System monitoring / Access / Workforce enablers – strategy / Digital enablers / Service design

Activity, Demand and Capacity Data Collection

- Templates were agreed with both ELFT and NELFT for the collection of:
  - Referrals (new and open cases),
  - Contacts (numbers and duration)
  - Waiting List
  - Staffing (WTEs and Costs)

- The data was grouped by Service / Team / Pathway name and locality – except for Crisis and Eating Disorder Teams, which operate across multiple boroughs.

- The following criteria applied to the data:
  - All children's mental health services, including Eating Disorders
  - Referrals and Contacts from between 1/1/2019 and 31/12/2020
  - Latest Waiting List (March 2021)
  - It should be noted that some over 18 year olds were included in the NELFT data

- Details on the how the metrics and the THRIVE mappings were calculated are in the "THIRVE Framework" section.

Structure for engagement interviews

Key Lines of Enquiry

1. How is change managed? How quickly can changes to service delivery new models
2. Rate maturity of The Thrive Framework use across the NELFT-run services and across partnering organisations
3. Across Havering CAMHS (NELFT) services (specifically respond to **a) assessment/early interventions, b) neuro developmental, c) eating disorder, d) crisis services, e) integration and f) transition from tier 2 - 3)** what are the:
    1. Strengths (examples / pathways of best practice)
    2. Weaknesses
    3. Opportunities (new ways of working, partnerships / integration, digital, COVID-19 lessons)
    4. Threats (consider failure of other services creating demand, COVID-19, future demographics)

Exploratory question lines

a) Is Thrive used a common language? If not is there a common language used across provides / commissioners?

b) What proactive prevention activities are there? Is there opportunity for more proactive prevention?

c) Who are your key partners and how mature is partnership working (e.g. structures and space to share)

d) Are resources and interventions based on needs? (Is this supported by data sharing?)

e) Who are the hard-to-reach groups?

f) How is stigma being reduced?

g) How embedded is shared decision making?

h) Are there outcome measured that rely less on clinical diagnosis and reflect impact of services on meaningful attributes?

i) How do digital systems and MHSDS support service transformation to better meet service user needs?

Demand and capacity modelling

Two models will be developed for NEL that allow the testing of agreed scenario's (and associated impact on access / demand) and a review of capacity against demand at a service level. An overview of the planned models is outlined below:

Model 1: Scenario model
Provider and NEL level

Key features:

- A high level scenario model has also been developed, to highlight to impact of a number of scenarios at Provider & NEL level
- 2019/20 baseline demand (based on data received)
- Scenarios (co-developed with stakeholders) include the impact of COVID, increased access for unmet demand, increased capacity in the community, digital and expansion of / new crisis services
- Scenarios applied at a Provider / Service level and aggregated up to NEL level
- Functionality to amend assumptions / % impact by user at NEL and Provider level
- Waterfall / Gap chart outputs

Model 2: THRIVE framework capacity vs demand
Service level modelling by Provider

Key features:

- An interactive demand & capacity service level model has been developed for NEL CAMHS services which pulls together a variety of inputs to highlight where there may be gaps in capacity, split by THRIVE framework group
- Apportions demand and capacity, by THRIVE framework grouping, with groupings agreed with Providers
- Takes WTE data from Providers and applies assumption around Patient Facing time to determine available hours of capacity
- Includes data and projections around 0-18 populations by borough and prevalence data
- Enables a view of WTE utilisation / required capacity based on current demand / future scenarios

Engagement

Commissioner engagement

	Name	Area	Position Title
Borough / ICP view point	Deborah White and Deborah Russell	Waltham forest	CAMHS commissioning lead and Childrens' Commissioning Manager
	Sherine Howell	Barking, Havering and Redbridge	Children's commissioner
	Marie Trueman-abel (with Philip Williams and Matthew Richardson)	Newham	
	Diana Viscusi	Tower Hamlets	Children's integrated commissioner
	Greg Condon	Hackney	City of Hackney
System viewpoint	Perpetua Kamwe	NHS England	Justice lead NHS
	Elaine Allegretti	NEL perspective	

NELFT engagement

Area	Role	Name
EDS	Head of Service	Rory Harnett
Interact – Community Crisis Team	Assistant Director	Caroline O'Haire
	Service Lead	Nicola Upton
Barking & Dagenham	Assistant Director	Mohammad Mohit
	Head of Service	Heather Kazingizi-kapota
Havering	Assistant Director	Pippa Ward
	Transformation lead	Michele De-Souza
Redbridge	Assistant Director	Mini Luckhea
	Head of Service	Diederick Meij
Waltham Forest	Assistant Director	Lynne McBride
	Head of Service	Sam Illaiee

ELFT engagement

Area	Role	Name
All areas	Associate Director	Lindsay Hobson
	Clinical Director	Cathy Lavelle
	Clinical director community	Julie Proctor
	Clinical director inpatient	Rifik Rafaat
EDS	Head of Service	Erica Cini
Community Crisis Team	Lead Nurse	
Tower Hamlets	General Manager	Bill Williams
	Associate Clinical Director	Hanspeter Dorner
	Psychological Therapies lead	Richard Simmons
City and Hackney	General Manager	Merrisha Gordon
	Associate Clinical Director	Sharon Davies
	Psychological Therapies lead	Roger Davies
Newham	General Manager	Fiona Stockley
	Associate Clinical Director	Priti Patel
	Psychological Therapies lead	Jon Wells

Other provider stakeholders

Area	Role	Name
All areas		
Homerton	Consultant clinical psychologist. Tier 2 services	Ruth Kossof
	Lead for CAMHS disability service	Susan Crocker
Kooth	Kooth NEL ICS contact (provided by Mark Scott)	Tristyn Eddings
Acute providers voice	Stakeholders to describe children and young people's changes in attendance at ED with MH / behaviour issues	Sophia Touzani Thames Paediatric Network focus group.
GP voice	Stakeholders to describe children and young people's changes in attendance at ED with MH / behaviour issues	Mark Scott. GP leads for mental health

Acute Hospital Focus Group

The North Thames Acte Paediatric Acute hospitals focus group organised a 90 min forum with medics and nursing colleagues who work within the emergency and inpatient locations of acute hospitals across the North East London.

The changing demand

Numbers presenting with mental health conditions and requiring inpatient stay has been increasing before Covid

CYP presenting in crisis at a younger age

Presentations with higher risk, more violent self harm, increased severity of drugs taken

Disorded eating

Increasing transgender issues

Workforce and training

Can negatively impact on staff

"Wecantalk" training accessed by nursing but not medics

Some hospitals have developed more specialised skill sets to better manage mental health issues

Acute staff do not feel equipped to handle this cohort

Lack of agency RMNs with paediatric experience

Education; neded by clinical, security and non-clinical teams interacting with CYP

Training on de- escalation

Knowing the CYP to de-escalate and tailor care

ELFT nurses have joined Barts bank

Risk management

Increases in groups attending ED after making a "pact"

CYP in close vicinity likely to share tips on self-harm

Risk assessments – not a standard across all hospitals

Difficult to access and manage a safe space

Risks to other children in the hospital

Risk management can lead to extended stay in ED until a bed is found but this brings many issues

Access

Social care support is difficult to access particularly for a safeguarding issues ad placement breakdowns

Access crisis line seen as a positive and sometimes . Although awareness could be improved

111 Crisis line in inner NEL in place

During Covid reduced access to lower level pastoral care within education has impacted on demand

Right environment; significant numbers now. Risk to others and selves

Wait in ED; causes frustration and increases agitation

Improve communication between crisis teams and acute team

Delayed discharge, finding beds

Interact team (NELFT) have extended their hours

Increased CAMHS resource to support smooth transition home

Access for crisis support harder on weekends and evenings

Acute Hospital Focus Group *continued*

.

Providing continuity

Accessing input from 'known' CAMHS consultant

Notes from CAMHS aren't always added into systems – chasing to obtain outcomes of assessments – more fluid communication

Distance to bed offered for CYP

Primary Care can provide understanding of wider family

Interventions

Not providing therapeutic care so YP not benefitting
Eating disorder children – who else can provide support?
16 – might open up to student nurse
What other facilities we can use, not always immediately go for MH nurse
Patients' with severe injuries from suicide attempt can be bed bound with multiple injuries. They involve CAMHS, parents/nurses supervising them. Teams are unclear what further support to provide as injuries improve and patient becomes more mobile and possibly will attempt risky behaviours

Strengths

CAMHS crisis team seen as a fantastic and supportive resource with good connections

CAMHS are doing a brilliant job working within the own financial and staffing constraints

ED CYP –develop clear plans with them, works really well. Once a plan is in place, there is then a process to follow especially if the care team know the YP and their triggers

CAMHS community team have sometimes come on site, responsive, obtain clear plans, same for ED team – good examples of how well this can work TAC approach – they do the same for the nursing team. Speaking with someone who knows the YP very well makes a big difference

Acute Hospital Focus Group *attendees*

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In attendance:

Neil Fletcher: clinical nurse specialist for Teenagers young
Alison Greene: matron Newham UH Paediatric IPs
Marianne Hill: snr paed nurse, Homerton
Laura Gannaway: Queens and KGH, specialist nurse
Ghislaine Stevenson: AD Nursing CYP WX
Tanya O'Driscoll: Lead nurse RL
Melissa Townson: Matron CYP ED Queens and KG
Sophia Touzani: North Thames Paediatric Network
Gin Thian Peh: Paed Consultant RL plus work with ED ser
Christine Headley ???
Louise Marshall: Transition Nurse, RL
Geraldine: Deputy Lead north thames paed netwrlk
Sarah Wilson: Chair NEL CYP MH Programme
Nasima Ahmed: Barts
Geraldine Munn-Mace: GOSH
Polly Payne: Barts
Janell Thomas: Barts
Luke Whittemore: Barts
William Toohey: BHRUT

Locality transformation plan summaries

Transformation Summary; Havering

Havering Children's and Young People's Mental Health Transformation Plan (refreshed October 2018) priorities

- Dedicated emotional support into Child Sexual Abuse service
- Local resilience training into schools
- Expand staff and parental resilience training with a whole family approach
- Timely identification of looked after children mental health needs
- Outcomes assessment mechanisms
- Early and timely transition protocols
- Wellbeing data to support resource allocation to the most effective services
- NEL-wide collaboration on IAPT services
- Alignment of school-based counselling services
- Expansion of perinatal mental health peer support services
- *Move to an integrated commissioning system (Barking Havering and Redbridge) – see right panel*

BHR Mental Health transformation programme March 2019

- Crisis response that meets the needs of under 18
- At least 34% of children and young people with a diagnosable mental health condition should receive treatment from an NHS-funded community mental health service
- At least 95% of children and young people with an eating disorder should be seen within one week of an urgent referral
- At least 95% of children and young people with an eating disorder should be seen within four weeks of a routine referral
- Increased access to NICE concordant community-based specialist perinatal mental health services (in secondary care settings) for at least 4.5% of their population birth rate

Transformation Summary; Redbridge

Redbridge Children and Young People's Mental Heath Transformation Plan refreshed October 2017

- Full implementation of the Wellbeing hub incorporating additional staff including crisis response
- Continuing to take forward schools training
- Development of schools links
- Looked after children pathways
- BHR
- Full implementation of the Wellbeing hub in each borough incorporating additional staff including crisis response
- Building on the outcome of the FSR to develop robust workforce plans
- Developing integrated pathways across NEL and further collaborative commissioning arrangements
- Developing and embedding an outcomes-based approach to our main contract

Transformation Summary; Waltham Forest

Deliver transformation in the CAMHS System to promote Children and Young Peoples' (CYP) mental wellbeing and to reduce the harm caused by CYP mental ill health through implementation of the agreed partnership transformation plan.

Deliver Aspirations and Metrics of the NHS LTP:

- Maintain delivery of 35% access Targets n a timely manner to evidence based treatments
- Roll out two Mental Health Support Teams in schools to be fully operational 12 months after the commencement of training for trainees from February 2022. (getting advice and getting help)
- Continue the Development of a targeted CAMHS offer to be provided in schools, GP surgeries and other community settings (getting help: evidenced based therapies for anxiety and depression)
- Expand and adapt services across health, social care, education and the voluntary sector, to develop and implement integrated pathways which deliver a comprehensive offer to 18-25 year olds, including management of Transitions
- A four-borough business case has been approved to enable the Eating Disorders service to meet the CYP referral to treatment target

.

Ensure partnership responds appropriately to the impact Covid, including the surge in demand and the impact on CYP mental health and wellbeing:

- Implement service adaptions which support CYP to access support as early as possible and to be provided the most effective and efficient evidenced based intervention available
- Ensure there is access for CYP to 24/7 crisis support and prevention services which are delivered across the Waltham Forest partnership, through Integrated system pathways
- Develop a comprehensive offer for young people with learning disabilities that require mental health support
- Roll out and development of Kooth expansion to align with CAMHS

Promote effective partnership communication and governance including the views of children and young people with mental health concerns.

- Continuation of the Young Mental Health Ambassadors Project
- Ensure the voices of children, young people and their parents are taken into account within the CAMHS path-way and in line with expectations within the Children & families act (2014) and the NHS constitution. Waltham Forest local area will demonstrate they have a mechanism for engagement with children and young people and their families.

Transformation Summary; Barking and Dagenham

Barking and Dagenham Children and Young People's Mental Health Local Transformation plan (2015-2020) refresh 2018

- Final procurement of the dedicated Emotional Support element of the Child Sexual Abuse local service
- Expansion of the local resilience building packages to schools delivered tailored solutions with particular emphasis on Special Schools
- Looked after Children, the focused services for their needs and timely identification of their requirements
- Confirmation of robust mechanisms around assessing outcomes from pilots and localised schemes and how these can inform post Transformation Business as Usual commissioning
- Establishment of firm early and timely transition protocols to support services users into adult services
- Expansion of the data reporting from the Wellbeing Hub to assist in resource being directed to the most effective agencies
- Expansion of staff and parental resilience training with a whole family approach
- Expansion of innovative 'on-line' services to young people
- Embedding of the Mental Health Direct Service for carers, schools, primary care
- Development of links with the VCS

Transformation Summary; Tower Hamlets

Tower Hamlets Transformation Plan for Children and Young People's Mental Health and Wellbeing 2016 - 2021

• New young people's mental health service	2017 to 2020	• Increase to 35% of diagnosable population seen by services
• Shorter waits	2016 to 2017	• Integrated services
• Attachment and help in early years	2016 to 2018	• Focus on specific improvements
• Better access and more CYP seen	2016 to 2021	• Whole system enablers
• Vulnerable CYP	2017 to 2019	
• Mental health for new mothers	2017 to 2021	• A stronger foundation –integrated help for parentsin early yearswith a focus on early attachment and mental wellbeing
• CYP mental health crisis response	2017to 2018	
• Improved pathway: CYP autistic spectrum	2016to 2018	• Improving the way children, young people, families and organisations find out about the help that is available, and increasing the number of young people with mentalhealth problems who receive help
• Vision for integrated services	2017to 2020	
• Integrated Personal Commissioning	2016 to 2018	
• Reduction in suicide	2017 to2021	
• Transition to adult services	2017 to 2021	• Continuing joint initiatives to improve mental health andwellbeingfor vulnerable young people
• Commissioning for outcomes	2016 to 2019	
• New service model for inpatient CAMHS	2016 to 2021	• Perinatal mentalhealth services and parent/infant mental health
• Workforce planning	2017 to 2021	• Strengthening the response of servicesto mentalhealth needs of young people onthe autistic spectrum
• iThrive	2016 to 2019	
		• Strengtheningthe crisisresponse to young peoplewith mentalhealthproblems.

Tower Hamlets Transformation plan sub elements

- The care plan is generic and needs to be more tailored. • Develop a process to make sure the Safety and Coping Plans (SCP) is up to date with all partners (e.g. messages on RiO to update when accessed) •
- Share the SCP with the complex case review meetings within each Local authority, when appropriate
- Develop and roll out a CAMHS recruitment and retention strategy across all sites.
- Create and recruit to CAMHS Ambassador Posts to improve collaborative working.
- Undertake a training needs analysis relating to mental health and crisis across the pathway
- Review the training available across each site and develop a consistent training programme across all sites.
- Improve the training offer to the OOH / all ages (e.g. adult) mental health liaison staff and ward staff to improve their confidence in crisis and appropriately managing risk referring appropriately
- Develop a social care pathway and implementation plan for CYP with social care representatives using the Social Care Institute for Excellence (SCIE) 2017 guidance.
- Improve social care engagement and/or develop training for staff to understand the social care process, including follow up, emergency duty team awareness and vice training in CYP mental health and crisis.
- Development of a co corporate identity/brand for mental health crisis service.
- Align the governance process and structure across all organisations within the pathway including acute paediatric sites and commissioners/local authorities.
- Standardisation of pathway and protocols across the pathway
- Develop a regular communication channel with primary care professionals, schools and the Police. •
- Ensure escalation policies across all organisations within the pathway
- Review the feedback loop to staff of communications and test the current communications channels work.

Tower Hamlets

Priority area	Key Transformation	Outcomes
Attachment and help in early years	Integrated services Evidence based interventions for mental wellbeing	TH prevention outcomes
Improving access and increasing numbers seen	Digital offer Participation and engagement Schools Waiting times Additional staff to deliver evidence based interventions Psychological wellbeing pilot Health equalities Eatingdisorders	MHFYFV target to see 35% of diagnosable population by 20121Digital activity, service user satisfaction, TH outcomes measures, improved take up from Bangladeshi and BME groups, eating disorder metrics
Vulnerable children and young people	Out of borough Pupil referral unit Criminal justice Virtual CSA hub Clinical input into new joint initiatives	TH MH outcome measuresSTP CSA activityand quality measures
Perinatal	Integrated local pathways□Join-up with STP-wide transformation	MHFVFV targets, improvements in parental anxiety and depression after treatment
Crisis and acute pathways	Earlier interventions Improved access and integration out of hours via children's social care and ELFT Join-up with STP-wide acute inpatient CAMHS transformation	TH MH outcome measures, no CYP admitted outside STP, improved crisis response Co-commissioning plan with NHSE

Transformation Summary; Hackney

City and Hackney CAMHS Transformation Plan (2016/17 refresh)

- Increase access rates from 25% to 35% by 2020/21
- Increase community based clinical capacity through joint workforce planning and CYP IAPT
- Reduce waiting times for assessment and treatment
- Elimination of all inappropriate in-patient bed use
- Establish 24/7 crisis resolution and liaison mental health service
- NICE concordant eating disorders service meeting access and waiting times standards
- Full age-range NICE concordant Early Intervention in Psychosis Service
- Collaborative commissioning of Youth Justice Liaison and Diversion Service
- Responding effectively to child sexual abuse
- Developing integrated and optimised perinatal mental health pathway
- Assuring NHS Digital submissions and contribution to the MHSDS
- Service redesign through innovation
    - Parenting
    - Transition
    - Crisis
    - Interfaces with Schools

Transformation Summary; Newham

Newham Future in Mind Local Transformation Plan 2015 – 2020 (18/19 refresh)

- Deliver CAMHS access targets 35% of CYP with a diagnosable MH condition receive treatment from an NHS funded community MH service
- Outcome metrics: implement national guidance and monitor service effectiveness
- Eating disorder: evidence provision 95% of children and young people receiving treatment within four weeks of referral for routine cases and one week for urgent cases.
- Early intervention 60% of people with first episode psychosis will be seen within two weeks and receive a NICE concordant package of care
- Perinatal mental health targets increased access to specialist perinatal mental health support in all areas in England, in the community or in-patient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it
- STP approach to expertly review and jointly commission
- Workforce development across the STP
- CAMHS access target achievement
- CAMHS outcomes reporting
- Digital platform
- Crisis care
- Transition to adult services
- Co-production with service users
- Strategy development
- Local transformation plans

Newham Transformation plan sub elements

- The care plan is generic and needs to be more tailored. • Develop a process to make sure the Safety and Coping Plans (SCP) is up to date with all partners (e.g. messages on RiO to update when accessed) •
- Share the SCP with the complex case review meetings within each Local authority, when appropriate
- Develop and roll out a CAMHS recruitment and retention strategy across all sites.
- Create and recruit to CAMHS Ambassador Posts to improve collaborative working.
- Undertake a training needs analysis relating to mental health and crisis across the pathway
- Review the training available across each site and develop a consistent training programme across all sites.
- Improve the training offer to the OOH / all ages (e.g. adult) mental health liaison staff and ward staff to improve their confidence in crisis and appropriately managing risk referring appropriately
- Develop a social care pathway and implementation plan for CYP with social care representatives using the Social Care Institute for Excellence (SCIE) 2017 guidance.
- Improve social care engagement and/or develop training for staff to understand the social care process, including follow up, emergency duty team awareness and vice training in CYP mental health and crisis.
- Development of a co corporate identity/brand for mental health crisis service.
- Align the governance process and structure across all organisations within the pathway including acute paediatric sites and commissioners/local authorities.
- Standardisation of pathway and protocols across the pathway
- Develop a regular communication channel with primary care professionals, schools and the Police. •
- Ensure escalation policies across all organisations within the pathway
- Review the feedback loop to staff of communications and test the current communications channels work.

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