Haringey Child and Adolescent Mental Health Services Transformation Plan

On behalf of Haringey Council and Haringey Clinical Commissioning Group

October 2016 Update

FOREWORD

Since publication of our CAMHS Transformation Plan in September 2015 Haringey CCG and Haringey Council have been working with our local providers to implement our CAMHS Transformation Plan. The Haringey CAMHS Transformation Board has been meeting regularly in order to drive this work and engagement from a broad range of commissioners, providers and patient groups has been sustained. Some elements of our Transformation Plan are being implemented locally, and others across a broader North Central London footprint. Regular meetings are held between commissioners from the five boroughs of Haringey, Barnet, Enfield, Islington and Camden to share ideas and developments and look for opportunities for close working. The NHS CAMHS Providers across NCL; Barnet, Enfield and Haringey Mental Health NHS Trust, Tavistock and Portman NHS Foundation Trust, Royal Free London NHS Foundation Trust and Whittington Health NHS Trust, have been working closely together on a number of developments. The purpose of this document is to provide an updated version of the plan to take into account the work that has been completed in the last year and to provide further detail on what implementation will look like over the next four years. It should be read in conjunction with the delivery plan, which is updated annually. This document is formed of two parts: Part One reflects the context and work going on in Haringey and Part Two is a summary of the priorities that we are working on jointly across North Central London.

Contents

Part One: Haringey CAMHS Transformation Plan 2016 Update

Part Two: North Central London CAMHS Transformation Plan Priorities

Part Three: References & Appendices

1. Executive Summary

A joint review of Child and Adolescent Mental Health Services (CAMHS) was launched in February 2015 by Haringey Council and Haringey Clinical Commissioning Group. The publication of 'Future in Mind' in March 2015 has framed this review in light of national drivers and provided a context by which to review Haringey provision. The Review has had significant input from a wide range of stakeholders and has been a collaborative process with local organisations delivering support to children and young people. Haringey has a rich array of provision, and a number of innovative partnership projects meeting the needs of vulnerable groups. On the whole CAMHS provision across the Borough is valued, and high quality; however there are also a number of areas that require development. Whilst there is a lot of support for families, it requires more coordination, better awareness and promotion amongst universal provision and a greater focus on early intervention.

1.1 Key Findings of the Review in 2015

1.1.1 Key Findings for Commissioning

Commissioning arrangements mean there is no 'whole system approach' and a lack of coherence to provision. Funding arrangements do not allow us to accurately determine levels of investment, spend and associated outcomes. Future in Mind requires a '**lead accountable commissioning body**' and a '**single separately identifiable budget for children's mental health services**'. Whilst there is a joint commissioner in place for this area, joint commissioning arrangements should be developed further to facilitate:

- Single CAMHS contracts across statutory commissioning agencies per provider
- Clearer, more transparent investment and monitoring of spend
- Joint planning and integrated services designed to meet the needs of the whole population

1.1.2 Key Findings for Provision

- The Review has identified a relative lack **of early intervention** (Tier 2) support. This should be expanded building on the CAMHS in GP practices pilot and the mental health links in Schools pilot in light of the borough's Early Help Strategy. Work with universal provision should be prioritised, developing understanding and support for attachment and promoting access to a coherent programme of **parenting support** using evidence based models. **Peer support** and **digital solutions** should be developed as part of this model.
- There is a lack of **out of hours** support around **crisis** presentations, pathways should be developed in partnership with neighbouring boroughs and the role of the Adolescent Outreach Team should be reviewed as part of this work
- Targeted services should be enhanced for **vulnerable children and young people** e.g. Looked After Children/Care Leavers/Children with learning disabilities/Autistic Spectrum Disorder/Youth Offenders/Young Carers/Children who are abused
- Services need to be more focussed on **outcomes**, using evidence based approaches and CYP-IAPT should be embedded across services
- Current capacity issues within Tier 3 are leading to long **waiting times**. Expanding early intervention services should reduce demand and improve access over time and use of **group interventions** and **digital solutions** should increase service efficiency.

- Interagency working and **communication** between CAMHS and the wider children and families work-force should be improved, linking CAMHS into other services and through the upskilling of the wider children and families workforce
- **Enablement** should be promoted through peer support models for children and young people and their families.
- Services should be more **accessible,** better **information** should be available to families early on and appropriate use should be made of **community assets** at the earliest stage to prevent escalation of mental health concerns.
- There is a need for improved **transition** between CAMHS and adult mental health services and increased flexibility in age eligibility criteria with appropriate and timely step-down for those who will not require ongoing support.
- Closer working between physical and mental health services is required. **Joint clinics with paediatrics** (social communication & neurodevelopmental clinics) and post assessment psychological support for families should be developed
- There are proportionally fewer children and young people accessing services from the most deprived areas in the Borough and work needs to be done to **target referrers and families** in these areas, especially in Black/Black British African communities who are **under-represented** in provision.

1.2 Recommendations

The key strategic recommendations of the Review:

1. Develop and implement a joint commissioning model which allows us to develop a whole system approach to child and adolescent mental health and emotional wellbeing
2. Ensure evidence-based, quality assured services which promote participation of children, young people and their families in all aspects of prevention and care
3. Develop an early intervention approach that is embedded across the whole system.
4. Transform the model of care to improve access, deliver seamless care, improve outcomes and promote enablement.
5. Ensure that all groups of children and young people are able to access appropriate support, and that those where there are higher vulnerabilities have tailored support to their needs.
6. Promote the recognition of emotional health and wellbeing across the wider children and young people's workforce, ensuring staff are engaged in transformation.

1.3 Implementation

The outcomes of the Review and strategic recommendations are being implemented through the Transformation Plan in Section 5. This is monitored through the CAMHS Transformation Board, a partnership board for the borough, which leads the implementation of Haringey's CAMHS Transformation Plan.

1.4 Outcomes

Implementation of the Transformation Plan will deliver the following outcomes for child and adolescent mental health services, families using these services and professionals working within the broader children and young people's workforce:

1. Integrated and comprehensive commissioning under an agreed local framework for all provision, delivering transparency, accountability and value
2. An early intervention approach that provides access to non-stigmatised triage and signposting with a focus on community support which avoids over-medicalising children and young people and that builds a system of support in natural contexts such as school and home.
3. A co-ordinated preventative approach for children and young people, parents/carers and families through systems around the child working well together to support emotional wellbeing across the children's workforce.
4. Improved access to the right service at the right time with better support for vulnerable children and young people to access appropriate support
5. Flexible services that meet the preferences and developmental needs of children and young people
6. Child and Adolescent Mental Health Services with the tools to provide an efficient and up-to-date response to the population with a well-trained and competent workforce for delivery
7. Better inter-agency working and improved communication with referrers and better discharge planning
8. More focused work that reduces dependency and promotes resilience and enablement
9. Improved crisis planning and pathways that provide timely support and robust follow up
10. Clear protocols for cross-boundary issues and working between child and adult services
11. Better engagement with under-represented communities/groups

2. Background

2.1 Introduction

The development of the Mental Health and Wellbeing Framework in Haringey has highlighted a need to gain a better understanding of local Child and Adolescent Mental Health Services (CAMHS). Haringey's commitment to developing early help services is especially poignant in relation to CAMHS. Peak onset of mental ill health is between 8 to 15 years; 10% of children have a mental health issue and half of lifetime mental ill health starts by age 14. If the appropriate support is in place at this critical time, we have a real opportunity to improve the lives of our residents and generate future financial savings for the system, through reduced adult mental health prevalence and through better life chances for our children and young people. For example it is estimated that children with early conduct disorder are ten times more costly to the public sector by the age of 28 than other children[i] and that overall lifetime societal costs associated with a moderate behavioural problem are £85,000 and a severe behavioural problems £260,000[ii].

Given recent key national developments and the changes to the landscape for CAMHS it was important that Haringey took stock of the current provision and the models of care currently being used. The Review sought to comprehensively review CAMHS spanning provision commissioned across health, education and social care, to get a holistic understanding of the current system. This however is an ongoing iterative process in many senses, as we seek to adapt and transform CAMHS provision.

The Review enabled us to gain an understanding of what is working well, and what barriers are facing children and young people. More fundamentally, it has supported us to be able to ensure that we are commissioning high quality, evidence based, efficient services that are accessible to our population.

2.2 Methodology

Haringey CCG and Haringey Council initiated the Review of CAMHS in February 2015. A project Board was convened to lead the Review consisting of:

- Haringey CCG
- Haringey Council: commissioning, public health and children and young people's services.
- Healthwatch
- NHS England
- NCL Commissioning Support Unit
- Parent representative

Needs analysis and mapping have been completed to understand the local needs and this has been triangulated with national data. The vast majority of local providers provided service level data to ensure the most accurate basis for any assumptions. Visits to other areas to look at examples of good practice include Bromley-By-Bow, Tower Hamlets and Hackney.

2.2.1 Feedback

In March 2015 a stakeholder event was held to launch the Review, comprising over 50 professionals from a broad range of statutory and non-statutory agencies. Further engagement has been undertaken with

stakeholders including children and young people, parents, statutory and non-statutory providers, Schools, GPs, social care and community and acute health services through meetings and online surveys. Feedback from CAMHS providers has been gathered through a series of provider meetings coordinated by Open Door, individual meetings with services and an online survey. Additionally themed workshops have been held on the following areas:

- The mental health of Looked After Children (25 attendees)
- Child and Adolescent Mental Health Learning Disability Services (23 attendees)
- Crisis care for children and young people (15 attendees)

Table 1: Online Survey Response Rates:

Stakeholder Group	Number of returned questionnaires
Children and Young People	33* (2.2% approx.) children/young people engaged with CAMHS
Parents/Carers	50* (3.3% approx.) current families engaged with CAMHS
Professionals/ Stakeholders	69 (Includes 11 GPs responding to follow up survey)
CAMHS Provider Staff	42 Total: 33 responses from staff and volunteers specific to Haringey (37% approx.) 9 responses from staff and volunteers from cross-borough services working with Haringey children and young people
Schools Audit	17 Schools (23% of Haringey Schools)

*As Child and Adolescent Mental Health Services are currently seeing approximately 1500 of Haringey's children and young people and their families the sample of service users and parent/carers was very low. Information was supplemented with outcome and satisfaction data from CORC (CAMHS Outcome Research Consortium), and other mechanisms within services used to gather feedback. Of the online responses the vast majority of young people were from Open Door and all were from young people over 15 years of age. Two workshops were held at Burgoyne Road, one for young people (5 attendees) and one for parent/carers (9 attendees); information gathered at these has also been considered as part of this feedback. The themes are summarised below, with a more detailed report at appendix 1.

Feedback Themes

- **Quality:** Young People and Parents find services helpful, on the whole providing positive feedback. Parents feel well supported, families are greeted in a friendly and supportive manner and report convenience of first appointment
- **Communication:** Families do not have sufficient information on services prior to attending CAMHS and referrers want more ongoing communication & better discharge information
- **Crisis:** Families do not know what to do in the event of a crisis, however they are able to contact services between appointments
- **Workforce:** There is a good range of skills and a broad range of modalities available however safeguarding training was found to be inadequate across services, with some staff not meeting their mandatory training requirements. Training for the wider children's workforce is required.
- **Choice:** Families are not offered choice of setting or location and would like more appointments outside of 9am-5pm
- **Access:** Families and referrers do not feel waiting times are acceptable

- **Enablement:** Young people and parents would like the opportunity to talk to other young people and parents affected by similar issues
- **Inter-Agency Working:** CAMHS services need better promotion to the wider children's workforce and pathways need to be clearer. Joint working is required between the Child Development Centre (paediatrics) and CAMHS to meet identified gaps around post diagnostic support for CYP with autism
- **Looked After Children:** Insufficient treatment services are available for vulnerable young people
- **Infrastructure:** Better systems including for IT are required to support a modern, efficient CAMHS

2.3 Policy and Context

There is a significant amount of policy and guidance in relation to CAMHS which has been consulted as part of this review (appendix 2). This policy and guidance should be consulted individually but some of the key developments are summarised here:

2.3.1 No Health without Mental Health

In February 2011 the Government published 'No Health without Mental Health'[iii] following the Royal College of Psychiatrists' publication 'No Health without Public Mental Health'[iv] in October 2010 outlining the importance of mental health on physical health. Since then we have seen a drive to increase the esteem within which mental health is held to equal that of physical health services, this policy is called 'parity of esteem'.

2.3.2 Health Select Committee Report

In February 2014 the Health Select Committee launched an Inquiry into Child and Adolescent Mental Health Services (CAMHS) in response to media concerns about the availability of Tier 4 beds and the Chief Medical Officer's Annual Report 2013. In November 2014 the Health Select Committee published their report outlining "serious and deeply ingrained problems with the commissioning and provision of Children's and adolescents' Mental Health Services. These reports cover the whole system from prevention and early intervention through to inpatient services for the most vulnerable young people."[v]

A joint NHS England/Department of Health Children and Young People's Mental Health and Wellbeing Taskforce was announced and they published their report 'Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing' in March 2015[vi].

2.3.3 Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report[vii]

This report released by NHS England in July 2014 sets out a range of national issues with inpatient services for CAMHS the most significant of which is a shortage of available inpatient beds.

2.3.4 Mental Health Crisis Care Concordat[viii]

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

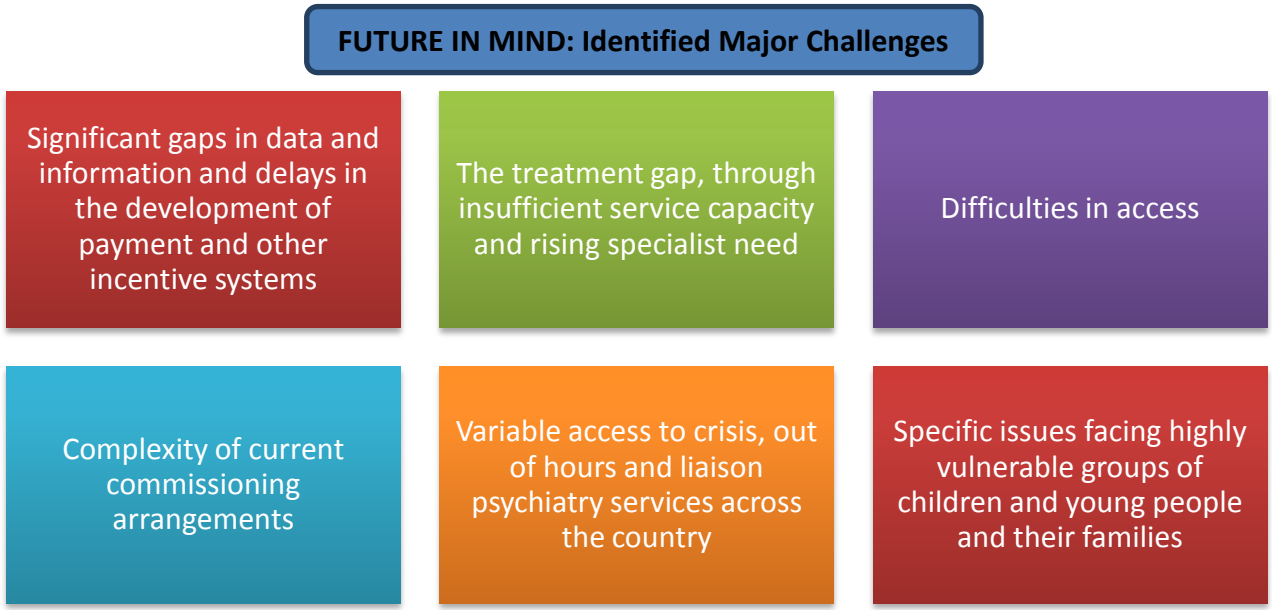
The Concordat focuses on four main areas:

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

2.3.5 Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing

The report sets out 49 proposals for Schools, Services and Commissioners, covering early years mental health, proposals for the most vulnerable, proposals for improving access and proposals around data and standards. The five key themes are:

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



As part of the government response to Future in Mind the Department of Health has allocated £30m for investment in eating disorders and self-harm services and a further £250m recurrent annual increase from 1st April 2015 for:

- Improved access to perinatal mental health
- Improved access to mental health care for children and young people with mental health problems:
    - New access targets (110,000 additional children and young people over next five years)

- New waiting time standards
- Expanding Children and Young People's Improving Access to Psychological Therapies transformational programme to the whole country and to include children with learning disabilities and under fives

The £280 million Transformation funding for CAMHS has been top sliced to support a number of pilots and national developments. Additionally each area has been given a proportion to implement local transformation plans. Haringey's allocation for both the CAMHS Transformation and Eating Disorder/Self ham element is £515,302 (2015/16) recurrent funding for 5 years. This does not include the perinatal mental health allocation which will be made separately.

2.3.6 Children and Young People's Improving Access to Psychological Therapies

Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) is a whole service transformation model that seeks to improve the quality of children and young people's mental health services. The principles behind CYP-IAPT will underpin the development and delivery of the 'Transformation Plans' outlined in Future in Mind.

It is different from the adult IAPT model (adult IAPT focused on setting up new services) CYP-IAPT is about improving the quality of existing Child and adolescent mental health services. The key principles are:

- Collaborative Working & Participation
- Routine Outcome Monitoring
- Evidence Based Practice

2.3.7 Transforming Care Programme

Transforming Care is a nationally driven programme, to improve services for people with learning disabilities and/or autism, who display behaviour that challenges. This includes those with a mental health condition who are likely to receive hospital treatment, the aim is to reduce inappropriate admissions and support timely discharge to the community. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home.

The Transforming Care programme focuses on the five key areas of:

- Empowering individuals
- Right care, right place
- Workforce
- Regulation
- Data

2.3.8 Regional & Local Context

Mental health continues to be a local priority in Haringey. Several key documents have emphasised the need for improved child and adolescent mental health support see appendix 2. On a local/regional level these include:

- Better Health for London

- Improving care for children and young people with mental health crisis in London: Recommendations for transformation in delivering high quality accessible care. (Healthy London Partnership – Children and Young People Programme)
- Haringey Health and Wellbeing Strategy
- Haringey Council Corporate Plan
- Haringey CCG Plan on a Page
- Haringey's Mental Health and Wellbeing Framework
- Haringey Early Help Strategy for Children, Young People and Families
- Haringey's Crisis Care Concordat
- Haringey's Youth Strategy

Additionally in late 2014 the Adults and Health Scrutiny Panel completed a panel report on 'Transition from Child Mental Health Services to Adult Mental Health Services'. This identified a number of areas for development which are being taken forward through the local transformation plan.

2.3.9 Child and Adolescent Mental Health Services (CAMHS) Models

The tiered model of CAMHS provision has been subject to increased debate in recent years. The model was first described in the National Service Framework for Children, Young People and Maternity Services, 2004.
Tier 1: refers to universal services. The level of support described here is informal and provided by professionals within the broader children's workforce such as teachers, GPs and health visitors, their main role is not specifically mental health, but they should be trained and supported to recognise mental health distress, and be able to support or signpost children for help.
Tier 2: offers more structured approaches provided by specialist trained mental health professionals. It is generally provided by professionals working on their own to support young people who require more support than is available at Tier 1.
Tier 3: is aimed at people with more complex or persistent mental health problems and is often delivered within a multi-disciplinary team in the community.
Tier 4: services are aimed at children and adolescents with severe and/or complex problems and may be offered in residential, day patient or out-patient settings. They provide a combination or intensity of interventions that cannot be provided by Tier 3 CAMHS. These services include adolescent in-patient units, secure forensic adolescent units, eating disorder units, specialist teams for sexual abuse and specialist teams for neuro-psychiatric problems.

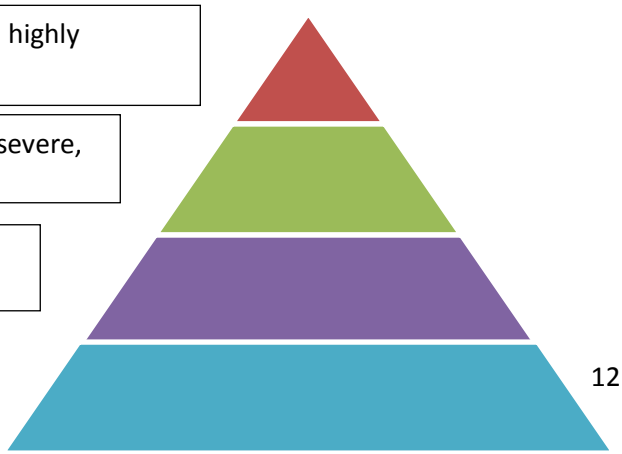
The Four Tier CAMHS Framework
National Service Framework for Children, Young People and Maternity Services 2004[ix]

Tier 4: Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units.

Tier 3: A specialised multi-disciplinary service for more severe, complex or persistent disorders.

Tier 2: A service provided by specialist individual professionals relating to workers in primary care

Tier 1: A primary level of care



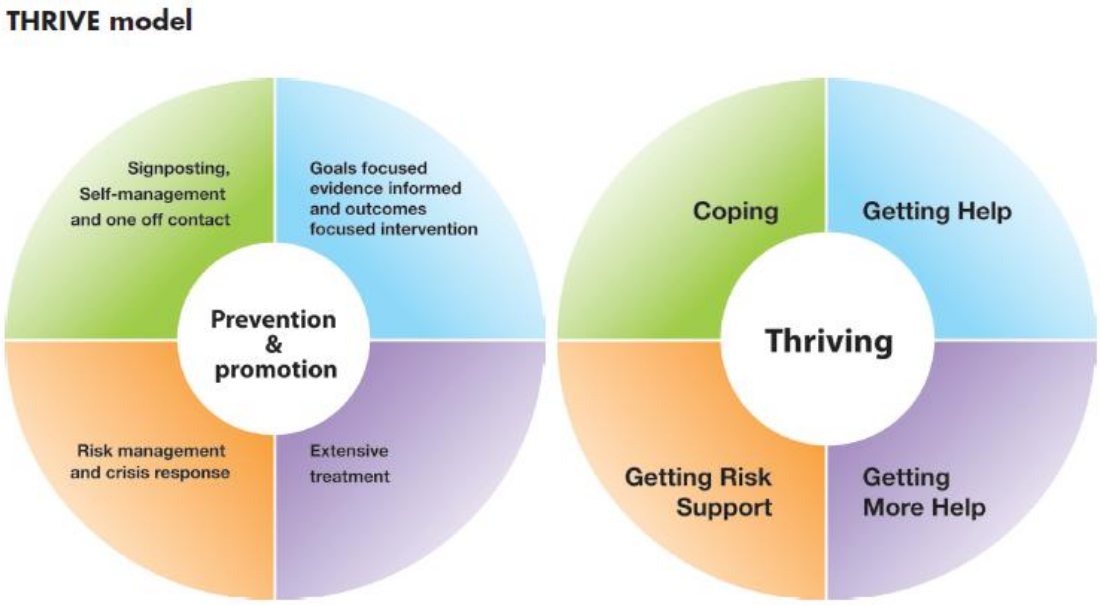
Whilst this has been a useful way to understand provision- giving the opportunity for standardisation and comparison of services across the country, concerns have been expressed that it has led to barriers between services, with children and young people not fitting neatly into a 'tier'. This was not the intention of the NSF which was to identify various types of provision, suitable for a variety of needs and that could/should be delivered across the whole system of healthcare, and not just by mental health provider Trusts. In reality due to a decrease in the level of support/intervention provided at Tier 2 (in most areas of the country) in recent years, mental health Trusts providing Tier 3 increasingly receive referrals which would previously have been sent to Tier 2 and are increasingly commissioned to provide this level of service. This, in turn, has meant longer waits for assessment and treatment.

However although CAMHS is articulated for the purposes of planning, by a series of separate commissioners and providers, from the point of view of the family there should be a seamless, integrated and coordinated offer. Until the Department of Health complete the updated prevalence survey outlined in 'Future in Mind' the best data available is framed in the tiered structure, and therefore tiers are referenced a number of times in the report for the sake of clarity and consistency.

Thrive: The AFC-Tavistock Model for CAMHS[x]

In November 2014 The Tavistock and Portman NHS Foundation Trust in partnership with the Anna Freud Centre published a new approach to CAMHS modelling that seeks to group children and young people into clusters according to the type of support and treatment they require.

The benefits of this model is that these clusters fit with final report of the CAMHS payment system project published in June 2015 and that it is articulated on need rather than diagnosis. The limitations are that there is no mapped prevalence data or modelling which indicates what levels of resource are required for each cluster. Work is being done to develop and pilot this model, and hopefully as this matures it can be used to inform commissioning intentions.



2.4 Current Service Provision

2.4.1 Commissioning Arrangements

The commissioning of CAMHS is a shared responsibility across health, education and social care. Historically the CAMHS grant was delegated to the local authority to invest in targeted services (Tier 2 and directed provision) whilst the bulk of provision delivered through specialist multi-disciplinary teams (Tier 3) was the responsibility of the local NHS. Commissioning for Tier 4 (inpatient and highly specialised outpatient resources) passed over from local NHS organisations to the NHS England's Specialised Commissioning Team in April 2013.

Public Health, which has recently moved into the Council, has responsibility for promoting emotional wellbeing at a population level and schools have the responsibility for supporting mental health in their schools through a healthy schools approach, this has recently been added to the OFSTED framework. As part of this responsibility schools commission their own counselling or psychological support to see pupils in school and for assessing and supporting access to education through educational psychology (provided by the Council). These overlapping responsibilities have generated disparity between what children and young people in one part of Haringey can access compared to another. An audit of Haringey Schools completed as part of this review shows even within the small sample (17 schools) there are variations in spend from £0 to over £10,000 per school.

2016 Update:

Work has now started to establish collaborative commissioning arrangements with NHSE to look at how pathways can be improved by integrating commissioning of inpatient services with intensive community support.

Work is being done at the moment to better understand what Schools are buying and to support schools in delivering a whole school approach as part of the Transformation Plan.

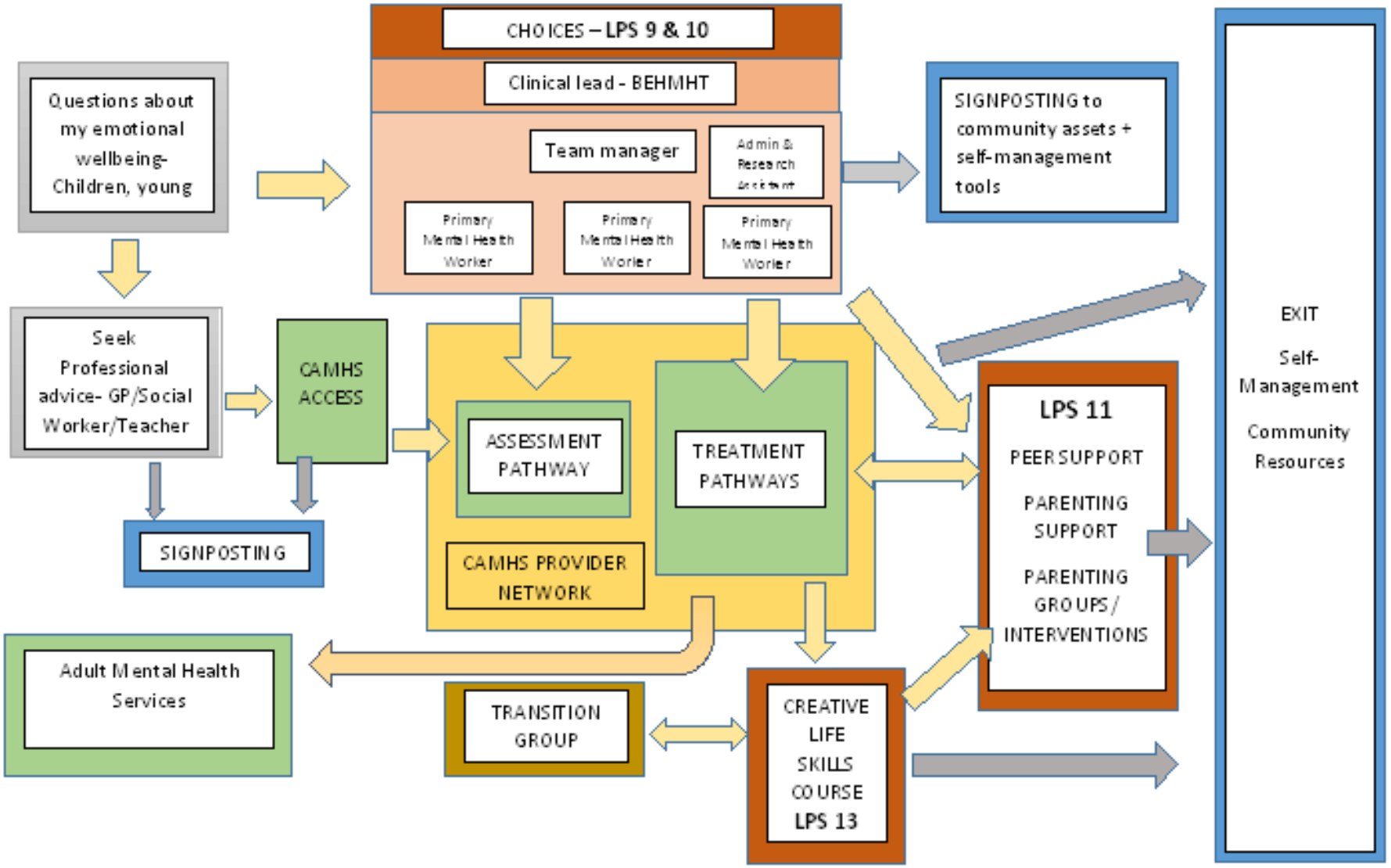
2.4.2 Service Mapping

Barnet Enfield and Haringey Mental Health Trust is the main CAMHS provider in Haringey, delivering a number of services including a single point of entry known as 'CAMHS Access', which was established in 2009. CAMHS Access functions as a front door for referrals to all commissioned Haringey CAMHS services, though some also accept direct referrals. CAMHS Access also links with non-CAMHS agencies such as Insight Platform who provide drug and alcohol services. Referrals to CAMHS Access can be made by a GP, School, Social Worker, Health Visitor or other professional but it does not currently accept self-referrals.

All tertiary services and bespoke packages where there is not a commissioned pathway are managed through Tier 3, for example second opinions from Great Ormond Street Hospital or South London and Maudsley NHS Foundation Trust. These are sometimes immediately identified by CAMHS Access but most often would be identified by a local CAMHS service having undertaken an assessment. CAMHS Access is currently only officially linked in to a small number of voluntary sector agencies. There are alternative pathways for some provision such as First Step, which is a notification service for all Haringey's Looked After Children and services commissioned directly by schools.

As of October 2016 a new service has been developed to provide a face to face one-off appointment for children and young people and their families. This new access point, named ‘Choices’ takes self-referral and CAMHS Access will be incorporated into this service over the coming year. This triage appointment will take a community asset based approach to ensure that those requiring CAMHS are quickly identified and those who can be supported by digital or community resources are diverted appropriately, with self-management information in line with the Thrive approach. Below is a diagram of the current pathways, incorporating the new local priority schemes (LPS).

Haringey CAMHS Transformation – LPS 9, 10, 11 & 13



Self- referral, peer support and tackling transition – enabling and empowering children, young people and families in Haringey

Dr. Nick Barnes

Standard Offer- Direct Intervention Services

Table 2: The following services are available across the Borough and are commissioned to provide services up to 18th birthday meeting the provider eligibility criteria

Service	Provider	Description	Age Eligibility
Choices	Barnet, Enfield and Haringey Mental Health Trust	Single appointment consultation service for CYP and families who have concerns around emotional wellbeing/behaviour , offering an assets based approach	0-18 years
Parent Infant Psychology Service	Whittington Health NHS Trust	Perinatal community service supporting parental mental ill-health and attachment	0-2 years
Generic CAMHS (Burgoyne Road)	Barnet, Enfield and Haringey Mental Health Trust	A multi-disciplinary service delivering a range of interventions to children and young people with severe/complex or persistent mental health concerns	0-18 years
CAMHS in GP Surgeries Pilot	Health and Emotional Wellbeing Service (HEWS) Barnet, Enfield and Haringey Mental Health Trust	Brief psychological interventions delivered in primary care for those not meeting the threshold for Tier 3 CAMHS currently running as a pilot	2-18 years
Haringey Adolescent Outreach Team (St Ann's Hospital)	Barnet, Enfield and Haringey Mental Health Trust	An assertive team who provide support on discharge from inpatient services, crisis and risk support in the community and outreach for those unable to attend clinic services/hard to engage with significant risk, also fulfilling the role of an Early Intervention in Psychosis service for under 18s. Currently 5 days and little evening cover	12-18 years
Open Door Young People's Service	Open Door (Voluntary Sector)	Psychological therapies for young people experiencing emotional difficulties ranging across tiers 2 and 3 with a focus on psychotherapy- both brief and longer term interventions are available	12-25 years
Parenting Teenagers Project	Open Door (Voluntary Sector)	Therapeutic support for parents of adolescents and young adults aged 12-21	Parents of young people 12-21 years
Paediatric Mental Health Team	Whittington Hospital	Support to children and young people admitted to hospital in mental health crisis or for self-harm and supports acute paediatric services with mental health presentations	0-16 years
Child and Adolescent Psychiatry Paediatric Liaison Team	North Middlesex University Hospital	A multi-disciplinary mental health team providing support to patients accessing North Middlesex University Hospital with medically related conditions. Does not provide an emergency response for deliberate self-harm.	0-16 years
CAMHS Inpatient Services	Various Local unit- The Beacons (BEHMHT)	Intensive psychological and psychiatric support and treatment for young people with significant mental health problems who cannot be successfully managed in the community.	0-18 years 13-18 years

Service	Provider	Description	Age Eligibility
Adult IAPT & Big White Wall	Whittington Health Big White Wall	Adult 'Improving Access to Psychological Therapies' Service provides access to brief psychological interventions primarily for anxiety and depression. Big White Wall is a monitored and supported online resource primarily for peer support. Both are available for young people 16+ subject to the appropriateness of the service for the individual young person.	16+ years
RAID at North Middlesex University Hospital & Barnet General	Barnet, Enfield and Haringey Mental Health Trust	Psychiatric liaison within hospital settings. For over 16s, this team will provide support 24/7 linking young people into CAMHS on discharge.	16+ years

*Services deliver up to but not including the upper limit age specified.

Tailored Offer- Direct Intervention Services

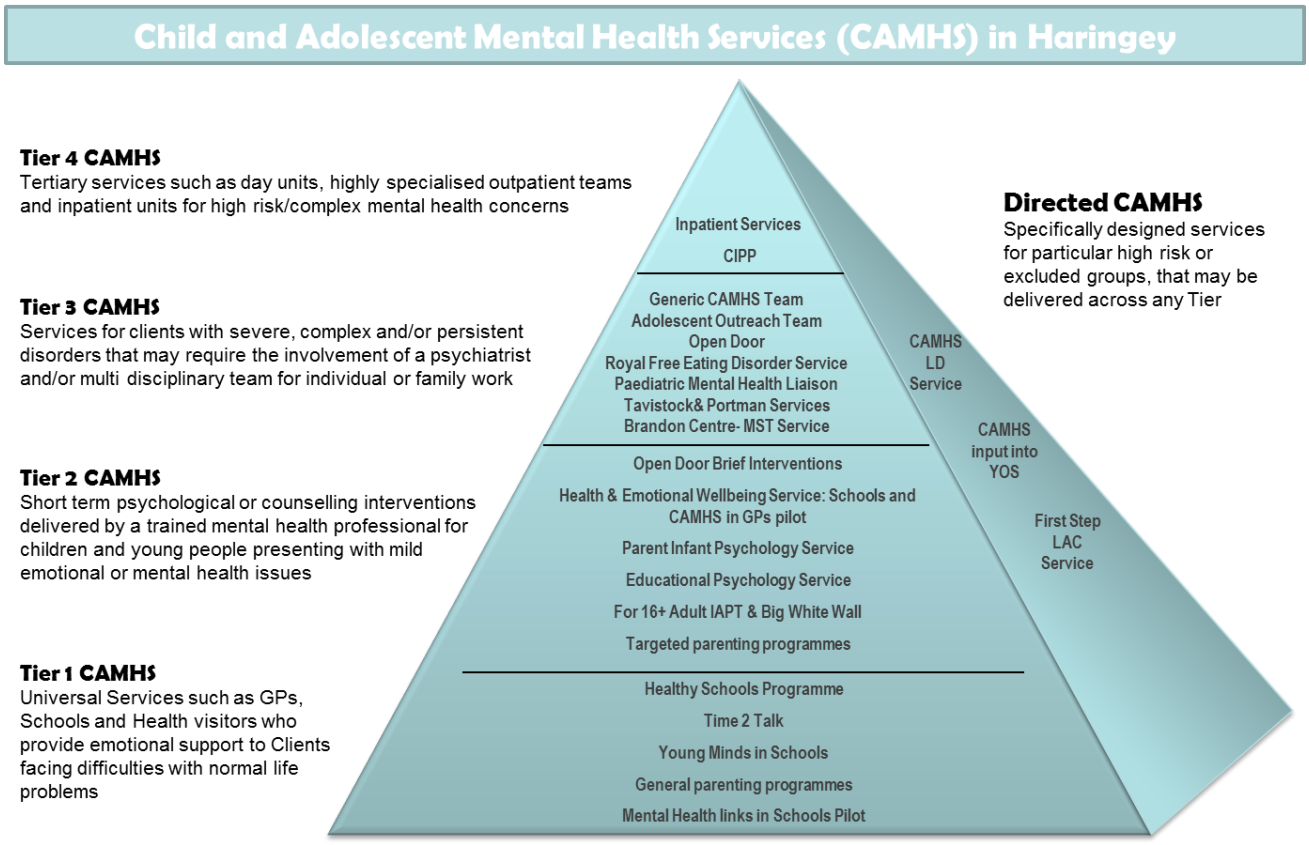
Table 3: The following services are designed to meet the needs of specific groups of children and young people and are not part of the standard offer. They may be commissioned for a particular group or for a specific locality

Service	Provider	Targeted Group
Health and Emotional Wellbeing Service (Schools)	Barnet, Enfield and Haringey Mental Health Trust	Commissioned by Schools for individual school populations
Counselling in Schools	Various agencies/providers including Open Door and Hope in Tottenham	Commissioned by Schools for individual school populations
Bounds Green Outreach Service	Tavistock and Portman NHS Foundation Trust	Commissioned by the CCG to provide generic CAMHS for the locality and an outreach base for Tavistock and Portman specialist services
CAMHS LD Service	Barnet, Enfield and Haringey Mental Health Trust	Service for children aged 3-18 with a learning disability (IQ below 50, P levels or low level national curriculum) severe challenging behaviours, or suspected co-morbid mental health issues
CAMHS input into Youth Offending Service	Barnet, Enfield and Haringey Mental Health Trust	CAMHS support hosted into the Youth Offending Service to support children and young people in the criminal justice system
First Step Looked After Children Service	Tavistock and Portman NHS Foundation Trust	A screening and assessment service for looked after children and up to six sessions where required
Tavistock and Portman Child and Family Services	Tavistock and Portman NHS Foundation Trust	Specialist Services meeting the needs of groups who need tailored treatment and support: • Fostering Adoption & Kinship Care • Adolescent and young adult transition service • Lifespan autism/ neurodevelopmental • Trauma and Refugees

Educational Psychology Service	Haringey Council	This service has a statutory duty around contributing to the Education Health and Care Plan process to facilitate an understanding of how learning can be accessed. Additional services can be commissioned by schools such as applying psychological principles, methods and techniques to help parents/carers, and schools increase the effectiveness of teaching and learning, for children where concern has been identified.
Centre for Interventional Paediatric Psychopharmacology (CIPP)	South London and Maudsley NHS Foundation Trust	Tier 4 Service for highly complex presentations of neuropsychiatric disorders
Gloucester House Day Unit	Tavistock and Portman NHS Foundation Trust	A highly specialist joined-up health and education service within a single setting, that can involve psychotherapeutic, psychiatric, psychological and social work input.

In addition to the above direct intervention services there are a number of projects within universal services to build resilience in more general populations, and time limited programmes targeted at specific groups. These include: State of Play, a project funded by Haringey Public Health, delivered in partnership with Tottenham Hotspur Foundation, New Choices for Youth and Haringey Adolescent Outreach Team and are usually time limited projects rather than services.

The below diagram represents Haringey CAMH specific services according to the Tiered Model.



2.5 Understanding Need

2.5.1 Prevalence Data

- *9.6% of children and young people aged between 5 and 16 years have a mental health disorder*
- *7.7% children aged 5-10 years have a mental health disorder*
- *11.5% of young people aged between 11 and 16 years have a mental health disorder*
- *In an average class of 30 school children 3 children will suffer from a diagnosable mental health disorder*

Future in Mind, 2015

Existing prevalence data is based on estimates from the latest epidemiology study by Green et al in 2004 (Future In Mind pg 5). The rates we have used are based on current population and according to the Green methodology. The limitations to this are that they do not include the 0-5 or the 16-18 groups to which CAMHS also deliver.

Future in Mind highlights the need for more up to date prevalence data, and this is likely to result in a national survey being completed every 5 years. When this becomes available we will use this data to update our needs assessment and assumptions. Additionally the Health and Social Care Information Centre (HSCIC) has developed a new data set for CAMHS. From 2016 providers are required to submit data including outcome data, which should improve national data and understanding of children and young people's mental health services.

Figures are also different depending on whether you look at the numbers which the council are responsible for (those living in Haringey) or those for whom the Clinical Commissioning Group is responsible (those registered with a Haringey GP). Various services are commissioned on the basis of these different parameters so therefore where possible both figures are included, though broadly the populations are similar.

Table 4: Estimated number of Haringey children with mental health disorders by age group and sex

		Estimated Number of Children 5-10	Estimated Number of Children 11-16	Estimated Number of Children TOTAL
Based on ONS (local authority)	BOYS	1100	1200	2300
	GIRLS	525	925	1450
	TOTAL	1625	2125	**3750**
Based on GP registration (CCG)	BOYS	1165	1230	2395
	GIRLS	565	955	1515
	TOTAL	1730	2185	**3910**

Table 5: Estimated number of Haringey children with mental health disorders by disorder 5-16 years

	Based on ONS (local authority)	Based on GP registration (CCG)
Conduct Disorders	2310	2410
Emotional Disorders	1490	1550
Hyperkinetic Disorders	630	660
Less Common Disorders	540	565

NB. Table 4 and 5 figures are both sourced from Chimat [xi].Totals differ as one in five of the children were diagnosed with more than one of the main categories of mental health disorder. The most common combinations were conduct and emotional disorder and conduct and hyperkinetic disorder

Definitions (Green et al, 2004 and ICD10 2015)

Emotional Disorders: Emotional problems involving anxiety, depression and obsessions.

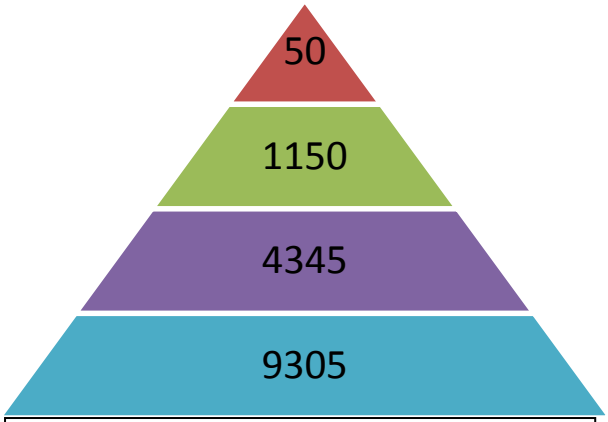
Conduct Disorder: Disorders characterised by a repetitive and persistent pattern of dissocial, aggressive, or defiant conduct. Such behaviour should amount to major violations of age-appropriate social expectations (ICD 10 version 2015) e.g. Oppositional Defiant Disorder

Hyperkinetic Disorders: Lack of persistence in activities that require cognitive involvement, and a tendency to move from one activity to another without completing any one, together with disorganized, ill-regulated, and excessive activity. (ICD 10 version 2015) e.g. Attention Deficit Hyperactivity Disorder

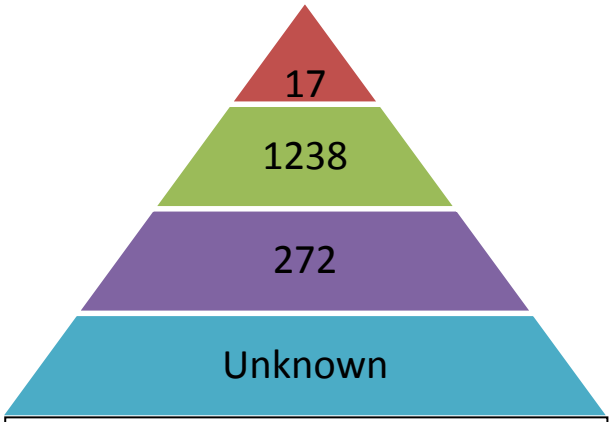
Less Common Disorders: Other disorders outside above such as autism spectrum disorders (developmental) tic disorders (motor and vocal tics) and eating disorders (anorexia nervosa and bulimia)

2.5.2 Mapped Activity Data

The majority of commissioned Haringey providers have contributed information and data in the course of this review. This data has been used to map prevalence data against activity data. It does not include activity within non-commissioned provision such as private therapists.



Children and Young People requiring a response by Tier: Estimates based on CCG population (under 18 year olds)



Approximate number of Children and Young People receiving a commissioned response by Tier in 2014/15

The figures in the left pyramid denote the number of children and young people who may experience mental health problems appropriate to a response at each of the tiered levels according to CCG population figures.

The figures in the right pyramid show the number of children and young people accessing a commissioned service at each Tier.

Tier 1

This relates to children and young people who are receiving emotional support through universal services such as schools, nurseries, children's centres and GPs who provide support to children and young people facing difficulties with normal live events such as bullying and bereavement. As this support is informal it is not recorded in any way and therefore it is impossible to know how many children and young people are accessing support at this level. Further intelligence will be gathered through a population survey currently being developed by public health. Delivered at this level are initiatives such as whole school approaches to mental health, and resilience programmes to promote a healthy environment.

Tier 2

In Tier 2 the figure used relates to the number of accepted referrals within 2014/15 as the caseload is likely to be unrepresentative due to the short term nature of the interventions. This however demonstrates the gap between commissioned provision and expected need. Tier 2 interventions are usually delivered by a mental health worker or counsellor in a uni-disciplinary way. Predominantly these are brief interventions aimed at young people who need additional support but who do not meet the 'severe and/or persistent' criteria for Tier 3. The figure in the table includes only commissioned services across the Council and CCG, and does not include any individually commissioned work by Schools outside of the Health and Wellbeing Service (HEWS) or private provision as we were not able to get exact figures for these, though they are unlikely to bring to total to more than a thousand.

Tier 3

Currently Tier 3 makes up the bulk of commissioned services. The data shows that the caseload of Tier 3 is roughly approximate to predicted need, however in addition to the caseload at period end there will have been some young people seen and discharged within the year. Where caseload data was not available accepted referral data has been used. This data excludes those seen by paediatric A&E liaison as these were not available. All figures relate to those seen by Haringey teams or under Haringey contracts, and could vary depending on whether reporting was organised by GP registration, residence or school attendance.

Tier 4

The majority of Tier 4 services are commissioned through NHS England. The figures included are the number of children who were admitted in 2014/15 and those accessing the CCG commissioned CIPP (Centre for Interventional Paediatric Psychopharmacology) Service or the Tavistock and Portman's Day Unit Gloucester House. Additionally some children may be accessing specialist services such as the Gender Identity Disorder Service at the Tavistock and Portman or the Portman Clinic which offers specialised long-term psychoanalytic psychotherapeutic help to people who suffer from problems arising from delinquent, criminal or violent behaviour or from disturbing and damaging sexual behaviours or experiences. These and other Tier 4 services which may have very small numbers are not included in these figures but are unlikely to increase the numbers accessing to anywhere near expected prevalence rates.

Since 2004 when prevalence rates were calculated a lot of work has been undertaken by local community CAMHS to reduce the numbers of children and young people needing to access support at this level. The small numbers in Tier 4 may reflect a robust community approach.

2016 Update:

Nationally there is a commitment to extend access for those with a diagnosable mental health condition to Child and Adolescent Mental Health Services. Calculations based on Transformation Plans estimate that approximately 25% of the population requiring CAMHS currently have access, with a target to improve this to 35%. The limitation of this is that there is not an agreed methodology nationally for calculating this prevalence rate, some areas are using the numbers they anticipate to need a Tier 2, 3 or 4 service, and others are applying the Future in Mind estimated 9.6% rate across their child population. Other areas are using the Public Health Fingertips Tool for estimated prevalence of MH disorder using 2014 ONS data, however this only includes 5-16 year olds. For Haringey these various figures are:

Table 6: Prevalence Modelling

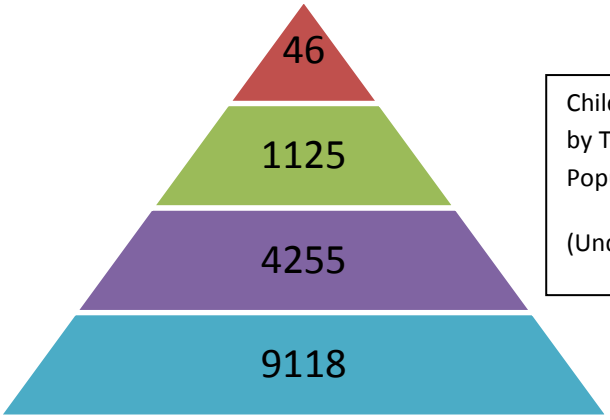
Source	Population numbers	Estimated prevalence of MH Condition
PHE Fingertips using 2014 ONS data calculating estimated MH Disorders for 5-16 year olds	37,905	3,745 (9.9% of 5-16 year olds)
Future in mind estimated prevalence (9.6%) using 2015 ONS data for 0-18 year olds	60,785	5835 (9.6% applied to 0-18 year olds)
Extrapolated Kurtz 1996 by Tier (including Tier 2, 3 and 4) using 2015 ONS data for 0-18 year olds	60,785	5426 (0-18 year olds)

Using our 2014/15 review data across services 1527 CYP were accessing commissioned CAMHS at Tiers 2,3 and 4, with a further 500 estimated to be receiving through school counselling. Using only commissioned figures the below table demonstrates the 2014/15 position against the 25% national estimate and 35% target.

Table 7: Activity Projections

Source	25% Estimate	35% Target	2014/15 Actuals %
PHE Fingertips using 2014 ONS data calculating estimated MH Disorders for 5-16 year olds	936	1,311	41%
Future in mind estimated prevalence (9.6%) using 2015 ONS data for 0-18 year olds	1459	2,042	26%
Extrapolated Kurtz 1996 by Tier (including Tier 2, 3 and 4) using 2015 ONS data	1356	1899	28%

Given that we will be calculating prevalence against service access we intend to use Kurtz as the figures are applicable to the 0-18 population that we commission and deliver services for. Additionally using this figure provides us with a stretch target, supporting our ambition to expand and invest in early intervention.



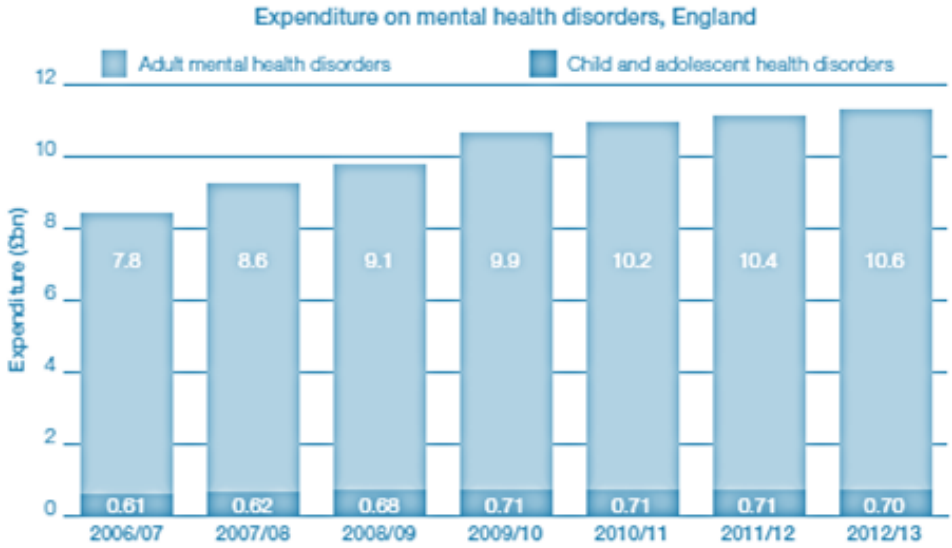
Children and Young People requiring a response by Tier: Estimates based on Local Authority Population using 2015 ONS figures

(Under 18 year olds)

2.5.3 Investment and Financial Data

Nationally it's been reported that in 2012/13 NHS expenditure on child and adolescent mental health was estimated to be £700 million or 6% of the total spend on mental health, however we do not currently have reliable local rates, and no nationally collected more recent data.

NHS expenditure on mental health



Gaining a clear understanding of investment in CAMHS has proved challenging. Neither Haringey CCG nor Haringey Council has specifically disinvested in CAMHS over the last few years; however some services have lost other funding avenues such as national grants, and in April 2016 the Brandon Centre gave notice on our MST service, which has not yet been re-commissioned. Part of the challenge is agreeing which services sit within the remit of CAMHS and being able to get reliable financial information on a service line level. The vast majority of CAMHS spend sits within block contracts and disaggregating this has proven challenging, for some services the funding is within the acute tariff and therefore not possible to report on a service line level.

Due to the nature of block contract arrangements, financial reporting for BEHMHT is based on activity (contacts) with costs then extrapolated. Financial data provided by BEH on the service costs show that the 2015/16 amount is an approximately accurate picture of funds allocated to the Haringey Service. As

reporting improves and we disaggregate the block we are getting a clearer understanding of spend. However we need to do more work to understand resourcing and outcomes and we cannot be confident that the level of investment made is translated into service capacity to provide the outcomes required for the population. In order to get this level of clarity we have provided notice to providers that we are looking to disaggregate the CAMHS Spend from within the block contract.

It is also important to note the vital contribution of the voluntary sector including Mind in Haringey and Open Door. Open Door receives only 42% of its total funding from statutory agencies, attracting a significant amount of investment into Haringey through national grants and charitable trusts. It is important to maintain voluntary sector capacity to draw in other funding, and the ability to pilot and test new approaches and respond to developing needs outside of statutory contracts.

Table 8: Financial Investment in CAMHS

CAMHS SPEND	CONTRACT	2015/16	2016/17 Budget
Haringey Clinical Commissioning Group			
Barnet, Enfield and Haringey Mental Health Trust	BLOCK	£2,436,203	£2,496,377
Tavistock and Portman Child & Adolescent Services (approx. 80% of block)	BLOCK	£449,162	£412,930*
Open Door	BLOCK	£121,000	£123,984
Extra-Contractual Referrals/Non-Contracted Activity	Cost Per Case	£13,500	£30,000
Primary Care CAMHS/CAMHS in GP Surgeries	BLOCK	£45,456	£- **
Royal Free (Eating Disorders & Generic)	Cost Volume (Estimated)	£256,280 ED £25,000 Gen	£264,660 ED £25,823 Gen
SLAM (CIPP)	Cost Volume (Estimated)	£25,000	£22,424
Whittington PIP	BLOCK	£235,000	£242,689
Paediatric Mental Health Liaison Team (Whittington)	BLOCK	Within Acute Tariff	Within Acute Tariff
Child and Adolescent Paediatric Liaison Team (NMUH)	BLOCK	Within Acute Tariff	Within Acute Tariff
TOTAL	TOTAL	£3,645,198	£3,618,988
Haringey Council			
Children and Young People's Services			
Tavistock & Portman (First Step)	BLOCK	£352,796	£362,921
BEH	BLOCK	£172,000	£172,000
BEH- Edge of Care	BLOCK	£38,000	£38,800
Brandon Centre (Multi-Systemic Therapy)	BLOCK	£114,000	£114,000***
Open Door (Development of Open Door Tottenham)	BLOCK	£37,000	£37,000
Open Door (18-25 years)	BLOCK	£9,500	£9,500
SUBTOTAL		£723,296	£734,221

Public Health			
Young Minds	BLOCK	£24,200	£21,200
Whittington PIP	BLOCK	£40,000	£69,000
SUBTOTAL		£64,200	£90,200
TOTAL		£787,496	£824,421
NHS England Specialised Commissioning London			
Acute Units in London	Cost per case	£500,394	N/A
Acute Units out of London		£94,219	N/A
TOTAL		£594,613****	N/A
HARINGEY TOTAL		**£5,027,307**	**N/A**

*Value is set based on activity figures from month 6 of previous year and fluctuates annually based on usage.
** Ongoing service past pilot phase funded through CAMHS Transformation Funding
*** This figure reflects the budget, however provider has given notice on service and we are yet to re-commission so anticipate underspend on this budget line.
**** This figure has been updated based on NHSE provided figures for 2015/16

CAMHS Transformation Funding

The below table outlines the estimated allocations made to Haringey CCG under Future in Mind, which are being invested in our Local Priority Schemes, outlined later in the document. Additionally it has been announced that a further £25 million will be available nationally to support CAMHS Transformation in 2016/17 and we are currently awaiting information on allocations, but will be using this money to reduce waiting times and support the implementation of improved crisis care with NCL partners.

Table 9: CAMHS Transformation Funding

Investment	2015/16	2016/17	2017/18	2018/19	2019/20
Transformation Funding	£368,203	£635,000	£747,000	£907,000	1,013,000
Eating Disorder Funding	£147,099	£160,000	£160,000	£160,000	£160,000
MH Links Funding	£150,000	£0	£0	£0	£0
CYP-IAPT Funding	£13,000	£39,000	TBA	TBA	TBA

2.5.4 Benchmarking Data

The latest CAMHS benchmarking data is from the 2013 CAMHS benchmarking report, some of the data from this is useable and has been utilised in this report, other data such as the exact staffing profiles and averages is not clear and the detailed information is only available to participating Trusts and CCGs, of which Haringey was not. What is clear is that Haringey has a very psychotherapy heavy staffing model. This is to an extent due to the nature of how the local voluntary sector has developed, looking at the workforce across providers is therefore important to ensure the right skills mix.

Haringey was part of the London and South East Collaborative for CYP-IAPT in the first wave. Emerging outcome data shows the partnership which currently comprises Barnet, Enfield and Haringey Mental Health Trust and the Educational Psychology Service are within the normal range for achieving clinical outcomes.

This data is gathered from a number of clinical outcome measures including Strengths and Difficulty Questionnaires and RCADs, however the data is currently only available in a small sample of cases (data completeness at 51.4% in quarter 3 2014/15 against a target of 90%) and significant work to improve recording and reporting on these measures is currently being undertaken.

Open Door has been collating outcome data for a number of years across their service and has recently joined the partnership. As CYP-IAPT becomes more embedded and data becomes more complete we will get a better picture of the clinical efficacy across commissioned services and how these compare to other areas.

Another source of benchmarking is CORC (CAMHS Outcome Research Consortium). Currently only BEHMHT is able to report on their CORC data, though Open Door has recently joined CORC and should be able to provide benchmarked data in future. Other services should also look to benchmark themselves against their peers.

As with the CYP-IAPT data BEH do not have enough data to make it a meaningful benchmark of provision in a number of areas. The latest report covering 2013-2014 only had CHI-ESQ (Child Experience of Service Questionnaire) returns for 14 children and 27 parents across the Trust, this rate is significantly lower than the CORC average and BEH should immediately look at improving collection mechanisms. One area where there was good comparative data was CGAS (Children's Global Assessment Scale) which is a numeric scale used to rate the functioning of children and young people. This showed no significant variances with other CORC services in the average scores and improvement over time.

What CORC does demonstrate is that across BEH services there are significantly more 0-12 year olds receiving treatment from CAMHS than comparator Trusts and less in the 13-18 age range. This is likely to be because of the availability of Open Door for teenagers. Another area of variance from other CORC services is the types of presenting problem, BEH see significantly more children with Emotional Disorder, Conduct Disorder and Autism Spectrum Disorder. Additionally BEHMHT routinely sees children and young people over a longer period of time than comparators; this is addressed later in the document. Open Door have been collecting data for a number of years and demonstrate good return levels and clinical outcomes using HONOSCA (Health of the Nation Outcome Scales for Children and Adolescents), CGAS and CHI-ESQ.

3. How Future in Mind Relates to Haringey

3.1 Accountability and Transparency

Future in Mind places a requirement on local areas to have lead commissioning arrangements for children and young people's mental health and wellbeing services with aligned or pooled budgets and a single integrated plan for child mental health services supported by a strong Joint Strategic Needs Assessment. At the same time national change to Special Educational Needs and Disability through the Children and Families Act 2014 places a duty on health, education and social care to jointly commission and provide services in collaboration with families and young people. In Haringey joint commissioning has recently been established for CAMHS between the Council and the CCG with aligned budgets, but without pooled resources. In practice this means that whilst planning is now being done jointly, areas such as the commissioning and contract management of providers are being duplicated. Additionally schools are not currently part of joint arrangements and continue to commission independently. A further requirement of Future in Mind is that investment be fully transparent, however the full picture of CAMHS spend is not available due to block funding arrangements, without a clear understanding of current investment levels it is difficult to assess the impact of CAMHS provision and ensure value for money.

2016 Update:

A section 75 agreement to pool budgets has been drafted between Haringey CCG and Haringey Council. A pooled budget for CAMHS will be established from April 2017 and work is currently being done to update and amalgamate specs to support the development of single contracts for providers.

3.1.1 Choice

In December 2014 the right to choice was extended to mental health[xii] as part of the work around parity of esteem between physical and mental health services. This legal right covers routinely commissioned mental health services and was extended in the final guidance to not solely cover the first appointment but also the entire episode of care for which the patient was referred. Currently the CCG who now have a duty to commission with regard to this guidance do not have any flexibility within budgets to allow the funding to follow the patient. In practice there have been very few referrals outside of Haringey contracts. However, any increase in choice will result in a cost pressure to the CCG. If choice is to be promoted resources will need to be flexible enough to 'follow the child'. This right to choice and personalisation of services for an individual child is also an ethos reflected in the SEND reforms as part of the new Children and Families Act 2014.

2016 Update:

The new Choices Service will provide us with invaluable data about the sort of services required to meet the needs of the population. An assistant psychologist is incorporated into the model to monitor the outcomes of the consultations and to provide us with more information around the services families want and need.

3.1.2 Payment By Results

In June 2015 the final report on the payment by results pilot was published. Payment by results for CAMHS is loosely based on the Thrive model, grouping people into three need based categories and within these diagnostic based subsections:

- Getting Advice
- Getting Help
- Getting More Help

Currently neither commissioners nor providers are in a position to move to PBR, however in order to prepare, services should begin clustering service users and make this data available to commissioners. The document does not outline any timescales for the implementation of CAMH PBR as further work refining and piloting the model is necessary.

3.1.3 Cross-Borough Working

Barnet, Enfield and Haringey Mental Health Trust (BEHMT) are currently commissioned to provide a service for any child living in, attending school in or registered with a GP in Haringey. This attempt at ensuring seamless services means that the team rarely rejects a referral on the basis of commissioning responsibility. Currently only 88.3% of referrals into the Haringey CAMHS team at Burgoyne Road relate to children and young people with a registered Haringey GP, however Haringey patients also make up 6.9% of the Enfield team's caseload and 3.39% of the Barnet caseload. Across the five NCL boroughs there is currently an agreement to accept if the GP cross-refers on the basis of patient choice. However Whittington Health who provide CAMHS for Islington and Tavistock and Portman who provide CAMHS for Camden both have contracts with the CCG, so this activity is cross-charged.

Islington and Camden do not have contracts with BEHMT and therefore this activity is not funded. Recently scoping work has been completed to look at the size of the issue which demonstrates Camden referrals are negligible and Islington make up only 1.75% of the referrals. However there are approximately 83 referrals from outside of Barnet, Enfield and Haringey coming into the team annually, at approximately £3000 per child for treatment, this revenue should be generated and transparently reinvested in the local teams or reserved by CAMHS access to facilitate choice where an interest in out of borough services has been expressed.

3.1.4 Better Commissioning

In order to ensure high quality service provision commissioning in Haringey needs to be improved. There are currently contracts without specifications, providers with multiple contracts across the statutory agencies and a lack of coherence to both commissioning and contract monitoring arrangements. In order to meet the challenges of providing choice and establishing a position of readiness for PBR it is important to undertake changes in the way commissioning is currently done. The landscape for commissioning continues to change across the country.

Block contracts that were issued for many years are now being disaggregated across the country in order to provide greater transparency on how resources are allocated. There is an increased focus on outcomes, accountability and value, and many areas have re-commissioned CAMHS in an attempt to transform services.

However this can have negative impacts on staff morale, can cause significant disruption to service delivery and can create a situation where staff are not invested or engaged in transformation. In order to create sustainable transformation it is imperative that the process is supported by families and staff.

As a matter of urgency outcome focussed specifications should be developed for all services, working with providers and staff to meet the challenges outlined in this report. These specifications should be developed with providers and families and be in-line with CYP-IAPT principles and best practice.

In order to get a better financial understanding of CAMHS investment and in order to facilitate the implementation of a single integrated plan a section 75 should be established to pool CAMHS funding across health and social care. Where practical Haringey should look to jointly plan with neighbouring CCGs, Councils and NHS England and to this end explore the possibilities of joint arrangements.

2016 Update:

All services will have clear contracts with specifications for 2017/18 under joint commissioning arrangements. We have also developed a single dataset to use across providers in order for us to aggregate data to provide a clear picture for the Borough and to manage performance through more accurate and meaningful data. We are also working across NCL to develop co-commissioning arrangements with NHSE for Tier 4 services, to improve pathways between community and inpatient CAMHS.

3.1.5 Quality Standards

3.1.5.1 Children and Young People's-Improving Access to Psychological Therapies (CYP-IAPT)

CYP-IAPT is a transformational model developed nationally for CAMHS. The key principles of CYP-IAPT are:

- Better evidence based practice - Increasing the availability and knowledge of best evidence based interventions
- Better collaborative practice - Goal focused and client centred interventions, using feedback tools to facilitate better working between mental health professionals and families and young people using feedback tools leading to more personalised care
- Better service user participation – Children, young people and their families having a voice and influence at all levels of the organisation
- Better Cross Agency Working - Encouraging and supporting cross agency collaboration between Health, Social Care and Voluntary and Independent sectors
- More accountable services – through the rigorous monitoring of clinical outcomes to be able to share outcomes with young people and families and demonstrate effectiveness to commissioners
- Increased awareness – working in partnership with organisations delivering mental health services, and those in other sectors working with young people and families to increase understanding of the importance of emotional well-being and decrease stigma.

Although Haringey has been part of CYP-IAPT for a number of years further work is required to embed CYP-IAPT across all the services. The Review found that participation is not sufficient and outcome monitoring was not consistent across the workforce. Additionally work needed to be done across providers to develop consistent outcome measures.

In 2014 CYP-IAPT published 'Principles in Child & Adolescent Mental Health services values and standards "Delivering With and Delivering Well"'. This document outlines the quality standards by which all Haringey CAMHS services should be measuring themselves. These are compatible with the Youth Wellbeing Directory with ACE-V Quality Standards which is also a valuable tool for ensuring quality provision.

2016 Update:

CYP IAPT Funding has facilitated the training of 2 members of staff in IPT-A over the last year. Additionally Tavistock and Portman NHS Foundation Trust have joined IAPT and are rolling it out across services. Open Door and BEHMHT have arranged training for a broader cohort of staff in CYP-IAPT principles.

3.1.5.2 National Institute of Clinical Excellence (NICE) Guidance

There is a broad range of NICE guidance available on child and adolescent mental health, however it is currently unclear the extent to which this guidance is being used to inform practice and pathways. It is the expectation of commissioners that providers complete an audit of their services against these standards to identify any areas which are not currently NICE compliant for development.

3.1.6 Data and IT

Currently data systems are not equipped to supply accurate data on either the children who are being seen by CAMHS or the outcomes from the treatment. Additionally staff raised IT as a barrier to efficiency and flexibility. It is imperative that an innovative approach is taken to data and IT, harnessing new technology and using the best systems to meet the needs of a modern efficient CAMHS. All patient records should be electronic and digital communications should be put in place, where not available, to reduce DNA rates. All CAMHS providers will need to ensure that EPR systems are ready to submit CAMHS minimum data set to HCSIS in January and that this data is locally available for reporting and informing clinical practice (session by session outcome monitoring).

2016 Update:

Significant investment has gone into supporting local providers to develop their IT systems. The majority of providers are now using text reminders for appointments and the new system will provide an improved interface with service users for the collection and collation of outcome data which will support improved use in both sessions with children and young people and their families and in staff supervision. Under of Transformation Plan we are also supporting all providers across the statutory and voluntary sectors to ensure they are able to contribute to the HCSIS data collection system, in order to inform better planning and performance management.

3.2 Promoting resilience, prevention and early intervention

Future in Mind and No Health without Mental Health both stress the importance of early intervention in mental health. Building resilience, promoting good mental health and early identification and support are all vital to ensuring the best possible outcomes for young people facing mental health concerns. There needs to be adequate support at an early stage to promote children and young people's ability to self-manage, reducing dependence on more extensive and ongoing support. This is in line with Council priorities around early help, and the shifting emphasis to prevention.

Half of lifetime mental health conditions are symptomatic by the age of 14

3.2.1 Perinatal Services

> Beginning with a healthy pregnancy, a safe birth and a strong bond between a baby and its parents is vital and health promotion programmes' delivered during pregnancy and the first years of life, when the foundations of future health and wellbeing are laid down, is vital. While it has been acknowledged for some time that this phase strongly influences outcomes in later life, recent evidence reinforces the importance of early intervention to reduce the impact of stress in pregnancy and to promote attachment and this is particularly true for children born into disadvantaged circumstances. Many problems which occur later in life, and lead to enormous expenditure on service provision, arise because children did not receive appropriate support in their early years
>
> Haringey Joint Strategic Needs Assessment

According to a recent study maternal perinatal depression, anxiety and psychosis together carry a long term cost to society of about £8.1 billion for each one-year cohort of births in the UK. 72% of this cost relates to the adverse impacts on the child rather than the mother, £1.2 billion of which is borne by the NHS[xiii]. In Haringey there is a perinatal mental health service that works with parents of children under 2 years old, addressing attachment and perinatal mental health issues. This service, the Parent Infant Psychology Service (PIPs) is delivered by Whittington Health and is co-located with health visitors and the family nurse partnership workers.

The service is funded in the majority by the CCG with one additional post funded by Public Health.

2016 Update:

From 2016/17 additional resource has been identified by Public Health to expand the PIPs team further and a recruitment process is currently underway.

Locally work has been completed across the five North Central London boroughs to develop a shared strategy to reduce inequalities across the boroughs generated by the number of Trusts delivering acute and mental health support. Further information on this is available in Part Two: NCL CAMHS Transformation Plan Priorities.

3.2.2 Mental Health Promotion and Promoting Resilience in Schools

Haringey currently has a good range of support at Tier 1 commissioned by public health, however further work is required in order to improve support to schools who identified through the online audit that they do not feel equipped to meet the presenting emotional and mental health issues in schools. It is planned to request all schools to nominate a lead for mental health and emotional wellbeing. Using these direct links into school we will be able to disseminate information, promote services, and provide support and training. This approach has worked well elsewhere and is due to be piloted by the DfE and DoH, Haringey has been successful for its bid for this pilot. All schools participating in the audit expressed an interest in nominating a lead and this can be promoted through the healthy schools programme.

The 2012 Children and Young People's Mental Health Coalition document 'Resilience and Results'[xiv] makes the case for school involvement in supporting emotional wellbeing.

Table 10: Summary of Evidence Base for Schools Supporting Mental Health Needs of CYP and Improved Attainment

RESILIENCE & RESULTS

Supporting everyone's emotional and mental wellbeing and giving emotional support to pupils with behavioural and emotional problems is important because:

- 1 in 10 or at least 3 young people in every average class will have a behavioural or emotional difficulty (Green, et al, 2005)
- Almost half of young people with fewer than five GCSEs graded A*to C said they 'always' or 'often' feel down or depressed compared with 30%of young people who are more qualified (Price's Trust, 2012)
- In an average classroom: 10 young people will have witnessed their parents separate, 1 will have experienced the death of a parent and 7 will have been bullied (Faulkner,2011)
- 1 in 4 young people of secondary school age will have been severely neglected, physically attacked or even sexually abused at some point in their lives (NSPCC,2011)

Having a behavioural or emotional difficulty can have a significant impact on young people's academic achievement, and other outcomes. Research has found that:

- Children with persistent conduct or emotional disorders are:
  - more likely to be excluded from school,
  - less likely to engage with out-of-school programmes to help them manage their behaviour and improve literacy,
  - more likely to be assessed with special educational needs, and
  - more likely to leave school without educational qualifications (Parry-Langdon, 2008)
- Children with conduct disorders and severe Attention Deficit Hyperactivity Disorder (ADHD) may be four to five times more likely to struggle to attain literacy and numeracy skills (Green, et al., 2005).

There are strong links between emotional wellbeing and children and young people's readiness to learn. Research shows that emotions can hinder or promote learning. If a pupil is feeling anxious, angry or stressed, the primitive functions of the brain will take over. This means that the part of the brain responsible for higher order thought and processing will not function effectively. Developing a whole school approach is key to supporting emotional wellbeing including:

- Promoting the confidence and self-esteem of all pupils in the School
- Ensuring child protection procedures are in place and being effectively implemented
- Providing planned opportunities for pupils to reflect on and discuss their feelings and personal experiences as part of the curriculum
- Providing opportunities for pupils to be consulted and take responsibility within the School
- Teaching pupils the importance of caring for each other and working together
- Making pupils feel welcome in new schools
- Developing pupils' skills to cope with pressures and problems

- Providing opportunities for pupils to seek and get help on a range of personal, health and emotional issues
- Ensuring teachers are trained to understand children's emotional development and how this affects learning
- Involving pupils in setting academic and personal targets for themselves.

It is therefore vital that schools take an active part in ensuring staff are appropriately trained to support emotional wellbeing, recognise symptoms of mental health problems, and know where and how to signpost the young person to appropriate support. Public Health have recently commissioned Young Minds in partnership with Barnet, Enfield and Haringey Mental Health Trust to develop a whole school approach to mental health and support schools to develop resilience in children and young people.

There is also a role for the wider CAMHS system in supporting Schools and work needs to be done to raise awareness of the range of resources and services available. Additionally our participation in the national pilot of Mental Health Links in Schools will support the development of training for mental health leads within schools and a school lead within CAMHS, improving links between the two.

There have been a number of innovative projects commissioned by public health which were targeted at vulnerable young people and developed and delivered by the Adolescent Outreach Team:

- A Game of 2 Halves which is a 12 week programme working with young people at risk of exclusion from secondary school was delivered in partnership with Tottenham Hotspur and has seen positive outcomes and reduction in behavioural difficulties in school.
- Time2Talk is a whole school approach to raising awareness about emotional wellbeing and has taken stories from young people who have had contact with mental health services, adapting these narratives to create a piece of forum theatre for each year assembly within the school, also adapting into a film that is now in use within PHSE.
- More broadly the Healthy Schools programme is available to all Haringey Schools to support them in promoting positive health and wellbeing within their school populations. Currently Haringey has 31 bronze, 10 Silver and 1 Gold rated school.

The Virtual School, which works with looked after children, has developed a range of attachment based tools - **How to BE-** to help professionals to support children and young people who have experienced trauma, including the emotionally friendly classroom, home and club. Training has been delivered with a number of schools and has recently been extended to supervising social workers. This work is an area which could be developed and expanded with applications beyond looked after children.

Some schools commission therapeutic services directly, buying services from Barnet, Enfield and Haringey Mental Health Trust's Health and Emotional Wellbeing Service (HEWS). Other providers include Hope in Tottenham (previously Fowler Newsam) who see approximately 400 students a year, delivering in over 30 schools.

Whilst this availability of in-school support is excellent for those able to receive it, it is not an equitable offer across the Borough as some schools do not commission any direct work. Work with schools forum is outstanding to explore further development of provision and appetite for jointly commissioning a standard offer. The independent, faith schools and alternative provision sector should also be invited to discuss

provision to ensure that students in these schools have the same ability to access support within their school.

2016 Update:

Haringey participated in a national Mental Health Links in Schools pilot which enabled 11 Haringey schools to work closely with CAMHS to provide more collaborative links. As part of this work we have developed a new pro forma for CAMHS to complete with key information for schools to improve communication between CAMHS and Schools. This pro forma includes information that schools identified as key, such as how they can support the child/young person within the school and information on any medication and side effects that may have been prescribed. Additionally we identified some areas that Schools would appreciate additional training on and held a multi-agency professionals training conference in July 2016 for over 100 professionals across the Borough with workshops on issues such as self-harm, attachment and online risk and resilience. We have also now adapted the Mental Health Link in School role to an Emotional Wellbeing Coordinator role and have extended this to all Haringey Schools. By Schools nominating an Emotional Wellbeing Coordinator they have access to training opportunities, information and support. We are also completing an audit with schools to better understand needs within the school population and the level of support provided.

3.2.3 Building resilience through families

Improving support to families and parents can also have a huge impact on the emotional wellbeing of children and families. Children can experience significant difficulties as a result of inconsistent or dysfunctional attachments with family members and other adult carers. Attachment difficulties and disorders can lead to interpersonal difficulties, academic under-achievement and failure to thrive. Currently there is a wide range of parenting support in Haringey but it is uncoordinated.

CAMHS, children centres and the voluntary sector all provide different parenting programmes including Webster Stratton, Triple P- Positive Parenting Programme and Open Door's locally developed programme, the Open Door Approach to Parenting Teenagers. At the moment access to this support depends on who the family are already engaged with and work needs to be done to develop a more coherent approach to these resources. Any professional in universal services should be able to signpost to resources and families should have the tools to seek support directly, and we should be better utilising family support workers and early help services.

Parenting interventions are also an area of development for CYP-IAPT which is now offering training in PT (Parenting for 3-10 year olds with conduct disorders). As part of developing an early intervention offer it is imperative that parenting support is developed. The majority of presentations at CAMHS Access relate to behaviour or family issues, therefore by having the right range of early intervention approaches extended, more intensive work may not be required. Additionally services to support attachment from early childhood through to the teenager years should be coordinated and scoped to ensure this key area is properly supported. NICE guidance on attachment is due to be released in November and should be the basis for an in-depth look at the pathway across health, education and social care.

2016 Update:

Haringey has recently developed a multi-agency Parenting Plan for the borough. This document maps the current provision and outlines the required actions in order to ensure a more robust approach to parenting

support. Implementation of the plan will be commenced immediately. In line with Haringey's Early Help Strategy the plan has the following five objectives:

1. Delivering prevention and early intervention to reduce escalation of need
2. Enhancing access to and co-ordination of integrated services
3. Sustaining resilience for children, young people and families
4. Developing the workforce to be more confident and empowered practitioners of early help
5. Increasing equity of access to quality provision for all children, young people and families

3.3 Improving access to effective support –a system without tiers

'Right time, right place, right offer' Future in Mind

Future in Mind outlines the challenges that face CAMHS nationally. These include access issues that we see mirrored in local services, a requirement to build a more enabling model of support through peer support and digital technologies and an expectation that children and young people will have appropriate support in crisis and through transition to adult services. On the whole feedback about services was positive in terms of the support and quality of treatment delivered. However locally there are issues concerning long waiting times, higher than benchmarked DNA rates in some services and lengthier interventions than comparators, creating capacity issues.

3.3.1 Waiting Times

One of the key issues facing Haringey CAMHS is access; waiting times are of concern across all services as demonstrated in the waiting time data provided by services:

Table 11: Waiting times to first appointment 2013/14 and 2014/15

Average Wait in Weeks	2013/14	2014/15
BEH- Generic CAMHS	14.43	10.14
BEH- AOT	1.43	1.71
BEH- CAMHS LD	8.86	7.86
BEH- HEWS	4.14	3.14
Open Door	22	16
Tavistock & Portman- General	6.2	6
Royal Free (Eating Disorders & Generic)	4.28	2.67
Brandon Centre- MST	6	4
Whittington- PIPS	Not Avail	5.7

As part of the stakeholder survey children, young people and parents were asked how long they waited for their initial appointment. The last national waiting time standards required families to be seen within 13 weeks, however 26% of both children and young people and parents completing the Haringey online survey reported waiting more than six months; double this timescale.

Waiting times are currently too long, and some children and young people are waiting for over a school term to be seen. In order to assure timely access for children and young people consistent waiting time standards need to be implemented across providers that meet the criteria of what is a reasonable period to expect a family in need to wait, in line with national standards. In order to meet these requirements services will need

to adjust the way in which they currently deliver in order to build capacity. Open Door have recently introduced a screening/triage system which has reduced their average wait to 6-8 weeks, learning from this approach should be shared across providers and used to inform the development of CAMHS access.

2016 Update:

We have been working with providers to establish a standardised method for recording waiting times. Across our main providers; Barnet Enfield and Haringey Mental Health Trust, Tavistock and Portman NHS Foundation Trust and Open Door, we have amalgamated data to show waiting time data for 2015/16 from referral to initial appointment (RTI), as outlined below.

Table 12: Waiting Times for Referral to Initial Appointment 2015/16

Waiting Times (RTI) 2015/16	
0 - 4 weeks	**46%**
4 – 8 weeks	**39%**
8 – 13 weeks	**9%**
13 – 18 weeks	**3%**
18 – 26 weeks	**1%**
26+ weeks	**2%**

Significant work has been undertaken to ensure that the referral to initial appointment (RTI) wait is significantly reduced. Choices has a standard of 4 weeks from referral to appointment and those who are deemed at too high risk for this service would be seen even more quickly. Therefore we expect to see the RTI waiting times significantly reduce over the next year to and for 90% of children and young people to be meeting this standard, with the rest being exceptions due to service user preference or unavailability. We would also expect this service to reduce the number of children and young people entering Tier 3 CAMHS as this will only be for further assessment or treatment. This will have a knock on impact that the average number of contacts is likely to increase as those who previously would have had a single appointment will now be given the self-management tools or reassurance to no longer require an appointment in Tier 3. Therefore we would expect to see waiting times within Tier 3 reduce due to the anticipated diversionary impact of the Choices service.

Locally we have been working with providers to find a way to measure waiting times from the perspective of the family to first appointment and to treatment, using a system-wide date of referral based on first contact with the system, regardless of provider organisation and with treatment defined as 'commencement of treatment in line with the care plan' as defined by clinician. However nationally there is also work going on to develop access and waiting time standards and in the interim NHSE are defining treatment as two or more contacts, and includes data on those waiting for treatment. We will be using this data to determine the success of a waiting list initiative funded through the additional non-recurrent money allocated by NHSE. We will use the funding to support pathways which we have identified as having the highest waiting times, these include ADHD and CAMHS Learning Disability and ASD Services and those provided by voluntary sector.

3.3.2 DNA (Did Not Attend) Rates

Currently DNA rates for services are as outlined in the table below. National examples of good practice where appointments are delivered on an outreach basis have DNA rates as low as 0%, this is locally the case for the MST service where the model is completely outreached. The latest national benchmarking data is 2013, for which the range was 2%-25% and the average 11%, in 2012 it was 12%. As demonstrated below local figures vary considerably. AOT's DNA rate is higher than would be anticipated for an outreach service and Open Door need to do some work to increase their understanding of why children and young people are not attending follow up appointments, though the improvement over the three years is recognised.

The profile of the service user will be an influencing factor, open door which provides services to teenagers who will often be attending on their own would be expected to have a higher DNA rate than CAMHS LD where parents will be a taking them. Learning from services with low DNA rates should be shared across providers and all services exceeding 12% should complete an audit of people referred to gain a better understanding of what deters people from attending, this will be completed in 2016/17.

Table 13: Did Not Attend rates and follow up rates of by CAMHS of those DNAs 2013/14 and 2014/15

	DNA RATE 1st Appointment		DNA RATE FOLLOW UP	
	2013/14	2014/15	2013/14	2014/15
BEH- Generic CAMHS	15%	17%	14%	13%
BEH- AOT	16%	14%	13%	14%
BEH- CAMHS LD	10%	17%	6%	6%
Open Door	2%	2%	13%	10%
Tavistock & Portman- General	5%	5%	6%	6%
Royal Free (Generic & Eating Disorders)	12.90%	4.30%	6.10%	6.80%
Brandon Centre- MST	0%	0%	0%	0%
BEH- HEWS	Not Avail	8%	Not Avail	13%
Whittington- PIPS	Not Avail	11.6%	Not Avail	11.6%

3.3.3 Length of Interventions

Haringey services have significantly longer lengths of intervention than CORC comparator services. Across CORC in 2013/14 94.4% of cases were closed within 6 months, within Haringey the averages over 2013/14 and 2014/15 were:

Table 14: Length of time on intervention caseload 2013/14 and 2014/15

Service	Average Length of Intervention in Weeks (13/14)	Average Length of Intervention in Weeks (14/15)
BEH- Generic CAMHS	62.9	99.7
BEH- AOT	54.4	56.3
BEH- CAMHS LD	141.4	127.1

BEH- HEWS	37.4	37.7
Open Door	39.0	38.0
Tavistock & Portman- General	43.0	27.0
Royal Free (Generic & Eating Disorders)	64.3	80.4
Brandon Centre- MST	24.0	24.0

Figures for 2014/15 show similar or increased averages across all services except for Tavistock and Portman who dramatically reduced their average length of intervention to 27 weeks. Data on the length of intervention was looked at across three years, using the average, median and longest length of treatment. From this it is clear that local treatment times far exceed the benchmarked standard. The median for tier 3 should not exceed six months, but this is the case across a number of services.

At Tier 2 the average and median should be far lower, and whilst Tier 2 lengths are lower they are still not within the expected range. Delivery of interventions across services should be more focussed, outcomes should be used routinely as part of case supervision, and approaches should be regularly reviewed to ensure they are meeting the desired outcomes. In addition expectations should be managed by services so that children and young people and their families are clear that their engagement with CAMHS is a focussed time-limited piece of work in line with recovery and enablement principles. It would not be appropriate to set a time limit on these interventions as the prescribed length depends on the modality and complexities of the presentation, however changes to practice as described below should help reduce the average and median lengths of intervention.

3.3.4 Single Point of Access

Future in Mind emphasises the need for a single point of access. CAMHS Access currently fulfils that role but is limited to paper/phone call triage, and involves no face to face interaction. CAMHS Access could be developed to offer 'choice' appointments, to place expertise at the front end of delivery systems to establish with children, young people and their families the intervention most appropriate to them, fulfilling a brokerage function. This would need to be developed with young people as one concern often raised by families is that of having to 'retell their story', it would need to be made very clear to families that the individual they met with would not be their ongoing therapist.

A benefit of this would be that it could incorporate a community asset based approach, so that social prescribing and alternatives to mental health treatment services could also be explored with the child, young person and their family. The community has a key role in supporting emotional wellbeing and non-CAMHS resources should be harnessed such as peer mentoring, volunteering opportunities and faith groups. A developed Access Service could also have a function as a 'hub' with information on local resources and provide a central point for signposting. Additionally it would mean that children and young people could be seen sooner, and could be prioritised more easily, diverting inappropriate referrals and ensuring timely follow up for those requiring more urgent support.

2016 Update

The new Choices Service has been designed to facilitate delivery of a THRIVE model approach for Haringey and focuses on the signposting, self-management and one off contacts to support children and young people cope. It provides a face-to-face triage function for those who require ongoing support, promoting engagement by providing better information for the Child/Young Person (CYP)/family on what to expect

from CAMHS. It also provides more detailed information on the CYP/family and their preferences, which is provided, to the services before they commence any treatment with the Child/Young Person, meaning that treatment services are more able to allocate appropriately disciplined clinicians from first engagement.

The service incorporates a community asset based approach, so that social prescribing and alternatives to mental health treatment services are also be explored with the child, young person and their family. The community has a key role in supporting emotional wellbeing and non-CAMHS resources should be harnessed such as peer mentoring, volunteering opportunities, faith groups and parenting support. Choices functions as a 'hub' with information on local resources providing a central point for signposting. Additionally, children and young people will be seen sooner, and may be prioritised more easily, diverting inappropriate referrals and ensuring timely follow up for those requiring more urgent support.

The Service will be a fully evaluated pilot which will include the evaluation of the service itself, including whether it is meeting the outcomes for families, and also the learning from the wider system, such as whether the referral pathways are clear or whether there are gaps or bottlenecks in provision. We will use this data to inform our commissioning intentions over the next few years and support our transformation.

3.3.5 Improved Choice and better resource management

Feedback from young people and parents shows that very few had any choice in the location or setting in which support was delivered. The resource implications of offering choice are often cited as a reason to maintain a clinic approach where there is reduced travel and time between appointments. However the feedback also demonstrates that the majority of children and young people are happy to be seen in a clinic or in a private room in a non-stigmatised community venue. Only 8% expressed a preference for home and only 13% for school; with such small numbers choice could be more available across services.

Additionally when staff were asked where they currently deliver 41% of respondents said they offer appointments solely within a clinic/organisational building setting, when asked where they thought their service should be delivered only 10% thought it should be solely within a clinic/organisational setting, with 73% saying it should be delivered in a mix of clinic and community settings. This is particularly pertinent for hard-to-engage groups. Services should be flexible enough to respond to the needs of the individuals, if engagement in school or at home is required then this must be a possibility for services to deliver. A more flexible, choice-driven model could reduce DNA rates and therefore improve efficiency within services.

2016 Update:

The CAMHS in GP surgeries allows the delivery of tier 2 CAMHS within primary care. Additionally the new Choices service is working closely with Early Help, Schools and Primary Care to deliver its consultations in a range of non-stigmatised community settings.

3.3.6 Use of group interventions

Group CBT is not currently part of the standard offer, however this is an evidence based intervention for both anxiety and depression. The Centre for Mental Health[xv] puts group CBT therapy for children at a cost benefit ratio of 31:1 and group CBT via the parents at a cost/benefit ratio of 10:1 for anxiety and a cost/benefit ratio of 32:1 for group CBT for depression in contrast to individual CBT which has a cost/benefit ratio of 2:1 and is nearly ten times the cost to deliver. Group CBT will not be appropriate for everyone, and this should not replace individual CBT, but should be a complementary part of the offer.

2016 Update:

As part of our Transformation Plan Open Door has been piloting group approaches to eating disorders and self-harm. We will be using the information from this pilot to inform future development and roll-out of group interventions in the Borough.

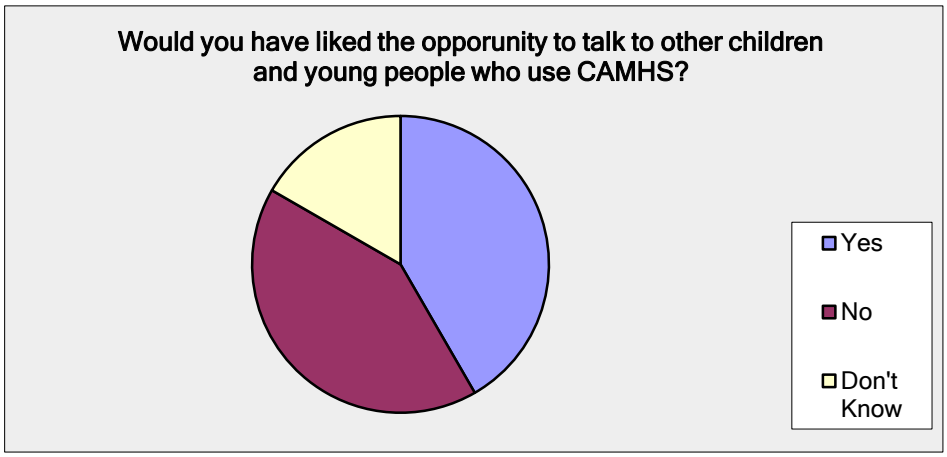
3.3.7 Investment in Early Intervention Services

Investment in early intervention services will ensure that Tier 3 CAMHS is appropriately meeting the needs of children and young people with severe and persistent mental health issues. As noted in the activity mapping there is a disparity between those we would expect to require an early intervention service and commissioned levels. Additionally current tier 3 activity exceeds that expected; if appropriate support were offered earlier, then it should reduce the number of people presenting requiring Tier 3 CAMHS.

This in turn should build capacity within Tier 3 and allow for people to be seen more quickly. An early intervention model will need to be scoped and commissioned building on the learning from the CAMHS in GP practices pilot, which is a brief intervention psychological service currently being piloted by the CCG, based in host GP practices within each GP collaborative. The early intervention offer needs to include developing services which support attachment and a coherent programme of parenting support using evidence based models. A key part of early intervention includes the up-skilling of the wider workforce and ensuring that universal services are equipped to support the emotional needs of the children and young people with whom they are working.

3.3.8 Peer Support for Children & Young People and Parents

Future in Mind highlights the need for development of peer support models for both children and young people and parents. Generally the parents we engaged with felt well supported by CAMHS. One area that emerged during the focus group was the opportunity for parents to talk to other parents of children and young people accessing CAMHS. This was followed up in the online questionnaire and half of parents responded that they would have liked/would you like the opportunity to meet with and talk to other parents/carers. Additionally half of young people said they would like the opportunity to talk to other young people who use CAMHS.



Some models of peer support have already been developed locally. **State of Play** is a partnership model between Tottenham Hotspur Foundation, New Choices for Youth and the Haringey AOT which uses sport as a way of engaging young people in tackling issues around mental health and wellbeing and challenging

stigma. This involves training young people as wellbeing champions and involving these young people in community projects where they can facilitate conversations about mental health and wellbeing. Learning from existing projects should be used to develop a sustainable model for peer support for young people. Work should be undertaken with parents to develop a peer support model that helps parents to understand mental health better and improves their ability to support their child through feeling better supported themselves.

2016 Update:

Barnet, Enfield and Haringey have established a peer support pilot for children and young people and Mind in Haringey have established a group for parents of children and young people with mental health problems. We will be evaluating these pilots by the end of 2016/17 in order to inform ongoing commissioning intentions.

3.3.9 Information and Communication

The stakeholder survey identified that further work is required to provide suitable and accessible information to families prior to attending. 26% of children and young people and 28% of parents said they did not have enough information at the time of the initial referral. This is something that can easily be resolved through appropriate use of resources such as 'my camhs choices', a website built for young people about what visiting CAMHS is like. There is also the need for regular information from all agencies such as leaflets to be updated and provided to CAMHS access so that this information can be provided at triage stage.

The stakeholder and GP surveys indicated that there is a need for better communication with referrers. Throughout treatment and post-discharge better information should be available to referrers, including information if a young person disengages with services, and how the referrer might be able to offer them alternative support.

2016 Update:

Significant work has been undertaken to improve communication with referrers, through the Mental Health Links in Schools Pilot we have developed a pro forma to provide feedback to schools on referrals made to CAMHS and Barnet, Enfield and Haringey Mental Health Trust have delivered GP training to improve understanding of the role of CAMHS and child and adolescent mental health within primary care. We are also developing a handbook for social care staff to help them to support children and young people to access services.

3.3.10 Digital Access

Future in Mind highlights the need to develop digital solutions. These can be used to both support access into services, and as a therapeutic resource. In Haringey services are currently not making the best use of technology. There are a range of resources such as 'mycamhschoices' for young people and 'MindEd' aimed at professionals which are being underutilised and under-promoted. Additionally there is currently no access to online therapy for children and young people and this is an area that should be developed. Some CAMHS services are offering online consultations and treatment appointments to provide flexibility for children and young people where they are not either willing or able to attend a clinic setting, this should be developed to promote choice and engagement. Use of apps should be supported by CAMHS clinicians, and professionals

working in universal services. Many are being developed in collaboration with children and young people and including:

- Silent Secret
- Madly in Love
- Moodbug
- Well Informed
- In Hand
- Headmeds
- Doc Ready
- Find Get Give

Awareness of these apps is also low amongst professionals and work should be undertaken to showcase and promote their use.

2016 Update:

Barnet, Enfield and Haringey Mental Health Trust are developing their website, additionally choices will be signposting to digital resources and we have integrated use of silent secret into our transition pilot.

3.3.11 Crisis Support

There is no agreed definition of what is meant by a 'mental health crisis' but Mind defines it as when a person is in a mental or emotional state where they need urgent help. Currently there is no out of hours community support and the pathway in crisis is via Accident and Emergency Departments. Hospitals have access to telephone psychiatric support which is available on a rota basis 24/7 for emergency presentations, but there is no facility for the physical presence of a child mental health professional. In many cases this use of Accident and Emergency is completely appropriate, where there is self-harm and the physical needs of the young person require attention. However there is no alternative pathway for out of hours support where self-harm is not presenting, and where the only health requirement is a mental health assessment. This should be considered in partnership with other local boroughs or through joining up with social care out of hours support.

Within office hours the Adolescent Outreach Team provides the role of crisis and home treatment, however it also fulfils a number of other functions such as early intervention in psychosis, assertive outreach and supporting children and young people with emerging personality disorder. The role and remit of this team should be further considered as part of the work to look at crisis models.

Only 50% of parents and 75% of young people said they knew what to do in a crisis, this was also an area highlighted in the parent focus group. Better crisis planning needs to be in place including information given to parents of who to contact and what to do should a crisis arise, especially out of hours.

Haringey has consistently had lower than the England average rate of self-harm over the last 5 years, the 2013/14 figures as stated in the June 2015 Child Health Profile[xvi] for Haringey are as follows:

Table 15: Recorded hospital admissions of Haringey young people for deliberate self-harm 2013/14

	Local Number	Local Value	England Average	England Worse
Hospital admissions as a result of self-harm (10-24 years)	81	173.7	412.1	1246.6
		Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2013/14		

Despite numbers being significantly lower than the national average this measure only relates to hospital admissions for deliberate self-harm, and national intelligence indicates that hospital admissions are only a very small percentage of self-harm. Certainly colleagues locally, across agencies, express concerns around self-harm, evident across both social work and school staff. When asked 'Do you think Schools have adequate support and resources to meet these needs?' eight of the twelve schools responding to this question identified training in mental health for staff as a gap.

If young people displaying self-harm are not presenting at hospitals then focusing our entire self-harm pathway around A&E is outmoded. Open Door report that 43% of under-18s that they see present with self-harm; and 29% of the parents accessing the Parenting Teenagers Project report knowing that their child has self-harmed. There is currently little information available on self-harm for parents locally and limited availability of literature on self-management, these are areas where investment could be targeted.

Crisis cover at the A&E at the Whittington Hospital is provided by the Whittington's paediatric mental health liaison team, this is currently commissioned through the acute contract. Assessment at North Middlesex University Hospital Trust is provided by Barnet, Enfield and Haringey Mental Health Trust's Adolescent Outreach Team (AOT) for under 16s and RAID for 16 and 17 year olds under the mental health contract.

Table 16: Recorded assessments at North Middlesex Hospital by AOT 2012-2015 (part year)

Calendar Year	AOT Assessments at North Middlesex
2012	16
2013	18
2014	20
2015 (Jan-May)	18

Presentations requiring attendance from the AOT equate to less than three a month over the last few years. Data from 2015 shows an increased level of assessments in the first five months and this will need to be monitored. Data should be combined with that of the Whittington, which was not available for inclusion in this review. A&E attendance data for 2014/15 from Hospital Episode Statistics indicates one presentation a week of Haringey patients across all hospitals. Consideration needs to be given to the different paediatric mental health liaison models across the two acute hospitals. Both the North Middlesex University Hospital and Whittington Hospital have liaison paediatric mental health teams, however only the Whittington team deals with crisis presentations and has out of hours cover.

The volume of out of hours crisis presentations is unlikely to warrant a 24/7 staffing model, however work should be done to scope what can be implemented. Currently young people presenting at North Middlesex University Hospital on a Friday evening will have to wait until Monday to be seen by the AOT. An on-call rota that covered Saturday and Sunday mornings could be a more economical way of providing expedited assessment. Scoping should be done in partnership with other CCGs to develop out of hours support across the three boroughs, to benefit from the increased scale and this work should include out of hours support where self-harm is not evident.

Stakeholders identified training needs across the workforce to enable them to respond appropriately at crisis point, this is also something that could be developed jointly. Stakeholders reported that Section 136 arrangements under which police detain an individual for the purposes of a mental health assessment are unclear. However as the suite at St Ann's only offers adult service mental health professionals, A&E is likely to be the most used place of safety for children and young people. Currently though, these assessments are

not being recorded routinely by hospitals, and therefore levels of use are unclear. In addition to Section 136, mental health assessments in custody are completed by the Diversion and Liaison Service, the vast majority of which are for boys. Stakeholders reported that young people may be kept in cells awaiting assessment out of hours and this will need to be looked at in more detail.

The recently published 'Improving the care of children and young people with mental health crisis in London: Emerging findings with recommendations for transformation of Services' states that approximately 50% of children and young people who attempt suicide fail to receive follow up mental health treatment and 77% of those who do are non-compliant with their outpatient treatment. This is not anticipated to be the case in Haringey given the current arrangements but work will need to done to look at this in more depth to provide assurance given these stark statistics. Communication with primary care and schools is key to ensuring ongoing engagement of these at risk children and young people who do not engage with CAMHS.

2016 Update

Earlier in the year we completed a review of crisis services in Haringey, this has confirmed gaps in out of hours provision and unclear pathways for section 136. As part of this review service users and parents were interviewed to get some qualitative data around patient experience of the crisis pathway. We are now working across NCL to look at addressing the identified issues as part of co-commissioning arrangements with NHSE for inpatient services. Further details are included in Part Two.

3.3.12 Inpatient CAMHS

Haringey CCG were provided information by NHSE relating to 22 of Haringey's children and young people admitted to Tier 4 inpatient resources: 12 in 2013/14 and 10 in 2014/15. These 22 children and young people represented 25 admissions as two young people moved unit during the course of their admission. Readmissions were at 0% compared to the London provider survey rate of 14%[xvii].

Of the 25 admissions to different units 44% (11) of the admissions over this two year period were to Barnet, Enfield and Haringey's 12 bedded acute adolescent unit, the Beacons, based in Edgware.

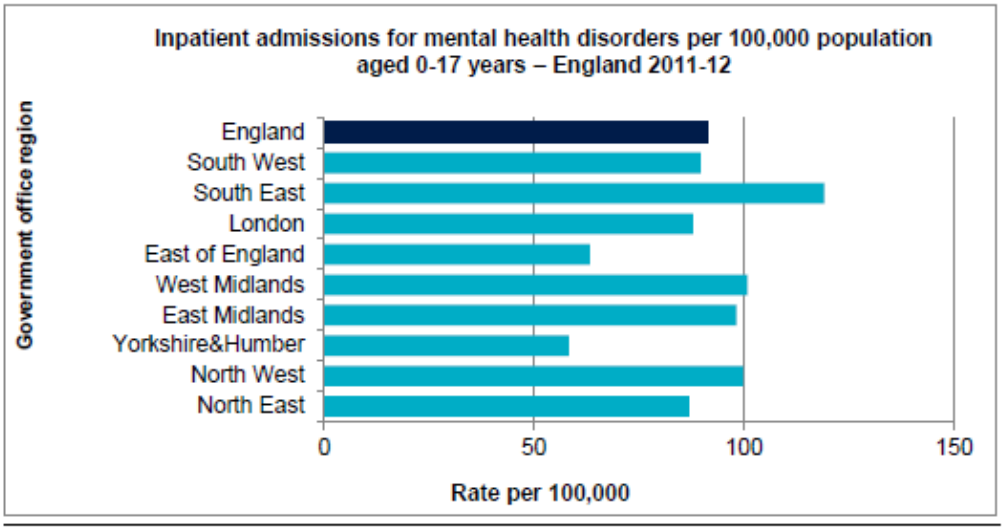
72% (18) of all admissions were within London, with a further 16% (4) within the neighbouring counties. Of the 12% (3) that were further afield, one of those was a specialist unit, one was the admission of a looked after child placed out of Borough, and one was a short term admission (10 days) when the young person was repatriated to a London unit. No issues were identified by NHSE in relation to the local CAMHS team response, however close working with NHSE is required to monitor out of London placements and ensure appropriate liaison from the local CAMHS service to support discharge planning.

Where issues have emerged around the inpatient pathway over the last two years it is in relation to looked after children, whose social care placement often ends when admitted to an inpatient unit. In order to be discharged they need a local CAMHS team identified and engaged in discharge planning however they cannot be referred to a local team without knowing where the placement will be. They cannot register with a GP prior to placement, and therefore they are currently falling between CAMHS teams and responsibilities. This is an area that should be picked up through the redevelopment of the First Step LAC screening and assessment service specification for 2017/18.

Staff within CAMHS were asked how they would rate the effectiveness of the pathway into inpatient services, and their perception was that access to a Tier 4 bed is difficult. Although many responding staff

noted that they did not have personal experience of the process. The current system means that the admitting team must find a bed, from a circulated list of vacancies that very quickly becomes out of date, finding an appropriate bed can sometimes take days. NHS England's Specialised Commissioning Team do not take responsibility for commissioning at the point at which the need for a bed is established but at the point at which the child/young person is admitted, therefore if all their commissioned beds are filled then the young person requiring the bed is the responsibility of the community team or the paediatric ward on which they are staying to manage until one becomes available. This is something which is being managed at present, and which is part of the national model to manage an expensive and limited resource.

Within Tier 4 based on the 22 cases examined the inpatient length of stay for Haringey children and young people ranged from 14 days to 555 days with an average of 142.76 occupied bed days per admission. There is little published data on the rate of inpatient admissions across CAMHS, the approximate rate for Haringey is 38 per 100,000 children and young people (0-17yrs). The NHSE Tier 4 report shows rates across England are much higher than in Haringey.



Future in Mind requires closer working between NHSE and local CCGs to co-commission to prevent inappropriate admission and facilitate safe and timely discharge. From the figures and feedback gathered through this review these are not issues that are currently evident in Haringey, though we will engage with discussions across Barnet, Enfield and Haringey and look at developing co-commissioning models as they emerge.

2016 Update:

NHSE has now compiled additional data for all CCGs and for Haringey this is as outlined below:

Table 17: NHSE Supplied Admission Data

Data Source	NHS E	NHS E	NHS E	NHS E	NHS E
Year	2013-14 London	2014-15 London	15-16 London	15-16 Out of London	15-16 total
Haringey estimated population 2016 aged 0-18 **31,504** (GLA, 2015)					
Admission	22	16	10	4	14
LOS London	1,331	1,532	435	151	586

Cost	£679,371	£821,833	£500,394	£94,219	£594,613
Av Cost	£510	£536	£1,150	£624	£1,015

BEH-MHT have now centralised the bed management function so that individual clinicians across the Trust are not simultaneously attempting to find a bed.

We are working across NCL to develop co-commissioning arrangements with NHSE and further information on this is provided in Part 2: North Central London CAMHS Transformation Plan Priorities.

3.3.13 Eating Disorders

The current pathway for eating disorder is via CAMHS access into the Royal Free eating disorder service which is commissioned across North Central London (NCL). This is an intensive service that has the flexibility to offer community support and reduces the need for admissions. This service has good outcomes and Haringey admission rates to Eating Disorder beds are low. Part of the transformation funding has been specifically ring-fenced for eating disorders in response to national inadequacies in commissioned provision, NICE compliant services and alternatives to admission. However Haringey is currently investing £256,280 a year in this service, which in 2013/14 accepted 13 referrals out of 15 and in 2014/15 accepted 14 out of 17. This is in contrast to Barnet figures of 62 and 49 for the respective years.

We have benchmarked our spend both with our peers and against the estimated costs in the eating disorder commissioning guide[xviii] (section 4.3.4) and have found that we are over-investing in this service based on our activity. The Royal Free have self-audited as not meeting the waiting time requirements of the new guidelines, however given the currently high level of funding from Haringey we will need to work with NCL commissioners to ensure any investment into the service is done on the basis of value for money and with consideration of current investment and usage levels. It is therefore not envisaged that we use our Eating Disorder allocation for further investment in this service.

Nationally it is believed that eating disorder prevalence is increasing, a study by UCL Institute of Child Health demonstrated a 15% increase in those diagnosed with an eating disorder between 2000 and 2009, with the biggest increase in eating disorders not otherwise specified (not anorexia or bulimia nervosa). This increase puts the estimated prevalence rate at 37.2 per 100,000 for ages 10-49. Incidences of eating disorders were seen to vary by sex and age with adolescent girls aged 15-19 years having the highest incidence of eating disorders (2 per 1,000)[xix]. Using 2014 ONS figures this means Haringey would expect to see 29 new cases a year just in the 15-19 year old age bracket, double current referral rates to the Royal Free service. For eating disorders falling under the classification 'eating disorders not otherwise specified' the peak age for diagnosis is 10-14 years, making it another key area to explore, working closely with primary care.

Open Door are reporting 24% of their activity as presenting with eating problems, suggesting that eating problems are an issue for our children and young people locally. It is proposed that it is at this early intervention level where funding is targeted. This may require upskilling within existing provision to ensure NICE compliance across the pathway or specifically commissioning an early intervention approach for this cohort. Investment from the eating disorders allocation can also be used for addressing self-harm in localities where eating disorders are not regarded an under-invested area. This could be done by using the eating disorders allocation to integrate support for self-harm and eating disorders into the early intervention model.

2016 Update:

As part of our early intervention approach to eating disorders, Open Door are delivering group interventions for Haringey young people displaying early symptoms of Eating Disorders and/or self-harm in an attempt to reduce the likelihood of escalation into requiring specialist ED and/or crisis services.

Further information on the work we are doing across NCL with the Royal Free Hospital NHS Foundation Trust is included in Part 2: North Central London CAMHS Transformation Plan Priorities.

3.3.14 Transition to adult mental health services

A model that's recently been developed and has already been implemented in Birmingham and Norfolk is the 0-25 approach to CAMHS. This is in line with the SEND reforms for planning for children with special educational needs and disabilities. Currently there is a good breadth of provision across this age range in Haringey with access to adolescent services via Tavistock and Portman and with Open Door providing support for young people up to the age of 25. However, pathways are not currently clear on how to access from primary care and this will need to be addressed. As 0-25 models expand and develop it will be necessary to review this in line with the overall model.
Future in Mind makes clear that access to services should not be based on arbitrary ages, but should be based on the developmental stage of the young person. The focus should not be on artificial boundaries but about seamless care, we will therefore need to develop a local response to this if we are not to move to a 0-25 model. This could involve relaxing age restrictions on both CAMHS and adult services to enable the most appropriate provision to the young person to be accessed. For children with learning disabilities closer working between CAMHS LD and the Learning Disabilities Adult Partnership should be developed to ensure effective handover of care.

In late 2014 the Adults and Health Scrutiny Panel completed a panel report on 'Transition from Child Mental Health Services to Adult Mental Health Services'. This identified a number of areas for development which will be taken forward through the local transformation plan. The new approach requires a change to the current model of care, through reducing lengths of intervention, delivering interventions which are more focused and which promote resilience, self-management and enablement.

All CAMHS providers will need to work in partnership with other children and young people's services to ensure that young people can be safely discharged with the support they need. Where young people are likely to require adult mental health services, planning should start early and more work needs to happen to develop information sharing and early transfer planning. Follow up of the Scrutiny Panel actions will be taken forward under our local transformation plan, in the context of improved inter-agency working, better planning and smooth transition.

2016 Update:
In the last year we have held a multi-agency workshop to look at how we can take forward the recommendations from the Scrutiny Panel and improve transition. This has resulted in an action plan being developed in collaboration between CAMHS and adult mental health commissioners and providers. Additionally we have used Transformation Funding to invest in a pilot of a co-designed creative lifeskills course for children and young people who require additional support but will not meet the threshold for adult mental health services.

3.4 Care for the most vulnerable

Just like adults any child can experience mental health problems, but some children are more vulnerable to this than others. These include those children who have one or a number of the following risk factors:

- From low-income households; families where parents are unemployed or families where parents have low educational attainment
- From black and other ethnic minority groups
- Who are looked after by the local authority
- With disabilities (including learning disabilities)
- Who are lesbian, gay, bisexual or transgender (LGBT)
- Who are in the criminal justice system
- Who have a parent with a mental health problem
- Who are misusing substances
- Who are refugees or asylum seekers
- In gypsy and traveller communities
- Who are being abused.

HM Government. 2010. Healthy Lives, Healthy People: Our strategy for public health in England

Data is more easily available in relation to some of these groups than others but where there is not currently data universal provision should be aware of these risk factors in order for them to support the young people they work with for whom these risk factors may apply.

3.4.1 Inequality within the Borough

Haringey is an exceptionally diverse and fast-changing borough. It has a population of approximately 254,900 residents, a quarter of which are under 20 years. The Borough stretches from the prosperous neighbourhood of Highgate in the west to Tottenham in the east, one of the most deprived areas in the Country. Nearly half of the residents and nearly 81% of our school children come from Black and Minority Ethnic (BME) communities and 190 different languages are spoken in our Schools.

High levels of deprivation, low educational attainment and unhealthy lifestyles (smoking, alcohol misuse and low levels of physical activity) primarily in the east of the borough, are all interrelated determinants of poor health outcomes and the considerable health inequalities in the borough. The level of child poverty in Haringey is worse than the England average at 26.8%, with significantly higher levels in the east of the Borough. The rate of family homelessness is also worse than the England average. When examined the CAMHS caseloads for Barnet, Enfield and Haringey Mental Health Trust and Open Door do not reflect the high need in the South East.

The below data show CAMHS caseloads for the two services mapped against the four GP collaboratives, the highest presentations are displayed across the West and North East collaboratives. This may mean that services are not accessible to those in the most deprived areas, and further investigation will need to be done, mapping caseloads against postcodes to ensure the most deprived wards have access. Updated deprivation data is due to be published immanently and should be used to ensure appropriate access across wards. This data reflects a similar picture of the uptake of the 'CAMHS in GP surgeries' project. Work with

primary care in the South East should be done to understand why referral numbers are so low, and what sort of services their patients may wish to engage with.

Table 18: Caseload data per GP collaborative: combined for Open Door and BEH

GP Collaborative	BEH & Open Door Caseload Rate per 10,000 weighted GP population
Central	35.83
North East	41.89
South East	37.27
West	41.02

3.4.2 Diversity and Ethnicity

Haringey has a very diverse population, so it is important to examine the demographic profile of service users against that of the population to ensure that no group are either over or under-represented in services. Across the aggregated service figures for 2014/15 ethnicity was recorded in 69% of cases, not stated in 7% and not known in 24% of cases. In order to get a full understanding of the relative representation of different ethnicities within services, recording figures need to be higher.

The introduction of the new national CAMHS minimum data set should support providers in resolving this issue. From the data recorded the service profile matches very closely with the latest available demographic data (Census 2011) across the majority of ethnicity groupings and it is incredibly positive that providers are meeting the needs of the diverse community within Haringey.

The largest variance demonstrates an under-representation in services of Black/Black British African children and young people. This will need to be monitored once we have more complete data, additionally work will need to be undertaken with the communities within this group to promote CAMHS targeting wards with larger African communities such as Northumberland Park and Tottenham.

Table 19: Haringey demographics population ethnicity and all CAMH services usage. Census 2011

0-17 inclusive	Haringey	Population Percentage	Service Percentage	Variance
All categories: Ethnic group	57,670	100%	100%	0%
White: English/Welsh/Scottish/Northern Irish/British	16,673	29%	30%	1%
White: Irish	451	1%	2%	1%
White: Gypsy or Irish Traveller	174	0%	0%	0%
White: Other White	10,193	18%	18%	1%
Mixed/multiple ethnic group: White and Black Caribbean	2,604	5%	6%	2%
Mixed/multiple ethnic group:	1,316	2%	1%	-1%

White and Black African				
Mixed/multiple ethnic group: White and Asian	1,722	3%	1%	-2%
Mixed/multiple ethnic group: Other Mixed	2,351	4%	8%	4%
Asian/Asian British: Indian	698	1%	0%	-1%
Asian/Asian British: Pakistani	505	1%	0%	0%
Asian/Asian British: Bangladeshi	1,463	3%	1%	-2%
Asian/Asian British: Chinese	576	1%	0%	-1%
Asian/Asian British: Other Asian	1,504	3%	2%	-1%
Black/African/Caribbean/Black British: African	7,734	13%	7%	-7%
Black/African/Caribbean/Black British: Caribbean	3,927	7%	11%	4%
Black/African/Caribbean/Black British: Other Black	2,894	5%	5%	0%
Other ethnic group: Arab	593	1%	0%	-1%
Other ethnic group: Any other ethnic group	2,292	4%	8%	4%

2016 Update:

Barnet, Enfield and Haringey Mental Health Trust in collaboration with Mind in Haringey have started work to better engage with faith and community groups to promote emotional wellbeing within some of the above communities in Haringey and to examine some of reasons behind the figures included above.

3.4.3 Looked After Children

Haringey Council is responsible for 451 looked after children (as at 31st March 2015), of those 121 live in the Borough of Haringey and 330 are placed out of borough. In addition to those looked after children who are the responsibility of Haringey Council there are a number of children placed into Haringey from other areas who require access to local CAMHS services, the data has not yet been published for 2014/15 but in 2013/14 there were 115 children and young people placed into Haringey by other local authorities.

NHS Responsible Commissioner Guidance places the responsibility for health commissioning on the CCG to which the child or young person was registered at the time of coming into care, so that Haringey CCG and Council have the same population to plan for. In order to better understand the mental health of Haringey's looked after children the Council commissioned the Tavistock and Portman to provide the First Step service. This service provides screening of all children and young people coming into care and annually thereafter through the Strength and Difficulties Questionnaire (SDQ). It then provides consultation to social workers and foster carers and up to six sessions with the children and young people where the SDQ results are outside of the normal range.

In some areas targeted services for Looked After Children (LAC) are commissioned by social care in order to provide either a lower threshold for LAC (Tier 2) or an expedited service. In Haringey the decision was taken to focus resources on broader screening and thorough assessment. This approach means that there is a far better understanding of the mental health of the whole looked after population, and issues should be picked

up swiftly. However national data indicates the average SDQ score for Haringey LAC has increased in 2013 and 2014 demonstrating a higher level of need. Between 2009 and 2012 Haringey average SDQs were lower than the national and London average, however in 2013 and 2014 averages exceed the London average, but remained lower than the national average. In terms of the rate falling within the normal range, this have gone from 59% in 2012, to 48% in 2013 and were at 54% in 2014. This means that there may be as many as 200 looked after children requiring some form of emotional or mental health support.

The limitations of the current First Step model are that it does not pick up those on the edge of care, nor provide longer term work. This means that those requiring a CAMHS intervention have to be referred to their local CAMHS which can then mean long waiting times due to the variability of CAMHS around the Country. Additionally stakeholders identified that for 0-5s it would be useful to have a fuller psychological assessment and liaison at the point of entering care. For this cohort there is a low return rate for SDQs and because the SDQ is age 3+ and does not fully reflect the psychological difficulties which may not yet be presenting symptomatically.

For those on the edge of care wrap-around provision for families should be available to include psychological support. To this end Children and Young People's Services are looking at having CAMHS and adult mental health practitioners hosted into targeted social care service for families with complex needs. Currently 0.5 WTE of a BEHMT CAMHS practitioner is working with edge of care services. Further work with Children and Young People's Services is required to understand how CAMHS can be integrated into social care to provide a multi-agency, multi-disciplinary approach that meets the needs of families with complex issues.

There is currently a lack of awareness across social care teams on how to refer to CAMHS and the remit of CAMHS provision. This is a fundamental pathway for children who are known to social services and all social workers should have clear understanding of how to refer and liaise with local CAMHS Services. In order to support social workers and team managers a tool and training should be developed to outline the processes by which children and young people can access mental health support and how they can ensure funding is in place from the responsible commissioner. It will also need to support social workers' understanding of what type of issues can usefully be referred to CAMHS and what sort of interventions can be implemented by the network around the child/young person.

Some looked after children may experience multiple placements in the course of a year. Whilst this is a small minority of cases, for these children there is a real lack of available CAMHS support as with every move a new referral to a new CAMHS service means they start at the bottom of the waiting list. Recent First Step data over the last 9 months shows 13 children and young people have had 10 or more placements and 81 have had over five. In order to meet the needs of this cohort, it is recommended that First Step have the flexibility within their contract to provide therapeutic support throughout the transition period. For some longer term interventions a stable placement is needed in order to successfully provide the intervention. However bridging support should be provided as the chances of a placement stabilising is likely to be increased if emotional support is continuously available to the child/young person and their carers.

Longer term work can then be initialised and planned as part of a coherent care planning approach, with an adequate understanding of the child/young person's needs. Additionally as noted earlier when a young person is being discharged from an inpatient provision there is a role for a holding clinician to support in order to facilitate the finding of an appropriate placement and a transfer to local CAMHS. As the number of looked after children has reduced over the last few years so has the funding for First Step, investment will

have to be considered in the context of the amendments made to the specification, and treatment provision could be piloted prior to any significant changes to the current model.

Another area identified by stakeholders is the lack of support to foster carers. The Virtual School, which supports the education of looked after children is currently training supervising social workers in how to create an emotionally friendly home, using the How to BE Tool. Support on this and other training on trauma and attachment should be developed directly for foster carers. Further to this CAMHS services should work in partnership with foster /kinship carers to deliver support for children and young people where they are not willing to engage. Services should also be accessible for adoptive partners, kinship carers and carers of children under Special Guardianship Orders, promoting attachment and supporting the stability of the family placement.

All CAMHS services should have the skills to adequately address the mental health of looked after children. LACS living in Haringey have access to the Fostering, Kinship and Adoption team at the Tavistock and Portman, while those placed out of Borough receive their local CAMHS service. Barnet Enfield and Haringey Mental Health Trust are currently not seeing Haringey's looked after children; this is an area that needs to be addressed as services should be based on need and the presenting issue rather than social care status. The Tavistock fostering, kinship and adoption treatment services should be targeted for those with specific issues arising from their trauma and familial separation. In order to ensure that services are sufficiently equipped to meet the needs of all looked after children living in Haringey BEHMHT will need to review training for their staff to meet the needs of this cohort. Interagency working and liaison is a necessary and intrinsic part of this work and BEH should feed into planning and support processes as required.

Care leavers are a group of particularly vulnerable young people, often having had traumatic experiences and without the familial support networks that many young people rely on when moving to independence. Mind in Haringey have been working with young care leavers to support transition, however the contract for this ends in December 2015. The outcomes of this work should be considered and mechanisms should be put in place for better identification of care leavers within mental health services, as this is not currently a recorded group. Further work is required to understand the levels of need and consider how this is met for the future in collaboration with adult mental health commissioners.

2016 Update:

As part of our Transformation Plan we have developed a 'First Step Plus' service, building on the First Step screening and assessment service delivered by the Tavistock and Portman NHS Foundation Trust. This new service is working with approximately ten complex young people who have had multiple placement breakdowns and who therefore have not been able to successfully engage with a local CAMHS. The team work with a child or young person no matter where they're placed in the Country, delivering direct interventions and/or support to the placement and network as appropriate to the needs of the child/young person.

3.4.4 Children with Disabilities and Special Educational Needs

Learning Disabilities

According to national statistics 40% of families with children with learning disabilities feel they do not receive sufficient help from medical professionals, social workers or mental health services.[xx]

The 2007 Report by Lancaster University 'The Mental Health of Children and Adolescents with Learning Disabilities in Britain' identified an increased risk of mental health problems for children with learning disabilities across all types of psychiatric disorders, with over 1 in 3 children and adolescents with a learning disability in Britain having a diagnosable psychiatric disorder, whereas the rate for the general population is estimated at 1 in 10. Their data suggests that children with learning disabilities are:

- 33 times more likely to have an autistic spectrum disorder
- 8 times more likely to have ADHD
- 6 times more likely to have a conduct disorder
- 4 times more likely to have an emotional disorder
- 1.7 times more likely to have a depressive disorder

In Haringey there is a specialist team dedicated to supporting these young people which was jointly commissioned in 2007 between the local NHS and the Council. The CAMHS Learning Disability Service (CAMHS LD) provided by Barnet, Enfield and Haringey Mental Health Trust is a small team comprising psychology and psychiatry. It provides support to children and young people who present with behavioural and/or mental health difficulties associated with learning disabilities. This service is currently aligned to BEHMHT CAMHS and this model seems to be working well with skills embedded across BEHMHT CAMHS.

The model of delivery is linked well into the local special schools and the Disabled Children's Team and provides a good example of inter-agency working. Additionally Open Door provides a specific service for teenagers with special educational needs and disabilities funded through BBC Children in Need. Feedback from the staff survey demonstrated that staff across services feel confident in addressing the mental health needs of children and young people with learning disabilities. In Haringey the estimated figure for children with a learning disability and mental health problem (2014) is 380 children and young people between 5 and 19 years[xxi]. The CAMHS LD service has a caseload of approximately 85-95 and accepts approximately 30 new referrals a year, therefore we may need to consider service capacity.

Autism Spectrum Disorder (ASD)

The National Autistic Society cites data estimating that 1 in 100 children have autism, and that more than seven in ten children with autism have a co-morbid mental health problem. They argue that many of these problems are preventable with the right support and that changes to the way that CAMHS are delivered can stop them from occurring. In Haringey local data shows prevalence to be much higher than one in a hundred, with referrals for autism assessment increasing significantly in the last few years (from 97 in 2011 to 229 in 2014). Local paediatric services report that between 2/3rds and 3/4s of referrals result in a diagnosis. With figures at this level autism within the Borough far exceeds the approximate number of cases a year we would expect to be diagnosed on the basis of prevalence data.

The current diagnostic pathway for children and young people is via the paediatric social communication and neurodevelopmental clinics for under 12s and via Great Ormond Street Hospital for over 12s. Specialist CAMHS currently do all ADHD assessment and treatment, and this split means that despite the high likelihood of co-morbidities there is no current mechanism for joint clinics between paediatrics and CAMHS. Psychological input into autism assessments will provide increased capacity, improved assessments and better integrated care for families; this is an area that should be developed whilst scoping the feasibility of providing a local diagnostic service for all children and young people within Haringey.

The CAMHS LD service will see young people with autism with a mental health or challenging behaviour issue but they are not currently commissioned to provide early intervention post diagnostic support, where these needs are not yet presenting. Neither does the Child Development Centre provide any psychological support. A key area to be considered for investment is the development of post-assessment follow up psychological and group support. This could be developed for families to support attachment, and help the families to accept and understand the diagnosis.

Sensory difficulties are commonly associated with attachment disorders, autism and ADHD. Occupational Therapy input as part of the autism diagnostic process and post diagnostic care is currently another gap. Increased access to Occupational Therapy as part of this pathway could reduce challenging behaviour related to unidentified or unmanaged sensory needs. This could prevent behaviour escalating to a level where medication is required and/or the family are unable to cope and expensive residential settings are necessitated. The CCG and Council are currently reviewing the whole life pathway for autism and this will need to be considered within that context.

Special Educational Needs

The SEND (Special Educational Needs and Disabilities) Reforms placed extended duties on health, social care and education services to work more closely in planning for children with special educational needs and disabilities. To date CAMHS involvement in the Education, Health and Care plan process has been limited. Training for staff is required to ensure they are aware of the duties and role of health professionals in this process.

Chronic physical health problems

Children with a long-lasting physical illness are twice as likely to suffer from emotional problems or disturbed behaviour. This is especially true of physical illnesses that involve the brain, such as epilepsy and cerebral palsy. Locally paediatric mental health liaison supports the integration of physical and mental health support, though joint clinics between community paediatrics and CAMHS would also provide additional skills within paediatrics to support this cohort.

2016 Update:

Issues have arisen relating to diagnosis for over 12s who were previously being seen at GOSH, who have adjusted their criteria and now only provide second opinions on complex presentations. In the short term we have agreed cover with the Tavistock and Portman NHS Foundation Trust's Lifespan service, however we need to find a longer term solution and this is an opportunity to develop a more local service. Additionally a joint working group between community paediatrics and CAMHS has been established and we have developed joint case discussion meetings with a view to developing closer working and looking at the possibility of joint clinics. We are also using this meeting to look at neurodevelopmental pathways and assessment processes. As part of the Transformation Funding we have established a CAMHS worker, hosted into the community paediatric service to provide post-diagnostic support to families.

3.4.5 Lesbian, gay, bisexual and transgendered (LGBT) Young People

Mental health and emotional wellbeing services often do not ask about or know the sexual orientation or gender identity of the young people who access their services. However a high percentage of LGBT young people have mental health problems, aspects of which are often related to coming to terms with their sexual

orientation and stigma. As such it is important to be aware that a proportion of young people being referred to CAMHS or to emergency departments in the case of self-harm, are likely to be in this vulnerable group. In order to do this we need to provide a culture of service delivery which promotes equality and safe disclosure. Additionally according to The School Report by Stonewall many of the emotional and mental health issues experienced are rooted in bullying and stigma. Schools have a role to play in promoting inclusive communities with a zero tolerance for bullying.

3.4.6 Young Offenders

A study completed by the Centre for Mental Health identified that poor mental health and childhood behavioural problems were a key risk factor for female gang affiliation, with nearly 40% of girls with gang associations having shown signs of behavioural problems before the age of twelve. Other risk factors included poor maternal mental health, exposure to violence in the home and experience of trauma. More broadly young women involved in violence or crime (and particularly those in custody) often have significantly higher levels of mental health problems that their peers and are more likely to self-harm or attempt suicide.

Point of arrest screening identified 10% of girls in gangs with suspected development difficulties (such as ADHD or autism) which is roughly comparable to rates found in males in the same sample and five times that of other females[xxii]. International studies also demonstrate higher levels of girls with ADHD in custody[xxiii]. Locally MAC-UK have been working in Haringey since November 2014 with 16-25 year olds to improve links between at risk young people and mental health support including through streetherapy, taking mental health provision out of clinic settings into the community and integrating it into wider engagement work.

In 2014/15 Haringey had 272 young people within the youth criminal justice system and the Youth Offending Service is currently working with 194 young people. The Haringey YOS has access to 0.3WTE CAMHS worker via Barnet, Enfield and Haringey Mental Health Trust. Additionally NHS England commission 1WTE post to screen first time entrants to the system (at arrest point) and those at Police stations. National research indicates a high prevalence of mental health conditions in youth offending and studies have indicated rates can be as high as 70%[xxiv]. Services therefore need to be integrated and accessible. This is an area for development and current resourcing should be increased in order to provide meaningful input into the youth justice pathway. 0.3WTE is insufficient to carry out assessment, consultation (for staff) and treatment for young people engaged with the YOS on Court orders and subject to formal interventions.

One of the evidence based interventions for these vulnerable young people is Multi-Systemic Therapy. It is an intensive in-home programme aimed at families of children aged 12-17 who are at risk of, or who have a history of arrest. It seeks to empower parents with the skills and resources to address the difficulties that arise in raising teenagers and to empower young people to cope with family, peer, school and neighbourhood problems. This was previously commissioned for ten of Haringey's young people, however in April 2016 the existing provider gave notice and we are yet to re-commission this service. We are currently examining the best approach to meet the needs of this high risk group.

2016 Update:

We are currently working with the Ministry of Justice to co-commission liaison and diversion services and mental health support to those on the youth justice pathway. We have identified that additional resource is

needed locally and are looking at how we use this to form an integrated approach with the MoJ commissioned provision. We are holding a multi-agency workshop in November 2016 in order to map current provision and look specifically at groups such as Looked after Children/care leavers and children and young people with Special Educational Needs and Disabilities to ensure that pathways are in place that meet their needs.

3.4.7 Young Carers and Parental Mental Health

According to the report produced by the Princess Royal Trust for Carers 'At What Cost To Young Carers' the implications of being one of the UK's 177,918 (2011 census) known young carers, include the risk of truancy, under-achievement, isolation, mental and physical ill health, poverty and stress. These risks are particularly acute for young people affected by parental substance misuse (250,000 young people in the UK), parental alcohol misuse (1.3 million young people) and parental mental health problems (4.2 million parents).

An increase in the number of unpaid carers aged 5 to 17 was observed in all regions between 2001 and 2011 (ONS). In England and Wales combined, the number of young unpaid carers increased by almost 19% during this period. The South East had the largest increase of 41.2%.

Haringey has the third highest rate of severe mental illness in London and a regular concern reported by Schools is supporting children and young people where parents have mental health needs. Interactions with families affected by parental mental ill-health often become very difficult for schools and they are often left feeling very isolated in dealing with complex situations and dynamics within the family whilst seeing the child struggle to access education. Adult mental health services should be trained in thinking about the holistic needs of the family including support to children where a parent is receiving support for their mental health.

In addition to parents affected by severe mental illnesses, many Haringey parents experience less severe but still debilitating anxiety and depression, often linked to financial or housing difficulties, or domestic violence. Haringey has high levels of lone parent households designated as statutorily homeless. Domestic violence is the most common reason for contact with children's social services in every ward across the borough, and 58% of parents contacting Hearthstone, the local voluntary sector agency supporting families affected by domestic violence, have mental health problems. Children whose parents are struggling with these issues may be both directly and indirectly affected in terms of their emotional wellbeing.

In Haringey parents with mental health problems have access to Kidstime. This provides workshops for children, young people and their parents who are affected by mental illnesses. It's a safe place where children and families can have fun, learn and get help and support from people who understand what's going on in their lives. The Kidstime workers create an environment which fosters a mixture of informal and intimate relations combined with their professional responsibility to protect both adults and young people.

In July 2015 the Department of Health and Department for Education launched a joint bidding process to pilot approaches for vulnerable groups in schools as part of their response to 'Future in Mind'. Haringey was successful in its bid to look at how this group can be supported, and was allocated £100,000. The pilot includes training for school staff in parental mental health and emotional wellbeing and resilience building support to young carers, however funding is only for 2015/16 and we must therefore consider sustainability. Additionally we currently have no data on the numbers of young carers accessing mental health services, or the mental health of our young carers and this should be developed to better inform planning.

2016 Update:

Using the pilot funding we have been working with schools in the borough to improve awareness of, and support to young carers. The pilot has been delivered by a partnership between Haringey SHED, Haringey Council, Barnet, Enfield and Haringey Mental Health NHS Trust and Family Action, with support from Haringey CCG. Haringey SHED worked with young people to produce a video, which is available on youtube as a training resource to professionals on what it means to be a young carer:

https://youtu.be/4sETL7nZSvA

This resource has been integrated into a training package that has been delivered to adult mental health teams, and will soon be rolled-out to Children's Services staff in the Council. The training seeks to explore the emotional impact of being a young carer, and how they can be supported. Additionally parent information sessions and drop-ins have been established in pilot schools. We are now reviewing our Young Carer offer and using the outcomes of the pilot to inform this.

3.4.8 Refugees and Asylum Seekers

Refugees and asylum seekers currently have access to specialist trauma services via the Tavistock and Portman contract. Benchmarking data for 14-15 has not been published yet but as at 31st March 34 unaccompanied asylum seekers were looked after by the local authority in Haringey. Further scoping work needs to be completed about the mental health needs of this cohort and their ability to access support.

3.4.9 Abuse and Sexual Assault

> A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by others (eg via the internet). They may be abused by an adult or adults, or another child or children.

How Safe Are Our Children, NSPCC. 2015

Children and young people who have been abused or are being abused are more likely to suffer from poor mental health than their peers. In Haringey 248 children were subject to child protection plans at 31st March 2015. Appropriate support should be offered for these young people and services should not be deterred by ongoing legal action. There are guidelines for how children and young people can be supported during the period awaiting legal resolution; however one parent reported that her child was refused any support on this basis, leading to an escalation of their mental health issues. New guidelines are due to be published by the Crown Prosecution Service which should provide more clarity and support to mental health services to enable appropriate support through-out a hugely traumatic time for children and young people.

In March 2015 NHS England in partnership with King's College Hospital undertook a Review of the pathway following sexual assault for children and young people in London. This report identified a lack of CAMHS provision within the pathway. Work is being developed on an NCL wide basis to look at the recommendations of this report and how this might be translated into improved CAMHS support.

2016 Update:

We are working on implementation of the CSA Review across North Central London. Further information on this can be found in Part Two.

3.5 Developing the workforce

At the time of the Review there were 90 staff working across Haringey services totalling 52.92 WTE (39.22 clinical, 13.7 non clinical and 6 volunteers). These figures are specific to Haringey and do not include staff working with Haringey children and young people based in services working across CCGs such as the Royal Free and Tavistock and Portman, nor does it include the Whittington PIP service. Using the 2004 National Service Framework recommendations the CAMHS workforce should equate to at least 15 WTE for every 100,000 population.

Given Haringey's population of approximately £267,541 (2014 ONS estimate) this would equate to 40 WTE. The Royal College of Psychiatrists[xxv] recommend 20 FTE and 5FTE primary mental health workers (Tier 2), this would make the recommended staffing complement of 53.5WTE in Tier 3 and an additional 13WTE primary mental health workers. Given the current clinical staffing of 39.22 plus the Tavistock and Portman and Royal Free staff input we are currently between the two recommended levels. As we increase our early intervention services, this will bring us more in line with Royal College of Psychiatrists' recommendations.

3.5.1 Skill Mix & Competencies

One of the benefits of the broad range of providers delivering CAMHS in Haringey is that there are a wide range of competencies and interventions available within the services including:

Table 20: Interventions available to Haringey Children and Young People

• Adult Psychoanalytic Psychotherapy	• Parent and Child Game
• Brief systemic intervention	• Psychoanalytic Psychotherapy
• Child and Adolescent Psychotherapy	• Psychodynamic Psychotherapy
• Child Psychodynamic Counselling	• Short-Term Psychoanalytic Psychotherapy (STPP)
• Cognitive Analytic Therapy (CAT)	• Solution-Focused Therapy
• Cognitive Behavioural Therapy (CBT)	• Specialist speech and language therapy (CAMHS LD)
• Dynamic Interpersonal Therapy	• Systemic Family Therapy
• Eye movement desensitization and reprocessing (EMDR)	• Systemic Psychotherapy
• Intercultural Psychoanalytic Psychotherapy	• Triple P Parenting
• Interpersonal Psychotherapy for Adolescents (IPT-A)	• Triple Track Therapy (locally developed)
• Medication	• Video Interactive Guidance (VIG)
• Mindfulness Based Therapy	• Watch Wait and Wonder
• Mindfulness counselling	• Webster-Stratton Parenting
• Multi-Systemic Therapy (MST)	

Due to the psychotherapy focussed nature of local voluntary sector provision provided by Open Door there is a very strong psychotherapy bias with Haringey CAMHS. However Open Door are also expanding to provide psychological interventions and have recently joined the CYP-IAPT partnership which will give staff access to additional training in psychological therapies. In order to get a clear understanding of the workforce Future

in Mind proposes a national audit. In order to support this but also to ensure that staff have the competencies to deliver evidence based models of care all providers should complete a skills audit identifying any gaps or training needs.

3.5.2 Training analysis of CAMHS provider staff

Across three of the main providers the review has identified training needs around safeguarding children. Whilst all responding staff either felt confident in addressing child protection issues themselves or knew where in the team to seek support, mandatory training is not being complied with. Some administrative staff had never undertaken safeguarding training and some clinicians working with families had not undertaken it within the last year, with a small proportion not having taken it in over two years. Action to rectify should be taken by providers and this will be followed up through contract management.

Other themes from the training needs identified by staff responding to the online questionnaire which should be considered by providers are:

- Mentalization based techniques and Dynamic Interpersonal Therapy (DIT)
- Cognitive Behavioural Therapy
- Family Interventions
- Dialectical Behavioural Therapy (DBT)

Despite Haringey being part of the CYP-IAPT programme for a number of years it has not been embedded across the Service. Close working with the London and South East collaborative to develop this has been started in recent months and they have agreed to develop brief training opportunities on the CYP-IAPT principles for staff, including session by session outcome monitoring and child and young person participation. As noted earlier training is also required for the workforce on the recent SEND reforms and how they can contribute to the Education, Health and Care Plan process.

3.5.3 Upskilling the Universal Workforce

Future in Mind states that anyone working with children and young people in universal settings should have training in children and young people's development and behaviours as appropriate to their professional role. Further than that it is vital that we have a skilled workforce who can both recognise mental health issues and which knows how support the child or young person to access appropriate help. This will be supported by developing links between CAMHS and other services, though it anticipated there will be additional workforce training needs.

Areas identified in this report specifically include training for Schools which will be addressed through the Mental Health Links pilot, through the Virtual School's How to BE programme and through the Young MInds work. Training for social workers and foster /kinship carers should be specifically developed appropriate to their roles with a focus on trauma. Training around self-harm, supporting children in crisis, how to recognise mental health issues and how to access services should also be available to all professionals working with families.

2016 Update:

In 2016 providers completed a return to Health Education England outlining their current staffing levels. Providers have submitted these returns to commissioners in order to ensure that we are able to plan across

providers for the Borough. The audit identified that as noted above Haringey Children and Young People have access to a broad range of interventions and support.

Open Door currently has two staff attending the IPT-A training and one member of staff attended the management training in addition. The Tavistock and Portman NHS Foundation Trust are now part of CYP-IAPT and are also accessing training, due to the multi-borough nature of the Tavistock and Portman's teams these staff are not directly allocated to Haringey, but some Haringey children will benefit from the broader access to psychological therapies.

Over the last year significant work has been done to develop the universal workforce including a CAMHS Training conference available to multi-agency professionals including school staff working with Haringey families, which was attended by over 100 professionals. In addition the Tavistock and Portman NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health Trust have developed training currently being rolled out to all teams across Haringey Council's Children and Young People's Services, tailored for each team. The aim of this training is to increase understanding of mental health, how to support it, and raise awareness of resources and services and how to access them. The Young Carers project includes training on identifying young carers and the impact of caring on the emotional wellbeing of young carers. This training has been rolled out to adult mental health services as well as children's teams across early help.

A key part of CAMHS Transformation is increasing the workforce in order to support children and young people requiring Child and Adolescent Mental Health Services. This has seen the workforce increase from 39.22 WTE clinical staff in 2015 at the time of the Review, to 44.44 WTE clinical staff at 31st October 2016, with a further 2 WTE clinical staff to be recruited into permanent positions by the end of the year. Additionally we intend to use additional workforce to provide temporary staffing in order to clear the current waiting lists, with the new Choices model expected to support the ongoing sustainability of reduced waiting times. Over the coming years the workforce will further increase in line with investment. The exact numbers are difficult to project as it depends on the final models agreed for both Tier 2 provision and crisis support. We will be evaluating the success of all pilots over 2017-2018 and will then commission based on what has worked well and delivered the required outcomes for children and young people.

4. Conclusion

As outlined in this report we have a good range of provision and skills within Haringey, the diverse tapestry of providers and provision means there are no significant gaps in service delivery at Tier 3. As we move to implementation of the recommendations of this report our intention is to work collaboratively with existing stakeholders and service providers to develop new models of care and embed an early intervention approach. In order to develop improved pathways we will need increased participation of children and young people and their families, and robust multi-agency partnership working. Some of the recommendations within this report will require additional funding, however some will require changes to practice within existing resources. Under each recommendation are a number of actions, and these are outlined in the Transformation Action Plan (section 5) with the proposed transformation resource.

4.1 Key Findings for Commissioning

Current commissioning arrangements mean there is no 'whole system approach' and a lack of coherence to provision. Current funding arrangements do not allow us to accurately determine levels of investment, spend and associated outcomes. Future in Mind requires a '**lead accountable commissioning body**' and a '**single separately identifiable budget for children's mental health services**'. Whilst there is a joint commissioner in place for this area, joint commissioning arrangements should be developed further to facilitate:

- Single CAMHS contracts across statutory commissioning agencies per provider
- Clearer, more transparent investment and monitoring of spend
- Joint planning and integrated services designed to meet the needs of the whole population

4.2 Key Findings for Provision

- The Review has identified a relative lack **of early intervention** (Tier 2) support. This should be expanded building on the CAMHS in GP practices pilot and the mental health links in Schools pilot in light of the borough's Early Help Strategy. Work with universal provision should be prioritised, developing services which support attachment and promoting access to a coherent programme of **parenting support** using evidence based models. **Peer support** and **digital solutions** should be developed as part of this model.
- There is a lack of **out of hours** support around **crisis** presentations, pathways should be developed in partnership with neighbouring boroughs and the role of the Adolescent Outreach Team should be reviewed as part of this work
- Targeted services should be enhanced for **vulnerable children and young people** e.g. Looked After Children/Care Leavers/Children with learning disabilities/Autistism Spectrum Disorder/Young Offenders/Young Carers/Children who are abused
- Services need to be more focussed on **outcomes**, using evidence based approaches and CYP-IAPT should be embedded across services
- Current capacity issues within Tier 3 are leading to long **waiting times**. Expanding early intervention services should reduce demand and improve access over time and use of **group interventions** and **digital solutions** should increase service efficiency.
- Interagency working and **communication** between CAMHS and the wider children and families work-force should be improved, linking CAMHS into other services and through the upskilling of the wider children and families workforce

- **Enablement** should be promoted through peer support models for children and young people and their families.
- Services should be more **accessible,** better **information** should be available to families early on and appropriate use should be made of **community assets** at the earliest stage to prevent escalation of mental health concerns.
- There is a need for improved **transition** between CAMHS and adult mental health services and increased flexibility in age eligibility criteria with appropriate and timely step-down for those who will not require ongoing support.
- Closer working between physical and mental health services is required. **Joint clinics with paediatrics** (social communication & neurodevelopmental clinics) and post assessment psychological support for families should be developed
- There are proportionally fewer children and young people accessing services from the most deprived areas in the Borough and work needs to be done to **target referrers and families** in these areas, especially in Black/Black British African communities who are **under-represented** in provision.

4.3 Recommendations

1. Develop and implement a joint commissioning model which allows us to develop a whole system approach to child and adolescent mental health and emotional wellbeing
2. Ensure evidence-based, quality assured services which promote participation of children, young people and their families in all aspects of prevention and care
3. Develop an early intervention approach that is embedded across the whole system.
4. Transform the model of care to improve access, deliver seamless care, improve outcomes and promote enablement.
5. Ensure that all groups of children and young people are able to access appropriate support, and that those where there are higher vulnerabilities have tailored support to their needs.
6. Promote the recognition of emotional health and wellbeing across the wider children and young people's workforce, ensuring staff are engaged in transformation.

4.4 Outcomes

Implementation of the Transformation Plan will mean the following outcomes for child and adolescent mental health services, families using these services and professionals working within the broader children and young people's workforce and Key Performance Indicators will need to be developed to measure the achievement of these outcomes, additionally each recommendation will produce a number of out:

1. Integrated and comprehensive commissioning under an agreed local framework for all provision, delivering transparency, accountability and value.
2. An early intervention approach that provides access to non-stigmatised triage and signposting with a focus on community support without over-medicalising children and young people and that builds a system of support in natural contexts such as school and home.
3. A co-ordinated preventative approach for children and young people, parents/carers and families through systems around the child working well together to support emotional wellbeing across the children's workforce.
4. Improved access to the right service at the right time with better support for vulnerable children and young people to access appropriate support.
5. Flexible services that meet the preferences and developmental needs of children and young people.
6. Child and Adolescent Mental Health Services with the tools to provide an efficient and up-to-date response to the population with a well-trained and competent workforce for delivery.
7. Better inter-agency working and improved communication with referrers and better discharge planning.
8. More focused work that reduces dependency and promotes resilience and enablement.
9. Improved crisis planning and pathways that provide timely support and robust follow up.
10. Clear protocols for cross-boundary issues and working between child and adult services.
11. Better engagement with under-represented communities/groups.

5. Five Year Transformation Action Plan

The below action plan outlines the recommendations of the Review for implementation over the next five years. Some of the actions are what we can currently identify as requiring action, and therefore this will be subject to change over this period as actions are completed and we are able to gather further information and inform our planning. We will publish an annual delivery plan which will take this into account and build on our progress.

Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
Accountability and Transparency						
1	A) Develop and implement a joint commissioning model which allows us to develop a whole system approach to child and adolescent mental health and emotional wellbeing. This will involve exploring the potential for: • Developing pooled budgets between the CCG and the Council • Disaggregating block funding arrangements • Joint commissioning with other boroughs to be considered • Developing choice through flexible commissioning • Looking at how we can jointly commission with schools for better outcomes • Working with providers to start clustering young people according to CAMHS PBR • Gaining a better understanding of what is important to children and young people and parents through better participation work using existing forums such as youth councils and supporting the development of new ones.	Haringey Clinical Commissioning Group, Haringey Council, Providers, Schools Forum, neighbouring CCGs and LAs, Children and Young People, Parents	September 2015-March 2017	• Improved commissioning • More integrated and coherent services • Better transparency of spend and outcomes • Increased participation of Children and Young People and Parent/Carers in commissioning and service delivery	Transformation funding may be required for: • Stakeholder engagement and participation work • Completion of any required audits • Developing and improving provider IT infrastructures • Commissioning resource to look at areas of joint planning across NCL • Commissioning resource to support transformation • Monitoring and evaluation of pilots/new ways of working across providers	• Joint Commissioning arrangements in place • Clear understanding and articulation of spend • Cross-borough protocols in place • Specifications in place for all services • Improvement in CYP-IAPT data completeness (90% target) • Providers ready to submit to HCSIS • Increased participation of

Recommendation	Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
B) Ensure evidence-based, quality assured services which promote participation of children, young people and their families in all aspects of prevention and care: • Working with providers to develop outcome based service specifications • Developing cross-borough protocols • Ensuring services are meeting quality standards e.g. NICE, CYP-IAPT • Supporting providers to develop an appropriate IT infrastructure to meet the needs of a modern and efficient CAMHS. All patient records should be electronic and digital communications should be put in place, where not available, to reduce DNA rates. All CAMHS providers to ensure that EPR systems are ready to submit CAMHS minimum data set to HCSIS in January and that this data is locally available to inform planning and clinical practice (session by session outcome monitoring) • Ensure all pilots are robustly evaluated so that learning from them can be shared and successful approaches sustained • Support providers to include children and their families in the planning and delivery of services		September 2015- March 2017			Children and Young People and Parent/Carers

Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
Promoting resilience, prevention and Early Intervention						
2	Develop an early intervention approach that is embedded across the whole system. This will include: • Developing a coordinated and coherent approach to the offer of parenting interventions across agencies including children's centres and CAMHS, linking in professionals to CYP-IAPT training where appropriate • Building on the learning from the CAMHS in GP surgeries pilot • Improving links between CAMHS services and universal provision through developing CAMHS leads within Schools and other key agencies and providing them with links into services, training and information. • Developing a robust local offer of brief evidence-based interventions to meet the current un-met need • Scoping the development of an attachment pathway to ensure this is supported across all ages and stages. • Developing early intervention approaches to eating disorders and self-harm • Scoping the use of digital solutions including online therapy services as part of the early intervention offer • Development of resource directory to support workforce in signposting and linked in to the local offer	Haringey Clinical Commissioning Group, Haringey Council, Universal provision, Schools forum, Children's Centres, CAMHS providers, Children and Young People, Parents	Planning in 2015/16 for implementation in 2016/17	• To reduce the level of un-met identified through local prevalence and activity data • Universal providers to have access to appropriate information and a good understanding of what's available locally and how to support families to access • Families to have appropriate support in parenting their children and developing secure attachments • Reduced reliance on Tier 3 CAMHS • Improved access to support for children and young people	Transformation funding may be required for: • Scoping and development of different early intervention models • Mapping and coordination of available support • Stakeholder engagement and participation work to support the development of the offer • Piloting different approaches in 2015/16 Funding levels to be increased from 2016/2017 for full implementation and commissioning of additional early intervention support	• Better understanding of available services across child and young person workforce • Increased proportion of Children and Young People accessing early intervention support against expected prevalence • Improvement in clinical outcomes for Children and Young People accessing commissioned early help services • Increase in number of foster carers using How To BE Tool

Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
Improving access to effective support- a system without tiers						
3	Transform the model of care to improve access, deliver seamless care, improve outcomes and promote enablement. This will include: • Broadening the range of available evidence based interventions to include group interventions e.g. CBT • Providers developing a broader range of community locations and their ability to offer home and school visits where appropriate • Building capacity for extended hours out so that children and young people can have appointments out of school time, especially where regular and ongoing work is required • Scoping the extension of CAMHS Access to improve front facing services and look at a non-stigmatised, integrated, community-asset based approach to triage and assessment • Improve information on locally available resources and ensure a more coordinated approach, which will improve accessibility through developing a local offer • Waiting time standards to be developed for routine urgent and crisis referrals in line with national standards • Providers to audit DNAs and gain a better understanding of the reasons for DNAs and disengagement • Developing peer support models for children	Haringey Clinical Commissioning Group, Haringey Council and CAMHS Providers, Schools, Acute providers, Referrers, Children and Young People and Parents	September 15-March 17	• More choice for children and young people • Better engagement with CAMHS • Improved access to CAMHS • Better crisis support for families • Improved transition to adult services • Enablement of children and young people • Improved support for parents/carers	Majority of changes to be made using existing resources, however transformation funding may need to be available for: • Piloting changes to CAMHS access • Project managing and supporting the development of peer support models that are self-sustaining and co-produced • Developing crisis and out of hours support • Implementing waiting time standards • Investing in digital solutions • Piloting new approach to transition	• Reduced waiting times • Reduction in DNA rates • Reduction in length of intervention • Increase in the number of children, young people and parent/carers accessing peer support • Development of an agreed pathway for crisis and out of hours support • Transition KPI to be developed

Recommendation	Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
and young people including opportunity for developing self-management skills and participation in the planning and development of services • Developing peer support models for parents and carers including training opportunities and developing their understanding of mental health conditions and management • Crisis and out-of-hours support to be scoped and developed in partnership with neighbouring boroughs including a more in-depth review of the role and remit of AOT and section 136 pathways • Work across NCL to ensure eating disorder pathways are in line with published standards. • Transition work to look at improving protocols between CAMHS and adult mental health services, using the principle of most appropriate service. Scoping work to look at step-down options for those accessing CAMHS who will not be eligible for adult mental health provision • Better promotion of digital solutions and apps available to children and young people. Providers to look at how these can usefully be used in clinical practice • Improving support for schools and parents in addressing self-harm • Better communication and inter-agency working. CAMHS to keep referrers better informed through regular updates, working					

Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
	with GPs and other referrers to understand what is helpful and developing information sharing protocols where necessary.					
Care for the Most Vulnerable						
4	Ensure that all groups of children and young people are able to access appropriate support, and that those where there are higher vulnerabilities have tailored support to their needs. This will include: • Work with the wider children's workforce to understand and recognise vulnerabilities to poor mental health and know how to support children and young people if they require it • Engaging with under-represented communities to understand why they are not accessing CAMHS • Reviewing current commissioning for LAC to ensure that there is flexibility to respond to need and offer interventions when no appropriate local CAMHS team can be identified/during placement moves • Gaining a better understanding of the training needs of the children's workforce including foster carers on mental health and how to support access to services. • Barnet, Enfield and Haringey Mental Health Trust to ensure they have the skills within the team to address the complexities of working with LAC where theirs is the most	Haringey Clinical Commissioning Group, Haringey Council, CAMHS Providers, Community health services, Schools, Children and Young People and Parents	Scoping Planning and establishing pilots Sep 15-March 16	• Improved access to services for a number of vulnerable groups • Improved quality of services available to vulnerable groups • Better supported and trained workforce • Better understanding of how we're meeting the needs of different communities and groups	Transformation funding may be required for: • Engaging with children and young people not accessing CAMHS • Piloting extension of LAC service to include treatment elements as outlined • Developing integrated role in YOS • Developing post-diagnostic assessment support Increased investment from 2016/17 to support full implementation	• Improved recording rates for ethnicity and vulnerable factors • Reduction in variation of engagement rates across the Borough • Improved interagency working (via stakeholder survey) • Improved mental health and emotional wellbeing for LAC • Improved clinical outcomes for young people engaged with the Youth Offending

Recommendation	Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
appropriate service • Developing joint pathways between CAMHS and paediatrics for children who require their physical and mental health needs to be looked at holistically • Improving data on hard to reach and vulnerable groups to be used in planning • Working with Children and Young People's Services to develop integrated roles including into early help, targeted services and the Youth Offending Service • Further work to look at how we support children and young people with learning disabilities and autism including improving access to psychological and group support for families post diagnostic assessment to support attachment, and how we might develop the CAMHS LD resource • Develop pilot for working with Young Carers and children and young people affected by parental mental ill-health in Schools • Closer working between SEND services and CAMHS to ensure that staff are meeting their duties under the SEND reforms to contribute to EHC planning. • Work with NCL partners to develop the sexual assault pathway and ensure appropriate CAMHS input.					Service • Increased proportion of parents of children with ASD reporting satisfaction with post diagnostic support • Improved pathway for child sexual assault

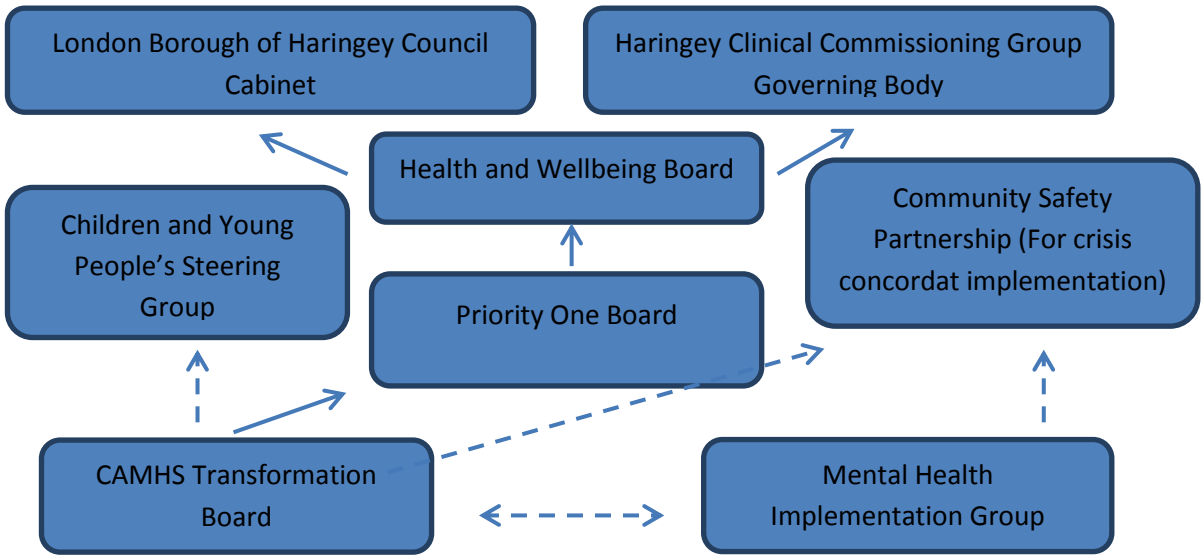
Recommendation		Relevant Partners	Timeline	The expected outcome of the scheme	Funding Implications and indicative costs	Key Performance Indicators
Developing the Workforce						
5	Promote the recognition of emotional health and wellbeing across the wider children and young people's workforce, ensuring staff are engaged in transformation. This will involve: • Events on CAMHS for wider children's workforce to promote CAMHS services and to provide an opportunity for non-CAMHS professionals to develop their understanding of mental health and the impact on social inclusion, development and the ability to learn including training needs as outlined in previous sections • Developing named contacts to be available across CAMHS to provide advice and guidance for worker supporting families where child/adolescent mental health is a concern including schools • Working with the CYP-IAPT Collaborative to develop brief training opportunities on CYP-IAPT principles to be available to all CAMHS practitioners across Haringey • Providers to immediately ensure that all staff have an appropriate level of up to date child safeguarding training. CCG to follow up through contract monitoring • All providers to complete a skills audit to ensure staff are qualified to deliver evidence based models of care appropriate to presenting need.	CAMHS Providers, Agencies working with children and young people, Haringey Council, Haringey CCG, Children and Young People and Parents	September 15- April 2016	• Improved skills and resilience within the workforce • Improved practice through the embedding of CYP-IAPT	Transformation funding may be required for: • Developing and delivering training events for wider children's workforce • Completing an audit of skills within CAMHS • Developing resources to support staff to promote emotional health Funding required in this area will be significantly less in future years.	• Improvement in Mandatory Training Compliance Rates • Children's workforce reporting they feel equipped to support the mental health needs of children and young people • Increase in those trained in CYP-IAPT evidence based therapies

6. Governance

6.1 Organisational Governance Structure

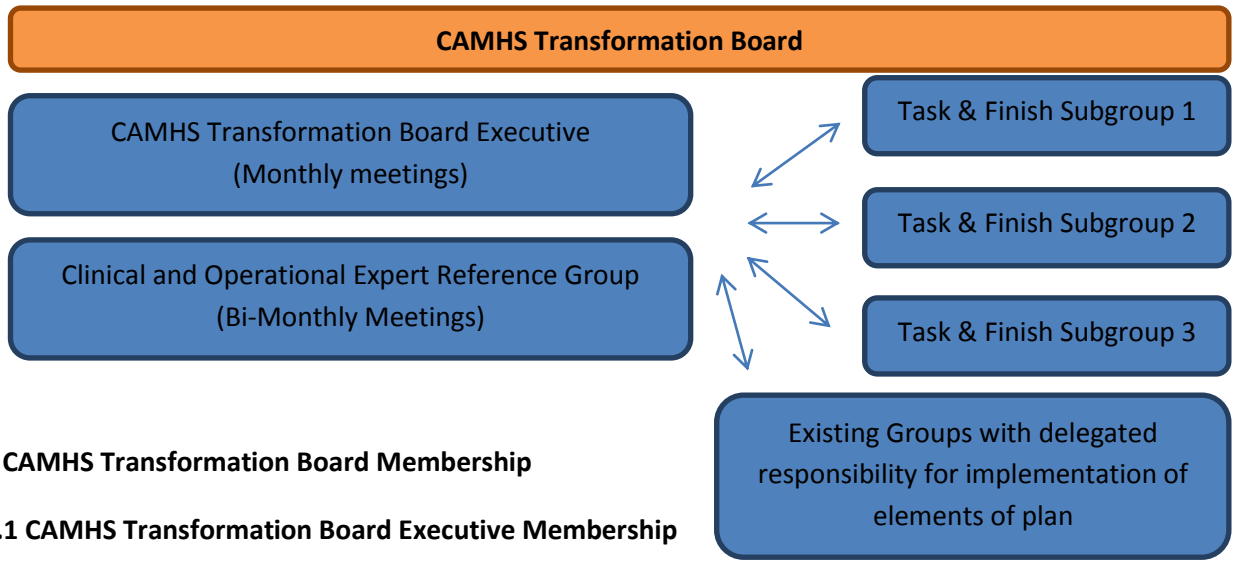
The implementation of the CAMHS Transformation Plan is overseen by a CAMHS Transformation Board. The CAMHS Review Board includes a CAMHS Transformation Board Executive and the previous provider forum and CYP-IAPT Steering Group have formed a Clinical and Operational Expert Reference Group. Currently we do not have any children and young people on this Board but do have parent and Health Watch representation. The CAMHS Transformation Board has now been integrated into the reporting structure for the Council's Corporate Plan under Priority 1: Outstanding for all: Enable every child and young person to have the best start in life, with high quality education. There is joint representation on this Board from health and the local authority.

The filled arrows below demonstrate the formal reporting structures for risk and accountability; the dashed lines demonstrate co-dependencies and informal reporting to ensure a consistent and joined up approach, linking the CAMHS Transformation in with both adult mental health services through the mental health implementation group, and with the broader health agenda for children through the CCG led Children and Young People's Steering Group.



6.2 CAMHS Transformation Board Structure

The CAMHS Transformation Board itself is a multi-agency partnership structure that supports a broad representation of partners but which also enables accountability in the Executive part of the Board which will bring together decision makers. The Executive meets monthly, and the Clinical and Operational Expert Reference Group meets bi-monthly separately. Every quarter the Executive and Clinical and Operational Expert Reference Group join together for a Full Board to ensure appropriate clinical input and partnership working. In addition there are a number of time-limited task and finish subgroups which are driving individual projects and programs sitting under the Plan.



6.3 CAMHS Transformation Board Membership

6.3.1 CAMHS Transformation Board Executive Membership

- Assistant Director Mental Health, Haringey CCG (Joint Chair)
- Director of Commissioning, Haringey Council (Joint Chair)
- Governing Body GP Lead for Children, Haringey CCG (Vice Chair)
- Assistant Director of Public Health
- CAMHS Case Manager, Specialised Commissioning, NHS England
- Vulnerable Children's Joint Commissioning Manager, Haringey CCG and Haringey Council
- Head of Integrated Service SEN & Disabilities
- Healthwatch Haringey Representative
- Parent Representative

6.3.2 Clinical and Operational Expert Reference Group

This Group comprises both clinical and operational representation from providers to ensure a good mix of clinical input into the delivery of plans and organisational buy-in from providers through senior representation.

6.3.3 Task and finish Subgroups

The focus of these groups changes over time and they pull together the right people from the Executive and Expert Reference Group as well as relevant partners to drive improvement in an area. They report into the Executive and Expert Reference Group and each have to identify how children, young people and their families will be involved in the workstream. Any decisions that are required can then be made through the Executive, depending on the level of the decision required this would then be signed off by Priority 1 Board, the Health and Wellbeing Board and/or the Council's Cabinet/ CCG Governing Body. Where there are existing groups that can take forward elements of the plan, these will have delegated responsibility for implementation; for example using the existing workforce development group which also sits under Priority 1 of the Council's Corporate Plan. Additionally for areas where there is a benefit to working closely with other CCGs/Councils we have developed joint task and finish groups. These groups also feed into the CAMHS Transformation Board.

PART 2

North Central London
CAMHS Transformation Plan Priorities

1.1 Mental Health is identified as a priority area in the North Central London (NCL) STP Case for Change. This has resulted in the development of the NCL Mental Health Programme as part of the NCL STP, which covers mental health support for all age groups. The programme currently has seven identified initiatives: community resilience, primary care mental health, acute pathway, female psychiatric intensive care unit, CAMHS and perinatal, liaison psychiatry, and dementia.

1.2 The CAMHS Transformation Plan Priorities are focussed on producing improved outcomes for children and young people, and on ensuring the best use of resources to generate those good outcomes. The transformation of children and young people's mental health and wellbeing services, and of perinatal mental health services, will not necessarily bring savings during the time period of the STP, but have been prioritised because of their future positive impact on the need for services. 50% of all mental illness in adults is associated with mental health needs that begin before 14 years of age, and 75% are associated with needs that are expressed by age 18[1]. Similarly, the negative impact on a child's mental wellbeing[2] associated with perinatal mental ill health confirms that these are two key service areas for ensuring improved long term mental health outcomes for our population.

Borough	Population aged 5-16	Est. prevalence of any MH disorder, aged 5-16 (2014)	
		Count	Percentage
Barnet	56,063	4,691	8.4%
Camden	27,904	2,546	9.1%
Enfield	52,460	5,195	9.9%
Haringey	37,905	3,745	9.9%
Islington	23,981	2,417	10.1%

Source: Fingertips, 2014

1.3 Across the 5 boroughs of NCL (Barnet, Camden, Enfield, Haringey and Islington) there are varying rates of mental ill health prevalence, and varying services and outcomes across the 5 boroughs; such as:

- Three of our boroughs have the highest rates of child mental health admissions in London (Fingertips, 2014/15)

[1] Cavendish Square Group
[2] Centre for Mental Health and London School of Economics

- There is limited perinatal community service in NCL, with no specialist team in the North and in the southern boroughs the service does not meet national standards (Maternal Mental Health Everyone's Business)
- Most of the liaison psychiatry and CAMHS services in hospitals in NCL do not see children within one hour at weekends and overnight (Mental health crisis care ED audit, NHS England (London), 2015).

1.4 In order to address variation and improve care for our population, as well as to meet the requirements set out in the Five Year Forward View and Future in Mind, the 5 NCL Boroughs will be working together on 8 areas as part of the NCL STP CAMHS and Perinatal initiative.

1.5 These are:

1. **Shared Reporting Framework** - to enable comparison and shared learning across the 5 boroughs
2. **Workforce Development and Training** - planning for the workforce in order to meet the mental health and psychological well-being needs of children and young people in NCL; including CYP IAPT workforce capability programme
3. **Specialist Community Eating Disorder Services** - dedicated eating disorder teams in line with the waiting time standard, service model and guidance
4. **Perinatal Mental Health Services** - to develop a specialist community perinatal mental health team that serves the NCL population and the physical health acute trusts within NCL
5. **Crisis and Urgent Care Pathways** - 24/7 urgent and emergency mental health service for children and young people with care delivered as close to home as possible for children in crisis; this includes local commissioning of Tier 4 CAMHS to eliminate out of area placements for non-specialist acute care by 2020/21; and review of S136 facilities for children and young people.
6. **Transforming Care** - supporting children and young people with challenging behaviour in the community, preventing the need for residential admission
7. **Child House Model/Child Sexual Assault (CSA) Services** - following best practice to support abused children in NCL
8. **Young People in the Youth Justice System** - working with NHS E to develop co-commissioning model for youth justice

1.6 In the development of the NCL CAMHS work, the principles of THRIVE will be used as an overarching approach with the aim of at least 32% of children with a diagnosable condition being able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

Priority 1: Shared Reporting Framework

Rationale for Joint priority across NCL:

2.1 In order to better plan across a broader NCL footprint we are working with providers to develop a minimum data set for local reporting on key indicators including quality indicators such as DNA rates and clinical outcomes. Importantly, we also wish to embed approaches such as the Thrive model with evaluation embedded in the process.

Our Ambition

- To better understand activity, performance and quality through the use of a set of metrics that support us to benchmark and combine consistently measured data
- To drive significant improvements in performance, requiring providers to demonstrate the production of better outcomes for children and young people, and holding them to account where they are failing to meet agreed outcome, output and quality targets.

Current picture

2.2 Across NCL there are currently a range of providers including:

- Barnet and Enfield Mental Health NHS Trust
- Tavistock and Portman Foundation Trust
- Whittington Health NHS Trust
- Royal Free NHS Foundation Trust
- Voluntary Sector Organisations unique to each Borough

2.3 Each provider uses a different Electronic Patient Record (EPR) system and has different reporting and monitoring arrangements with commissioners.

What we are aiming to achieve across NCL:

2.4 Currently we have a range of providers both within the NCL Boroughs and across them. We are working with all providers to agree a data set using definitions from the mental health minimum data set where available to ensure consistency. This will provide a mechanism for local reporting that will pick up a set of basic indicators to better monitor activity and performance across multiple providers, both for each
borough and across the broader STP footprint.

- Agree a dataset with providers for more consistent and comparable monitoring
- Agree a methodology for recording RTI and RTT waiting times from the perspective of the Child/Young Person based on NICE Guidelines

2.5 Improving access is a key driver for us. In order to better ensure that access is improving we are working on waiting time standards and an agreed methodology for measuring waiting times which takes into account the wait from the perspective of the family. Waiting times will be measured from the first point of contact with the system, rather than from the first point of contact with a particular service. This will ensure that people being redirected or passed to an alternative provider are not disadvantaged.

Key Milestones

- Development of Dataset (Completed)

- Agreement of Dataset with Providers (Partially Completed)
- Implementation of Dataset (2016/17)
- Reporting on Dataset (2017/18)

Funding

2.6 The changes to reporting do not require any additional funding and will be managed through the contracts.

Linked to key policies and initiatives

Future in Mind	• Mental Health Minimum Dataset (CAMHS) • Children and Young People's IAPT Programme

Priority 2: Workforce Development and Training

Rationale for Joint priority across NCL:

3.1 Across NCL, there are three mental health trusts that provide CAMHS services for the 5 boroughs. In addition, the specialist Eating Disorder Service for the 5 boroughs is provided by Royal Free London NHSE Trust. Due to the shared provider landscape, along with the migration of our population within the NCL patch, it has been agreed to conduct workforce mapping across the entire patch as this is seen as the most beneficial and efficient method of doing so, while also allowing for local variations in workforce need. The result will be a multiagency strategy to develop the workforce for the NCL STP footprint.

Our Ambition:

3.2 To review the current workforce provision which will enable the planning for the workforce requirements in order to meet the mental health and psychological well-being needs of children and young people in NCL; including the CYP IAPT workforce capability programme. It is anticipated this will result in more children and young people being able to access support, with more professionals able to support children and young people with mental ill health.

What we are aiming to achieve across NCL:

3.3 From undertaking the mapping of the current workforce, we will be able to identify what changes to the NCL CAMHS workforce will be required in order to deliver the new model of care and support contained in the 8 sections of the NCL CAMHS and Perinatal STP initiative, and achieve the ambitions of the Five Year Forward Plan, the Mental Health Taskforce and Future in Mind. Questions to be addressed are: what additional staff are required, and how will we recruit these; what new roles are required; what alternative ways of delivering support are required; and what training is required to ensure the workforce is adequately skilled to deliver the support required by children and young people with mental health needs. The mapping will also inform plans and commissioning intentions.

3.4 This multiagency workforce plan will be developed across partners and wider stakeholders, looking at how care can be delivered to maximise support. This may result in care and support being delivered in alternative ways to how it is delivered currently, such as increasingly through the voluntary sector, school and colleges. We do not envisage moving to a single workforce model for each area but will share ideas, expertise and learning across the area in order to produce a more efficient CAMHS system.

Key Milestones

- Secure funding – September 2016
- Appoint resource to conduct mapping – October 2016
- Completed mapping to be reviewed and next steps agreed – November 2016
- Wider stakeholder engagement – January 2017
- Completed workforce plan – March 2017

Funding

3.5 Commissioners are seeking funding for initial mapping work from NCL MH STP Programme funding.

Linked to key policies and initiatives

Linked to key policies and initiatives:	Aims
Five Year Forward View	• Reduce waiting times • Increase access to meet 35% of need
Future in Mind	• Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc. • Developing the workforce • Roll out CYP IAPT – incl. training via CYP IAPT for staff under 5, autism, and LD • Make MH support more visible and easily accessible • Professionals who work with children and young people trained in child development and MH

Priority 3: Specialist Community Eating Disorders Services

Our Ambitions

4.1 All NCL CCG's submitted plans for improving provision for eating disorders across the area in our Local Transformation plans 2015 / 16. NCL jointly commissions the specialist Eating Disorders Service at the Royal Free Hospital, Barnet CCG is the lead commissioner. The services comprise of the Intensive Eating Disorder Service (IEDS) and the Community Eating Disorder Service. Priorities we identified in Transformation Plans 2015.16 included

- Increase capacity and reduce waiting times to meet key requirements of NICE Guidance
- Outreach education training for eating disorders to primary care health and education staff
- Offer telephone support for General Practitioners
- Improved performance monitoring and management

4.2 Baseline performance for referrals under 4 weeks was 54% 2014.15. NCL and RFL agreed milestone for improvement at 60% Q4 2015.17, 80% 206.17

Progress against Ambitions

4.3 Overall the number of referral in 2015.16 (181) increased by 50% since to 2012-13 (119) and increased 26% compared to the two previous years. 94.5% of referrals received were accepted in 2015.16.

Referrals for all five boroughs for 2015.16		
CCG	**Number of referrals received**	**Number of referrals accepted**
Barnet	63	60
Camden	35	33
Enfield	22	21
Haringey	32	31
Islington	29	26
TOTAL	181	171

4.4 Waiting times for first appointment for ED patients seen in 2015/2016: In 2015/2016, 69.2% of patients were seen within 3 weeks and 6 days of referral and 97.5% within 6 weeks. This was a significant improvement from previous year (54%).

CCG	Waiting Times to first face to face contact (weeks)	Number of patients (Percentage of patients)
All NCL CCGs	**0 - 3**	69.2%
	4 - 6	28.3%
	7 - 9	2.5%
	10 - 12	0%
	13 – 18	0%
	18+	2.2%

4.5 The table below shows the waiting times for first appointment for patients referred in Q4 of 2015/2016 which evidences progress in the first period after the additional investment was made. At this time referrals were not categorised in the RFL reporting system as 'urgent' or 'non-urgent'.

	Waiting Times Q4	Performance
All NCL CCGs	**0 - 3**	36 (75.6%)
	4 - 6	9 (22.2%)
	7 - 9	1 (2.2%)
	10 - 12	0 (0%)
	13 – 18	0(0%)
	18+	0 (0%)

4.6 NCL led by Barnet CCG initiated performance monitoring meetings in Q1 2016.17 with a new set of targets and data reporting. RFL began reporting urgent and non-urgent referrals separately and further progress was made in reducing waits with 100% of urgent referrals seen with 1 week and 85% of non-urgent with 4 weeks so a total of all referrals seen with 5 weeks of 97%

		Waiting Times Q1 2016.17	***Waiting Times Q1 2016.17***
All NCL CCGs		**Urgent**	**Non-Urgent**
	0 – 1	4 (100%)	2 (7.4%)
	1 – 2	0 (0%)	8 (29.7%)
	2 – 3	0 (0%)	7 (25.9%)
	3 – 4	0 (0%)	6 (22.2%)
	4 – 5	0 (0%)	3 (11.1%)
	5 – 6	0 (0%)	0 (0%)
	6 – 12	0 (0%)	1 (3.7%)
	12+	0 (0%)	0 (0%)

Workforce Capacity NCL/RFL Eating Disorders Services: Roles	***Grade***	***Existing funding WTE CAMHS and Eating Disorders***	***+Transformation Funding additional WTE Eating Disorders***
Clinical Psychologist	***7***	***1.4***	***1***
Clinical Psychologist	***8a***	***1.2***	
Clinical Psychologist	***8c***	***1***	
Psychotherapist	***8d***	***.6***	
Psychotherapist	***8a***	***1.9***	***.4***
Family therapist	***8a***	***.8***	
Family therapist	***8b***	***.6***	
Family therapist	***8c***	***.4***	
Psychotherapist	***7***		***.8***
Family therapist	***7***		***.8***
Assistant Psychologist	***4***	***4.6***	
Health Care Support Worker	***3***	***1***	
Reception/Med sec	***3-5***	***3.1***	***.4***
Dietician	***7***	***.4***	***.6***
Consultant		***4.4***	
Junior Medical Staff		***1***	***.6***
Nursing outpatient	***6***	***1***	***.87***
Nursing outpatient	***7***	***1***	
Nursing	***8a***	***2***	

Nursing	***7***	***1***	
Nursing	***6***	***2***	
Nursing	***5***	***7***	

Next Steps	**Targets**	**Performance milestones**
Service Improvement	RTT Non-Urgent < 4 weeks Urgent < 1 week	90% 2017.18 95% by 2018.19
Performance Management	Quarterly reports and Meetings Change from Reporting RTA to RTT (Referrals to Treatment)	Ongoing By Q4 2016.17
Workforce Capacity	Recruit to vacancies	Ongoing
Transformation and Development	RFL Service Review More community based work and prevention Community facing training events in place for school and primary care practitioners starting 18th November 2016.	Q4 2016.17 Q4 2016.17 Q3 2016.17

Linked to key policies and initiatives

Linked to key policies and initiatives:	**Aims**
Five Year Forward View	• Reduce waiting times • Increase access to meet 35% of need
Future in Mind	• Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc. • Developing the workforce • Improving access and reducing waiting times • Make support more visible and easily accessible • Professionals who work with children and young people trained in child development and MH
NCL Sustainability and Transformation Programme	

Priority 4: Perinatal Mental Health Services

Rationale for Joint Priority across NCL

5.1 The population of NCL is approximately 1.4 million people. There are 4 acute Trusts, three mental health Trusts and a range of community providers. In 2014-15 there were approximately 20,000 births to NCL residents and 24,000 births delivered by the local Trusts. Within this provider geography are specialist maternity services centred around a single tertiary level neonatal unit, as well as a number of midwifery led units and home births.

5.2 This is a population with high levels of risk and vulnerability to mental health problems. The population is diverse and growing and experiences significant churn as people using health and care services move in and out of the city. The network covers areas of deprivation and includes women who are older, more likely to be overweight and obese and to experience gestational diabetes during pregnancy when compared with national averages. There are high numbers of households in temporary accommodation across the patch and around a quarter of the population in NCL do not have English as their main language.

5.3 Suicide is one of the leading indirect causes of death (CMACE 2011). In a recent audit by BEH Mental Health Trust there were two maternal suicides in 2014/2015.

Our Ambition

5.4 Our ambition for 2020 is to improve the care pathways so that there is better continuity of care. This may involve redesign and investment. As part of the redesign services should be co-located with maternity services e.g. IAPT, drug and alcohol services. All CCGs will have parent infant services.

5.5 There is an NCL working group led by the Tavistock and Portman Clinic. The work of this group is informed by stakeholder involvement e.g. Cocoon, the NCL maternity services participation groups, the Family Nurse Partnership in the Maternity Services Liaison Committee.

Current picture

5.6 There is no specialist community mental health service in NCL despite having some good parent-infant and psychology services. The majority of the local maternity services have perinatal mental health specialists. The continuity of care and the care pathways is very complex across several mental health providers and local community services. In Barnet, Enfield and Haringey Mental Health Trust there is no specialist perinatal mental health service and BEHMHT is one of two mental health trusts in London without a dedicated service.

5.7 The availability of services for families affected by perinatal mental illness in North Central London is dependent on where a woman lives and where she chooses to have her baby. Only women who choose to give birth at the Whittington can expect to have access to a comprehensive, specialist perinatal mental health service. Services are in effect provider delivered, rather than effectively commissioned.

5.8 NCL partner organisations have calculated that 1,200 women a year will be supported by a proposed perinatal mental health service model. This is equivalent to 5% of all women giving birth in NCL and includes women that have a previous history of serious illness, those experiencing psychosis, serious depression or other complex difficulties. The service will focus

resources and develop approaches to engage people who find help harder to access including teenagers and mothers from some BME groups including those for whom English is not their first language.

5.9 Outlined below are the rates of perinatal psychiatric disorder per thousand births and the numbers that would be expected by borough.

2014 births ONS	[redacted]		Barnet 5244	Enfield 4824	Haringey 4006	Camden 2700	Islington 2879
Disorder	Established rate per 1000 births	% women affected	Expected cases	Expected cases	Expected cases	Expected cases	Expected cases
Postpartum psychosis	2/1000	0.2%	10	10	8	5	6
Chronic serious mental illness	2/1000	0.2%	10	10	8	5	6
Severe depressive illness	30/1000	3%	157	145	120	81	86
Mild-moderate depressive illness	100-150/1000	10-15%	524-786	482-724	400-601	270-405	287-431
Post-traumatic stress disorder	30/1000	3%	157	145	120	81	86

Birth Data: ONS, July 2015

What we are aiming to achieve across NCL

5.10 This ambition is dependent on additional funding. An NCL application has been submitted to NHS England by Islington CCG and clinically led by the Tavistock and Portman Trust.

5.11 We are proposing a hub and spoke model for North Central London. The hub will be primarily administrative with a central meeting place for training and to oversee and maintain quality and equity across the patch and co-ordinate activity and outcome data. Accommodation has already been provisionally identified on both the St Ann's and Whittington sites. There will be five spokes each relating to one of the five maternity units in NCL so that each maternity unit has clinicians with whom to make effective relationships but facilitating cross cover and a capacity to respond to urgent referrals. Although the maternity units are best placed to identify early vulnerability throughout pregnancy and the early post-natal period, we anticipate that many women will be identified by other professionals including GPs, adult MH workers including IAPT, HVs, CAMHS, Children's Centre staff, etc. The work strand will overlap with, and be included in, work being undertaken on pathways.

Key Milestones

5.12 In addition to the proposed implementation plan submitted as part of the NCL application, the key milestones have been identified:

1. Continue to develop NCL Perinatal Mental Health partnership and workstream
2. Secure additional NHSE funding for community based perinatal mental health service
3. Continue mapping of care pathways

4. Continue improving communication between providers
5. Continue improving care pathways from pre-conception to one year after birth
6. Continue NCL/Pan London perinatal training programme
7. Continue NCL/Pan London perinatal mental health champions programme
8. Ensure each service provider has perinatal mental health champions

Funding

5.13 Below are the proposed costs for implementing the community perinatal health services within NCL.

	2016/17		**2017/18**		**2018/19**	
Costs Staffing, building, equipment and training	£163k		£1,233k		£1,218k	
Existing and proposed North Central London annual resource	Barnet Camden Enfield Haringey Islington	- - - - -	Barnet Camden Enfield Haringey Islington	£ 50,000 £ 40,000 Resource to be identified through redesign of existing services. £ 80,000 £ 150,000	Barnet Camden Enfield Haringey Islington	£ 100,000 £ 40,000 Resource to be identified through redesign of existing services. £ 80,000 £ 150,000

Note: There are other costs associated with the care pathways and part of the NCL Perinatal Mental Health Group will be to identify existing services, current expenditure and gaps.

Linked to key policies and initiatives

- NCL Perinatal Mental Health Strategy
- Healthy Child Programme
- NICE Guidance on Perinatal Mental Health

Priority 5: Crisis and Urgent Care Pathway and Collaborative Commissioning proposal of Tier 4 beds.

Rationale for an NCL wide approach

6.1 Local management of CAMHS beds and the development of 24/7 community based rapid response service for children and young people experiencing mental health crisis are national and regional priorities. The North Central London Sustainable Transformation Plan, mental health work stream, includes out of hours crisis response for children and young people across all boroughs. Our ambition to deliver this will work best across NCL wide population to deliver economies of scale and an effective, efficient service.

Aim

6.2 We will develop a local integrated pathway for CYP requiring beds that includes rapid community based response to crisis. This will result in admission prevention, reduced length of stay and support appropriate and safe discharge and a reduction of admission to acute paediatric beds across the footprint. We will work closely with Specialised Commissioning and jointly with Health and Justice Commissioners to develop local integrated pathways including transitioning in or out of secure settings, SARCs plus liaison and diversion provision.

I. Local management Tier 4 beds (Collaborative Commissioning)

6.3 The Tavistock and Portman NHS FT is co-ordinating a provider led bid to NHSE to manage inpatient stays of children and young people across NCL. The stakeholder partnership includes Barnet, Enfield and Haringey Mental Health NHS Trust, Whittington Health, Royal Free NHS Foundation Trust, CAMHS commissioners from all boroughs. The data we have on admissions and length of stay in CAMHS beds across NCL is shown on the next page.

NCL Tier 4 CAMHS Admissions

Data Source	NHS E	NHS E	NHS E	NHS E	NHS E	HLP	HLP	HLP
Year	2013-14 London	2014-15 London	15-16 London	15-16 Out of London	15-16 total	15-16 HLP London	15-16 HLP Out of London	15-16 HLP total
Barnet est popn 2016 aged 0-18 **48,471** (GLA, 2015)								
Admission	33	39	34	7	41	35	6	41
LOS London	1,923	2,220	2,740	749	3,489	2,852	735	3,587
Cost	£958,686	£1,007,955	£1,595,878	£467,354	£2,063,232	£1,597,062	£459,307	£2,056,369
Av Cost	£499	£454	£582	£624	£591	£560	£625	£573
Camden est popn 2016 aged 0-18 **22,597** (GLA, 2015)								
Admission	5	19	9	14	23	11	10	21
LOS London	650	1,218	701	1,064	1,765	1,049	1,021	2,070
Cost	£143,739	£601,102	£630,340	£663,904	£1,294,244	£631,263	£645,020	£1,276,283
Av Cost	£221	£494	£899	£624	£733	£602	£632	£617
Enfield est popn 2016 aged 0-18 **44,312** (GLA, 2015)								
Admission	20	23	5	6	11	4	5	9
LOS London	1,187	1,165	185	213	398	473	207	680
Cost	£663,675	£625,566	£291,389	£132,906	£424,295	£291,389	£174,103	£465,492
Av Cost	£559	£537	£1,575	£624	£1,066	£616	£841	£685
Haringey est popn 2016 aged 0-18 **31,504** (GLA, 2015)								
Admission	22	16	10	4	14	9	2	11
LOS London	1,331	1,532	435	151	586	833	148	981
Cost	£679,371	£821,833	£500,394	£94,219	£594,613	£500,394	£90,018	£590,411

Av Cost	£510	£536	£1,150	£624	£1,015	£601	£608	£602
Islington est popn 2016 aged 0-18 **21,344** (GLA, 2015)								
Admission	13	17	7	2	9	7	3	10
LOS London	697	1,591	857	81	938	1,234	81	1,315
Cost	£142,332	£810,165	£786,502	£50,542	£837,043	£786,502	£53,600	£840,102
Av Cost	£204	£509	£918	£624	£892	£637	£662	£639
NCL est popn 2016 aged 0-18 **168,226** (GLA, 2015)								
Admission	93	114	65	33	98	66	26	92
LOS London	5,788	7,726	4,918	2,258	7,176	6,441	2,192	8,633
Cost	£2,587,803	£3,866,621	£3,804,503	£1,408,924	£5,213,427	£3,806,609	£1,422,048	£5,228,657
Av Cost	£447	£500	£774	£624	£727	£591	£649	£606

Note

- 15-16 out of London cost base assumed at £623.97 per unit
- Data excludes ED, CLD, PICU, Low Secure, Medium Secure, Daycare, SCAAND (GOSH, Ellern Mead excluded)
- For HLP OOA where NHS E had provider cost as £0, updated to £623.97
- Before managing tertiary budget locally, would need support from NHS E to validate data as variances between data sets
- Due to LOS and cost coming from different sources for in London placements, cannot be 100% sure that the LOS and costs align. Admissions and costs do align.

II. Community based rapid response to young people experiencing crisis

6.4 A mental health crisis is defined as when someone is in an emotional or mental state where they need urgent help. A mental health crisis can be unpredictable. A person in crisis may need support at any time of day or night. They may seek help from a GP, or medical attention from a local hospital, or the crisis may result in an intervention by the police.

6.5 We are in the process of gathering data about the numbers of children and young people presenting to emergency departments and those being admitted in all boroughs.

6.6 The picture at the moment is that at least **350** children and young people were admitted to acute paediatric wards in 15-16. However at this stage the data is incomplete. We are also consulting with children and young people to inform both proposals for the local management of inpatient beds and development of crisis care provision.

III. Crisis Concordat and young person appropriate Place of Safety

6.7 Crisis Care Concordat planning is taking place across North London Central (NCL) with local forums developing action plans for Camden & Islington and for Barnet, Enfield & Haringey. This has led to work on revising local S136 pathway protocols and exploration of options to further young person appropriate develop local place of safety provision.

6.8 Simultaneously work is being undertaken by the NCL stakeholder partnership group to review places of safety currently provided across NCL, focussing on the appropriateness of provision for children & young people.

Key Milestones

1. Project plan locally to pilot extended hours for community based out of hours crisis response across NCL. November 2016
2. Recruitment plan with identified provider Trust December 2016
3. Proposed go live date of April 2017
4. NHSE approval to develop local management of provider led CAMHS inpatient beds
5. Project plan to implement local management of inpatient beds. January 2017

Summary

1. NCL boroughs will develop jointly a whole system pathway to respond to children and young people experiencing mental health crisis as required. This will include primary care.
2. The system wide pathway includes local management of inpatient beds for children and young people as required
3. Outcomes will include reduced attendance and admissions to acute hospital beds; reduced admissions and length of stay to T4 beds; improved patient experience and patient outcome measures
4. The timescale for delivery of 24/7 response is by 2020.

Priority 6: Transforming Care Programme

Rationale for Joint priority across NCL

7.1 Transforming Care is a nationally driven programme to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home.

7.2 The Transforming Care programme focuses on the five key areas of:

- Empowering individuals
- Right care, right place
- Workforce
- Regulation
- Data

7.3 We are working together across North Central London, and in collaboration with Local Authority Children and Young People's Services, in order to deliver this programme and have identified a number of areas in common for joint work.

Our Ambition

- To keep Children and Young People with their families through commissioning an appropriate range of community and respite provision that reduces the need for residential and inpatient admissions.

What we are aiming to achieve across NCL

I. Care and Treatment Reviews (CTRs) and Admission Avoidance Register

7.4 When someone is identified as being at risk of admission they are placed on an 'admission avoidance register'. This enables professionals to arrange a Care and Treatment Review meeting with the child/young person and/or their parent/carer to think about what can be done to support them in the community and to retain oversight and regular review of the case. In NCL we are working towards a single process for this. Guidance is being completed for professionals to support the identification of those at risk and how to seek consent from the family to join the register. We are also looking at how we can also support those at risk of requiring a residential placement, through additional support to enable families to stay together.

II. Early support for behaviour

7.5 There are different models for delivering behaviour support across NCL. We intend to undertake a sufficiency audit to look at those different models, and numbers of children and young people accessing this support against identified need.

III. Intensive Family Support

7.6 Enfield are currently developing an intensive family support model based on the Ealing model, using positive behaviour support. The proposal is for an Intensive Behaviour Therapeutic & Assessment Service (IBTAS) to develop a viable local alternative to for a cohort of young people with challenging behaviours so that they are intensively supported preventing such behaviours deteriorating to the point where external placement become the only solution. The new service aims to avoid permanent

residential accommodation for approximately four children / young people per year through a combination of timely and intensive therapeutic support and the provision of regular, planned short breaks. With small numbers such as these across each of the Boroughs consideration is being given to the possibility of a jointly commissioned service, or roll-out of a single model across the five CCGs.

IV. Shared Learning to inform Commissioning

7.7 The Care and Treatment Review process enables colleagues across NCL to share learning about what is helpful in both preventing the need for Tier 4 services, including hospital admissions, and for expediting step down. We aim to monitor the approaches tried across NCL to inform future commissioning intentions. For example we are looking at the possibility of mentors who visit the young person in hospital and then support them when they return to area. As admissions are very small numbers, this is an area which would be better considered across the larger NCL footprint.

V. Improving Pathways and Models of Care

7.8 We are currently working across adult's and children's services to look at the pathways for ASD, from pre-diagnosis to post-diagnosis support, looking at any opportunities for joint working. Additionally we will be considering the different models of CAMHS delivered to those with learning disabilities and/or ASD. There are a number of teams across NCL using different models, we will be working closely to review these models in order to take a view as to which functions are better delivered locally (for example support into special schools) and which could create improved quality and efficiency through jointly planning for (for example specialist assessments).

VI. Workforce

7.9 Integral to the pathway review outlined above is the workforce. This will be reviewed in the context of the pieces of work to look at current services and pathways and in the context of the HEE and CYP-IAPT opportunities for staff development. Some of the presenting issues which our teams support are quite rare, providing an ability to call on a wider workforce mean that specialist expertise are available to a larger range of families, reducing the need for high cost specialist assessment and treatment services which may currently be contracted on a cost per case basis, and enabling that resource to be used to invest in local services.

VII. Market Development

7.10 In order to deliver a flexible model of community provision to avoid admission to hospital or residential units, we need to develop the market across the sector. This will involves stimulating the market and working jointly to attract providers who can provide innovative solutions. Commissioning intentions will be led by the outcomes of the sufficiency audit around early help, and the learning from CTR processes.

VIII. Capital and Housing

7.11 NCL will have a representative on the pan- London Capital and Housing sub-group to support the development of capacity on a regional basis.

Key Milestones

- Establish consistent process for admission avoidance register

- Improve data through work with providers to record LD/ASD and through better use of and profile of admission avoidance register
- Develop a clear engagement plan to ensure patient/family rep are engaged as partners at all stages and levels of decision making
- Complete sufficiency audit of current behaviour support and complete any required business cases for funding
- Market Testing
- Develop a new service model (avoidance of admission)
- Develop a new service model (moving individuals back to the community)
- Reduce the use of hospital beds in line with the TC assumptions from 43 in April 2016 to no more than 21 in March 2019

Funding

7.12 We will be seeking to bid for Transforming Care funding in order to support this area of transformation. We will also be looking locally at developing business cases to support this work through the reduction of costly residential placements.

Linked to key policies and initiatives:

- Transforming Care: A National Response to Winterbourne View - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
- Care and Treatment Review: Policy and Guidance - https://www.england.nhs.uk/wp-content/uploads/2015/10/ctr-policy-guid.pdf

Priority 7: Development of local Child Sexual Assault (CSA) Services / Child House Model

Our ambitions

8.1 This priority area sets out the work to date at a pan-London level and locally in North Central London to progress towards the Child House model for victims of child sexual abuse (CSA), including sexual exploitation. The 2015 "Review of the pathway following Children's Sexual Abuse in London" recommended the Child House model based on the Icelandic Barnahus[1]. This model has been subsequently been supported by Children's Commissioner for England, Home Secretary and the London Mayor.

8.2 It was estimated by the NSPCC study[2] that 9.4% of 11 to 17 year olds had experienced sexual abuse (including non-contact) in the past year. The same incidence as childhood asthma (9%) and more common than diabetes (2.5%), and yet these children are hidden from sight. When they do come forward, the minimum that all children and young people that experience sexual abuse should expect includes:

- A safe place to live
- Being listened to and believed
- Ability to develop a narrative
- Early emotional support is available before therapeutic interventions start e.g. strategies for coping with feelings, emotional resilience and symptoms that impact on returning to normal daily life – such as night terrors, flashbacks, self-harm
- Reducing risk of further abuse

8.3 Following the publication of the Review of services in London, a North Central London sector steering group was established, one of 5 across London, to look at the outcomes of the review and take forward recommendations across a sector wide partnership. CAMHS services are central to this piece of work and NCL CAMHS Commissioners have come together to support this initiative and ensure the sector wide work is reflected in CAMHS transformation plans as well as being linked into our NCL Sustainability and Transformation Plan.

I A single pathway for C&YP across NCL who have experienced child sexual assault

8.4 The partnership is working to bring clinicians together from existing services, identifying resources to ensure CAMHS and Advocacy support is available as part of the pathways, and agreeing access for young people is based on what makes sense for them rather than geographical boundaries. This is viewed as the first step in improving available support and initial funding has been made available from DH to support a 1 year pilot of providing CAMHS and Advocacy into these pathways.

II Development of the Child House Model

8.5 Ultimately the ambition is to develop the Child House Model in NCL. Following the development of this initiative, we would envisage a reduction in service demand on tier III CAMHS, and reduced wait times, through early intervention to minimize the risk of severe and enduring mental health

[1] Link to Children's Commissioner report on Barnahus
https://www.childrenscommissioner.gov.uk/sites/default/files/publications/Barnahus%20-%20Improving%20the%20response%20to%20child%20sexual%20abuse%20in%20England.pdf

[2] Radford L, Corral S, Bradley C et al. Child abuse and neglect in the UK today, 2010

conditions. Safeguarding teams and children's social care teams will be supported by a streamlined process to access all health and police investigations immediately after disclosure, as well as through a case management and advocacy service in the Child House.

Current picture

8.6 NCL Commissioners previously invested CAMHS Transformation funding in a demand and capacity mapping project of CSA/CSE services. This work was commissioned to map current commissioning arrangements and service provision, estimate future demand, and provide an options appraisal and business case for the CSA hub and Child House model.

8.7 Early intervention emotional support services are being designed as part of the CSA Hubs in North Central and South West London, funded by the Department of Health and local CCGs respectively. This evidence-based support gives immediate access to CAMHS or advocacy services and is predicted to reduce progression to PTSD and the need for long-term CAMHS intervention.

8.8 In the North Central Sector:

- CSA medical examinations are being provided by two CSA Hubs at University College Hospital and St Ann's Hospital.
- The Department of Health has funded an early intervention emotional support service for all children and young people accessing the CSA Hubs. The service will be provided by the Tavistock and Portman and Solace Women's Aid, and will consist of 1 WTE CAMHS clinician and 0.8 WTE Child Advocate. The service is currently being designed and is due to launch in September 2016.
- 3 of the 5 North Central CCGS have funded demand and capacity mapping to be completed in August 2016
- A multiagency co-design workshop ran in March 2016 with more than 50 professionals attending. A smaller multiagency group is now working to develop the detail of the Child House model for the sector
- Engagement with children and young people is ongoing with consultations already conducted with Barnet Youth Board, Enfield Youth Parliament, and Islington In Care Council

8.9 Funding has been secured from MOPAC to support the development of two Child House Pilots in London. We are currently awaiting a decision as to where these pilots will be sited.

8.10 If successful in the first instance this will be done by looking to redesign existing resources and services to enable CAMH services to be delivered from a Child House to support C&YP across NCL accessing services here.

8.11 We will also be utilising the findings of the NCL mapping to consider the data and the projected numbers of C&YP expected to access services (it is thought this project will uncover current unmet need) and jointly consider commissioning arrangements to further support the model with CAMHS input

Benefits

- Clear pathway for children and families to use existing commissioned services in paediatrics, CAMHS and early help as well as third sector provision
- Reduced pressure on CAMHS specialist inpatient and outpatient services, through early emotional support and stabilisation of child and family, reducing the risk of progression to long-term mental health conditions and emergency presentations in mental health crises

- High quality medical examinations – sufficient throughput to meet the RCPCH guidelines in all boroughs
- Children and families less traumatized
- Doubling of conviction rates at trial [3] [4]
- Significant long-term savings for the health and social care economy through reduction in chronic mental health, drug and alcohol use, further abuse and sexual violence, school refusal and unemployment, dependency. NSPCC estimates London Alone spends £0.4billion on the outcomes of unsupported victims of CSA.

Next Steps

- October 2016 – Notification of decision re location of MOPAC funded pilot sites for Child House Model
- December 2016 – Discussion with existing providers re service reconfiguration to support implementation by April 2017 (if successful pilot area)
- April 2017 – Review and consider how the current CSA CAMHS and Advocacy services (1 year funding from DFE) are mainstreamed into our local pathways.
- December 2017 – review Child House reconfigured pilot and numbers of C&YP access data to consider additional funding to be made available across the sector for April 2018.

Funding

8.12 Commissioning intentions reflect a commitment to service redesign to reconfigure existing pathways in the first instance to support the Child House Model

8.13 We are awaiting the outcome of the funding decision by The Mayor's office regarding the location of the 2 proposed pilot sites in London.

8.14 Further funding decisions will then be made across NCL re identification of additional funding if and where required.

Linked to key policies and initiatives:	**Aims**
Five Year Forward View	• Increase access to meet 35% of need
Future in Mind	• Promote early Intervention • Improving access and reducing waiting times • Make support more visible and easily accessible
NCL Sustainability and Transformation Programme	• MH Workstream

[3] Link to Children's Commissioner report on Barnahus
https://www.childrenscommissioner.gov.uk/sites/default/files/publications/Barnahus%20-%20Improving%20the%20response%20to%20child%20sexual%20abuse%20in%20England.pdf

[4] http://www.bvs.is/media/barnahus/Dublin,-sept.-2013.pdf

Priority 8: Pathways for Young People in the Youth Justice System

Our Ambitions

9.1 Future in Mind 2015 outlined the need to transform 'care for the most vulnerable' which includes mental health of children who come to the attention of criminal justice system. The 'Health and Justice Specialised Commissioning of Children and Young People's Mental Health Services' transformation work stream aims to address this gap.

9.2 We wish to ensure timely assessment and support for vulnerable young people with mental health problems before they become ingrained with offending culture. Since 2007, there have been 82% fewer young people coming into the formal Youth Justice System as a result of diversionary activity. Furthermore, the number of young people aged 10-17 years in custody has fallen by 70% over the last decade. Therefore we will develop an NCL offer that reaches young people in the early stages of contact and provide assessment and treatment where needed including those already in YOS caseloads.

Mental Health Needs of Young Offenders

Youth Justice Board research (2005) found that 31% of a 300 sample of CYP had mental health needs, which included:

- 18% having problems with depression
- 10% suffering from anxiety
- 9% reporting a history of self-harm within the last month
- 9% suffering from post-traumatic stress disorder
- 25% identified as having learning difficulties
- Individuals involved in gangs have higher chances of diagnosable difficulties and poorer general mental health than other young people (Coid, et al., 2013).

North Central London STP

9.3 NCL CCG's and YOS Managers are working with Health and Justice partners in the London region across their STP footprint to enhance the local health offer for CYP that come into contact with the justice system. We have agreed and signed a Memorandum of Understanding with the NHSE Health and Justice Team in relation to roles, responsibilities, funding and governance that jointly ensure a comprehensive local response is in place for CYP in the justice system. Detailed proposals for local service provision will be submitted by December 2016 for assurance in order to release resources for commissioning of new capacity

Priorities and Outcomes for the Health & Justice work stream

9.4 Due in part to the success of liaison and diversion schemes in keeping young people out of formal court proceedings we believe that additional capacity for mental health within youth justice must also extend to exploring options for pre-court interventions Our objective is to close the treatment gap and promote integrated commissioning in line with the national health and justice work stream priority areas:

- Development of Specialist Child and Adolescent Mental Health Services for High Risk Young People with Complex Needs

- Development of Collaborative Commissioning Networks between Health & Justice regional teams and CCGs

9.5 Across NCL STP we wish to achieve a reduction in variation in care for CYP in London in contact with the justice system. CYP Mental health pathways will seek to support diversion of individuals, where appropriate, out of the youth justice systems into health, social care, education and training, or other supportive services. We will offer a mental health assessment to every young person at second appointment to support a reduction in re-offending and/or escalation of offending behaviours.

9.6 Each CCG will develop KPI's with their local providers and YOS managers. Some of these will be congruent across the STP footprint while others will have a local focus to reflect the different starting positions of each area. NCL will aim to establish a greater level of consistency across the STP footprint by ensuring all areas have:

Principals of NCL CCG Model for Health and Justice CAMHS
• Single local point of access for all YOS/CAMHS referrals • Service design based on in-reach to YOS and strengthening pathways into community and specialist CAMHS • Measure outcomes using YJS performance monitoring and CAMHS minimum data set • Benchmarking reported outcomes across NCL by 2017.18 • Each YOS/CCG area to develop bespoke aspects of provision based on local needs

NCL also exploring options for STP wide work including:
• Early intervention for Sexually Harmful Behaviours • Self-Harm and Crisis Care • Transition from secure settings into community CAMHS

Linked to key policies and initiatives:	**Aims**
Five Year Forward View	• Increase access to meet 35% of need
Future in Mind	• Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc. • Developing the workforce • Improving access and reducing waiting times • Professionals who work with children and young people trained in child development and Mental Health
NCL Sustainability and Transformation Programme	• Efficient use of resources and provision with a view to future proofing local health services.

Part Three

1. References

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[iv] http://www.rcpsych.ac.uk/PDF/Position%20Statement%204%20website.pdf

[v] Report: Children's and adolescents' mental health services and CAMHS (PDF 1.49MB)

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2. Appendices

2.1 Policy and Guidance

Appendix One- Policy and Guidance

2.2 Stakeholder Feedback Summary

Online Survey Summary