Healthy London Partnership

Healthy London Partnership (HLP) Children and Young People's Mental Health Shared Learning Event

CYPMH transformation and support tools presentations:

System Dynamic Modelling Tool
CYPMH - demand and capacity, waiting times and productivity
North Staffordshire Combined Healthcare ADHD pathway
The Brighton & Hove Wellbeing Service: Our Waiting List Journey

Supported by and delivering for:

Public Health England

NHS

LONDON COUNCILS

SUPPORTED BY MAYOR OF LONDON

Planning & Modelling Services for Children & Young People

www.cypmh-model.nhs.uk

Presented By:

Lee Wemyss

July 2019

healthcare Decisions

www.HealthcareDecisions.co.uk

Can you solve a problem like CYPMH?

…less than

1/3

of children with a diagnosable mental health condition accessed support

Future in mind quotes: Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005).

Waiting lists of up to 6 months

In length

The Times Tuesday October 8th 2018 quotes: Education Policy Institute (EPI) Think Tank

70

of children and adolescent admissions were classed as 'out of area' in 2016/17

The Times Tuesday May 1st 2018 quotes: BMA

"If you aren't reaching your goals, you need to change your actions."

When governments attempt to do this do this they re-arrange organisations

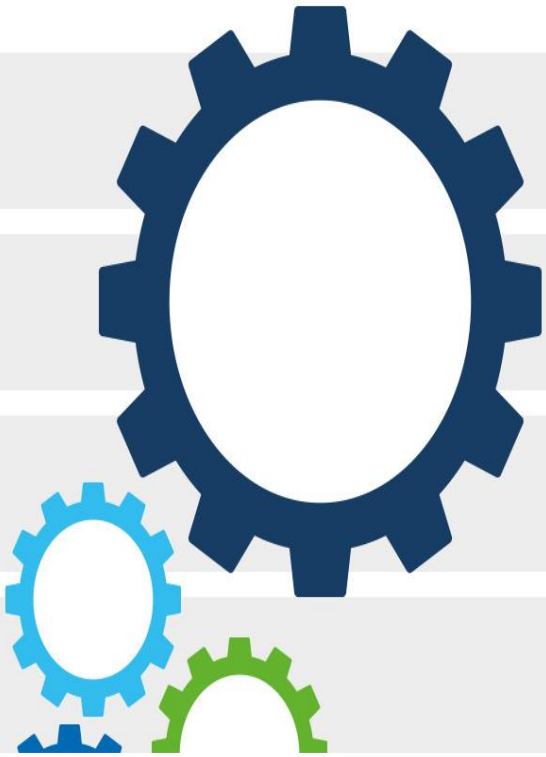
When organisations attempt to do this do this they have to change the SYSTEM

SYMPTOM / SILO RESPONSE

SOLVE THE ROOT CAUSE

Overview

1. The journey so far
2. The theory
3. Getting started
4. Q&A



The journey so far

The history of the tool

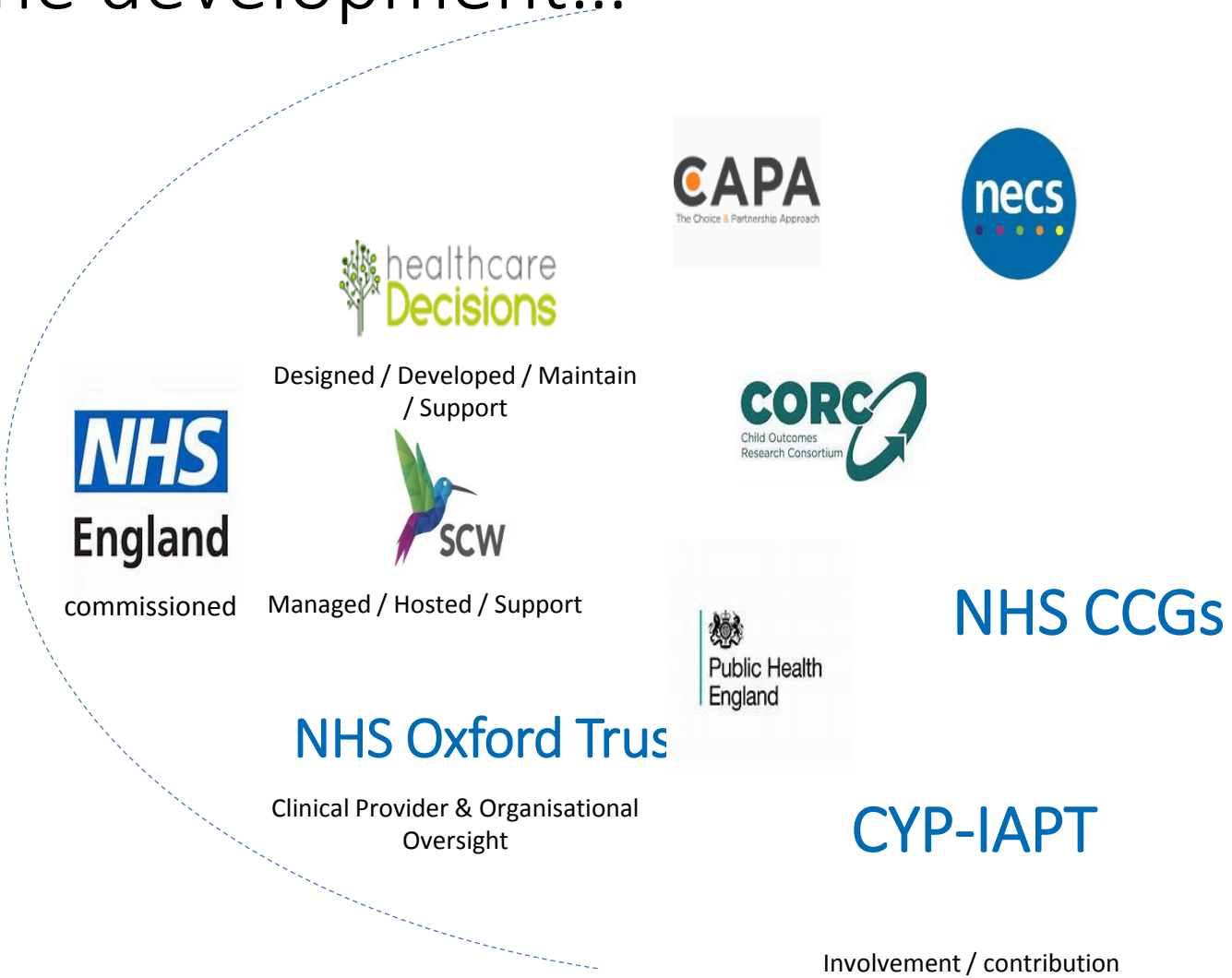
- In 2015, NHS England commissioned SCWCSU and HealthcareDecisions Ltd. to develop a Modelling Tool (working alongside Oxford NHS FT)

- During 2017/18
  - ✓Engagement exercises were carried out in ten regions
  - ✓Modelling was undertaken by commissioners and providers to support planning in their community services and to support them to test local assumptions

What is the real ‘value-add’

- ✓Enables the review and improvement of current CYP MH services
- ✓Enables planning of future service provision and investment,
  accelerating place-based commissioning plans
- ✓Support transparency with providers
- ✓Helps to make the targets in the FYFV and LTP feel achievable

Colleagues who were contributors to the development…



The vision for the future

Vision for 2019/20

- Exploring options for including in guidance e.g. Local Transformation Plan KLOEs'
- Use of the tool will support planning for all aspects of service provision, (particularly planning for workforce)

What your colleagues say

"I see it as an enabling tool, in terms of selling its use with providers that's very important."

"after using the tool, It feels like we're beginning to have different conversations…with providers"

"It's enabled us to spark a conversation"

"This iterative, thoughtful project has challenged all those involved to find innovative solutions to support joint working"

Project Sponsor

"Be really clear what you want to model…Keep it simple to begin with"

The theory

So what is the problem?

Is the problem insufficient resource to meet the demand?

(Why does everyone assume so…because we always have waiting times?)

You don't know you have insufficient resources (for sure) until you first understand the underlying problem…

How many patients arrive in a week? UNCERTAINTY

How severe is a patients needs? UNCERTAINTY

How many patients will be emergency? UNCERTAINTY

How long will a patient have to wait? UNCERTAINTY

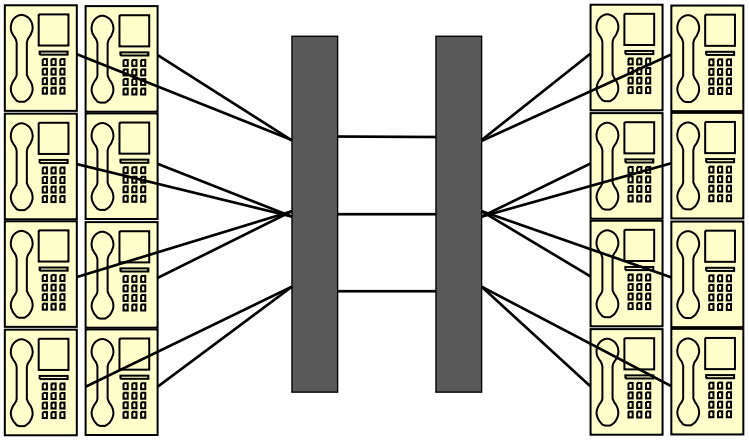
How much care will a patient need to get better? UNCERTAINTY

Do we have sufficient resources? UNCERTAINTY

COMPLEXITY

Why do we need a tool?

The problem is uncertainty…and this problem was resolved in the 1920s by Agner Krarup Erlang in the form of the telephone exchange



Mathematics (Probability Theory) gives us the solution: Queueing Theory

This is the principle on which the tool has been built

Here comes the science bit!

Queueing models analyse how people receive a service by considering:

- The arrival process (the probability of someone arriving)
- How people behave in the queue (waiting, going elsewhere, not turning up)
- The service discipline (How many service lines, and treatment times)
- Waiting room (how you arrange queues)

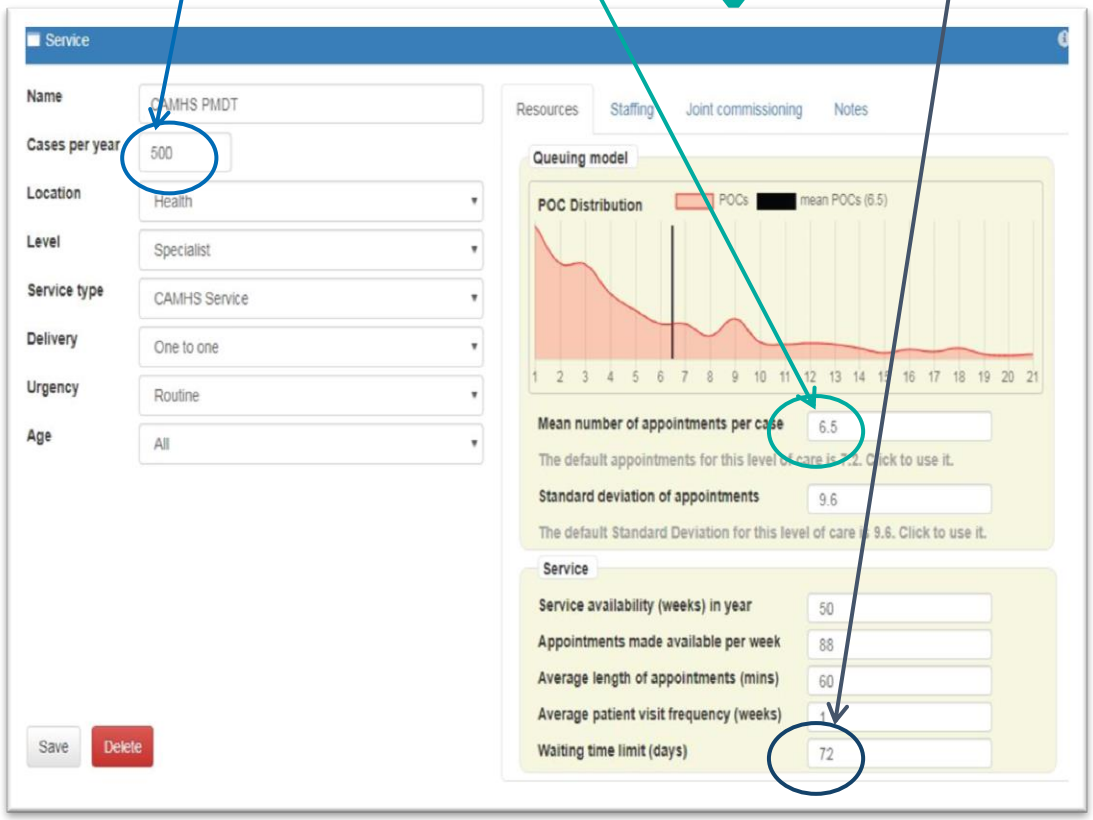
Theory into practice

500 people per year requiring specialist treatment

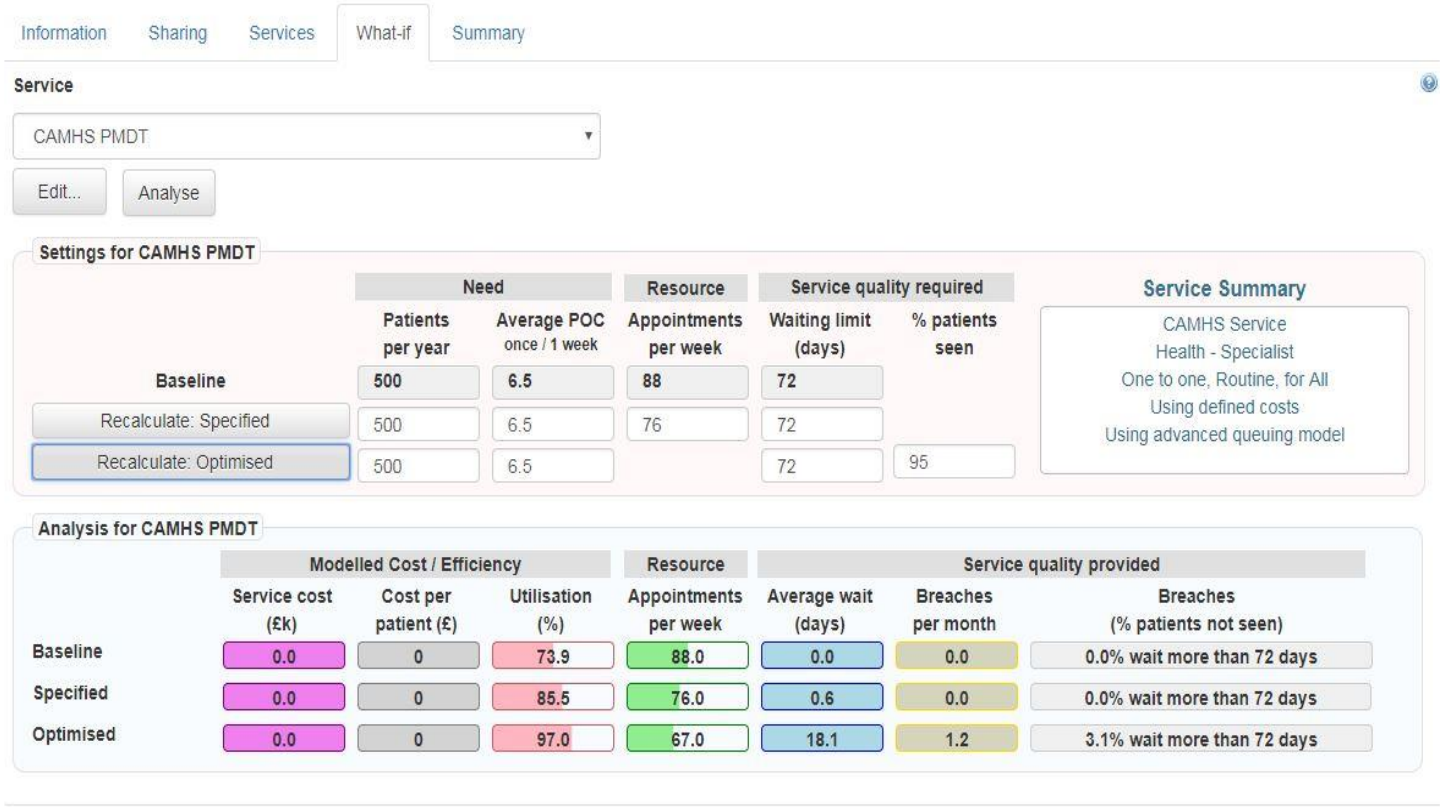
Average period of care is 6.5 appointments

Locally defined waiting time target < 12 weeks

All patients seen in region



Theory into practice



Information | Sharing | Services | What-if | Summary

Service

CAMHS PMDT

Edit... | Analyse

Settings for CAMHS PMDT

	Need		Resource	Service quality required		Service Summary
	Patients per year	Average POC once / 1 week	Appointments per week	Waiting limit (days)	% patients seen	CAMHS Service Health - Specialist One to one, Routine, for All Using defined costs Using advanced queuing model
Baseline	500	6.5	88	72		
Recalculate: Specified	500	6.5	76	72		
Recalculate: Optimised	500	6.5		72	95	

Analysis for CAMHS PMDT

	Modelled Cost / Efficiency			Resource	Service quality provided		
	Service cost (£k)	Cost per patient (£)	Utilisation (%)	Appointments per week	Average wait (days)	Breaches per month	Breaches (% patients not seen)
Baseline	0.0	0	73.9	88.0	0.0	0.0	0.0% wait more than 72 days
Specified	0.0	0	85.5	76.0	0.6	0.0	0.0% wait more than 72 days
Optimised	0.0	0	97.0	67.0	18.1	1.2	3.1% wait more than 72 days

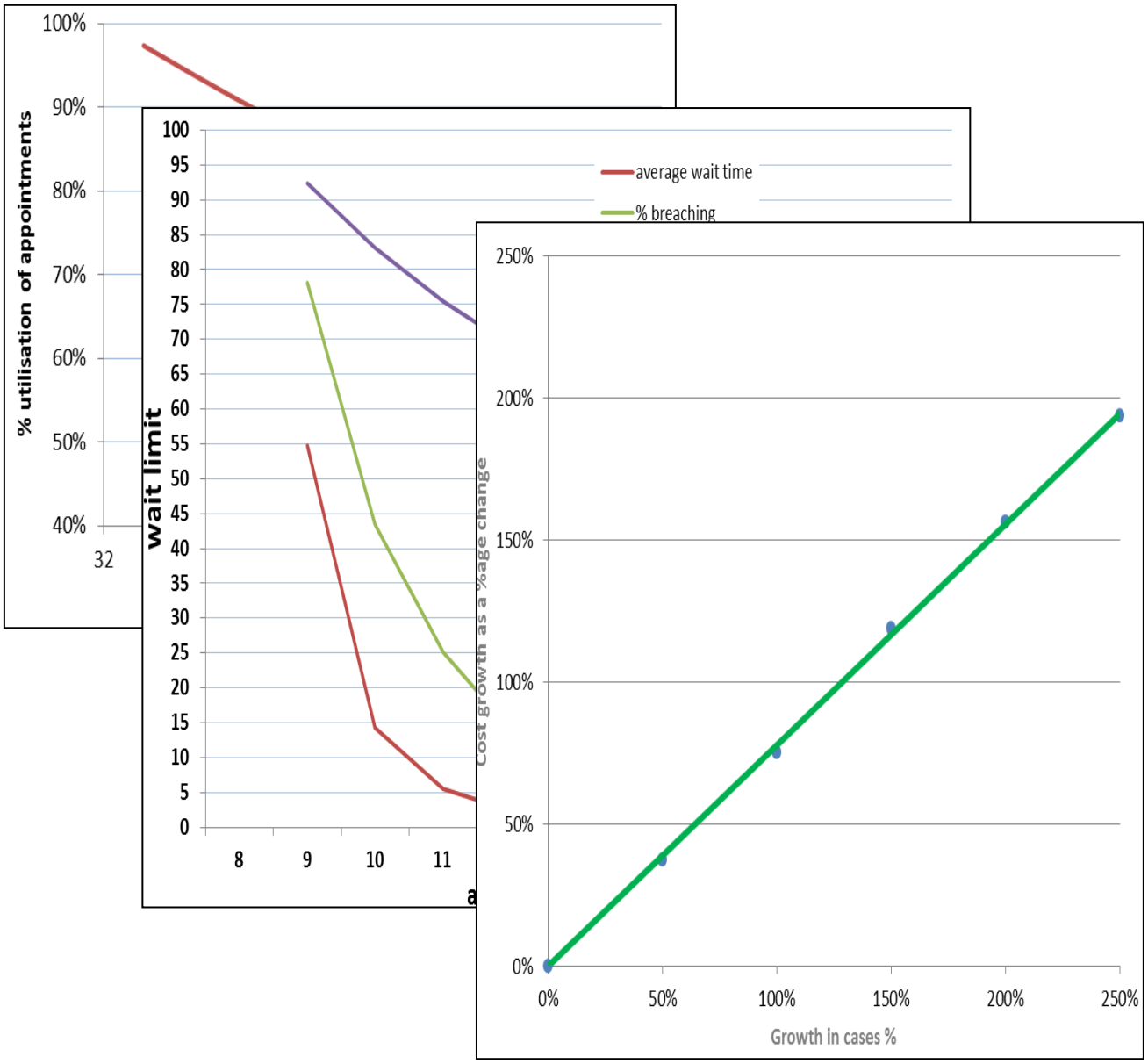
500 people per year requiring specialist treatment

Average period of care is 6.5 appointment

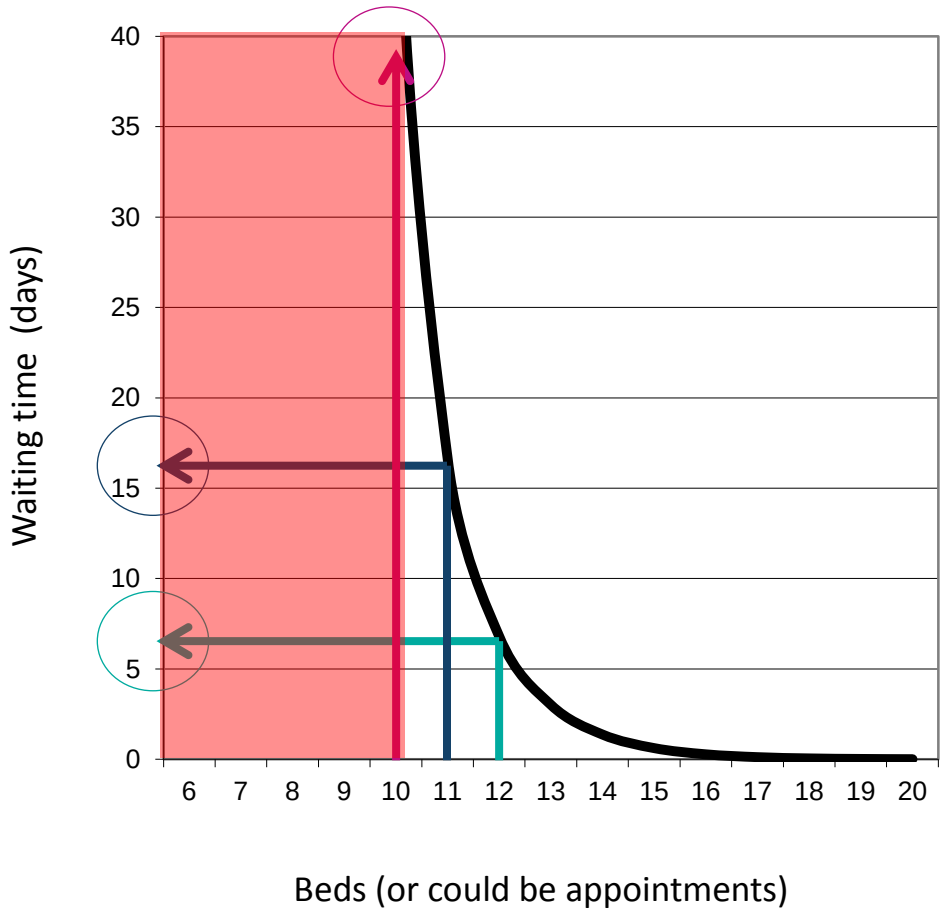
Locally defined waiting time target < 12 weeks

All patients seen in region

Making use of the data



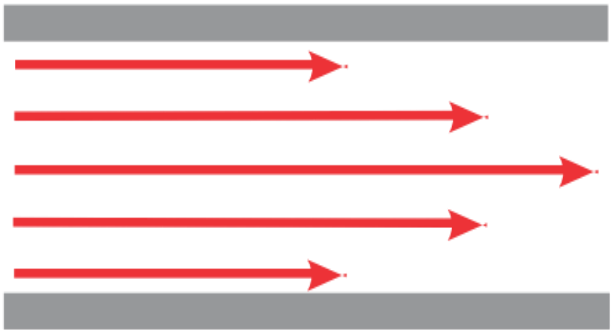
A practical example



LIVING ON THE EDGE OF CHAOS

Applying a Systems Thinking /Engineering analogy

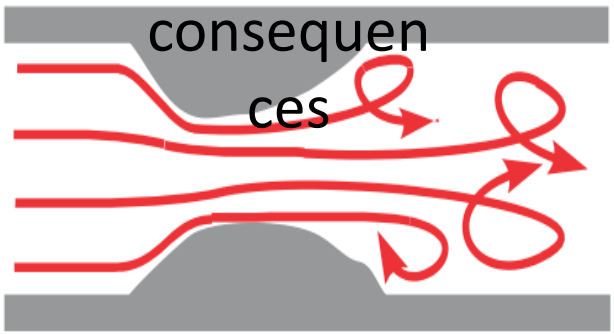
Manage to maintain ✓



Laminar Flow

- Maintains performance
- Maintains control

Manage the consequences ✗



Turbulent Flow

- Impairs performance
- Limits control
- Can be catastrophic

Natural systems are a good analogy for what we're trying to deal with

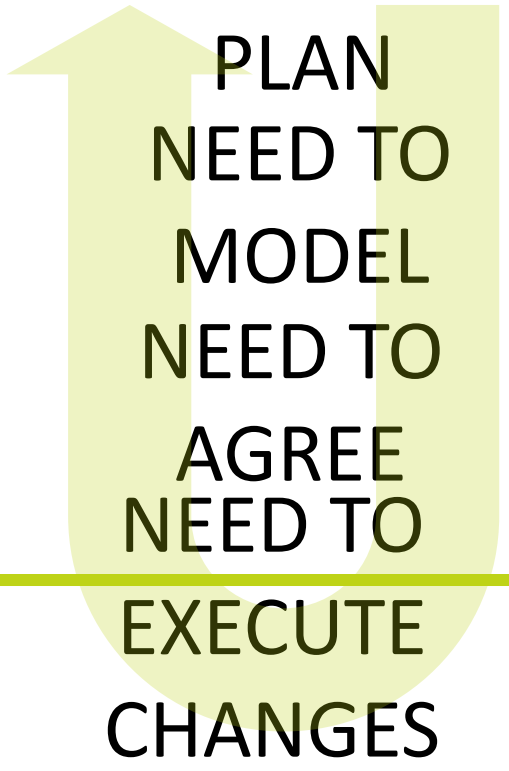
You need to get three things right to resolve the waiting time/out of area problem…

(or to stand a chance of resolving!)

1) SUFFICIENT RESOURCES…

2) IN THE RIGHT PLACE…

3) AT THE RIGHT TIME



USE THE CYPMH PLANNING TOOL TO HELP YOU DO THIS

Getting started

Next steps

The tool is available via **cypmh.scwcsu.nhs.uk**

- User guide
- Video walkthrough
- Access requests

Sign up and get access

Support in using tool provided by:

CSUs or via HealthcareDecisions Ltd.

http://www.cypmh-model.nhs.uk

https://www.healthcaredecisions.co.uk/case-study-1

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Tel: 07803 036552

Healthcare Planning and Technical Support is available from www.healthcaredecisions.co.uk

Thank you

Baseline Assessment

Michael Watson

Mental Health – Intensive Support Team

NHS England and NHS Improvement

The Intensive Support Team – Mental Health

- Part of NHS Improvement working closely with NHS England
- A free resource to NHS organisations
- Work with local health communities that are facing particular challenges in delivery of national standards within the context of the 5YFV MH.

Data completeness and data quality

Demand and capacity and waiting list management

Pathway design

Value for money / productivity

CYP

Children and Young People's Mental Health

EIP

Early Intervention in Psychosis

IAPT

Improving Access to Psychological Therapies

Complete picture: Domains / Good Practice Indicators

Domain	CYP-MH Good Practice Indicator statement
Strategy & Collaboration	1. Seamless, system wide collaboration which is represented in a joined up vision and clear sustainable investment across the locality.
Access & Waits	2. Support to CYP who have concerns regarding emotional and mental wellbeing is commissioned and provided in a way that is easy to access, responsive and requires minimal waits.
Workforce	3. THE CYPMH workforce has sufficient expertise and capacity to deliver clinical pathways and plans for sustainability in place
Evidence Based Practice	4. The local offer including the assessments and interventions available to CYP and their families are evidence and best-practice based
The Model	5. A coherent STP wide model for delivery of CYP MH is in place which is based on CYP-IAPT values and principles, early intervention and recovery. The model is co-produced, evidence based, effective and encourages local innovation.
Involvement & Participation	6. Involvement and participation of young people and their support networks is embedded throughout service development, delivery and review
Productivity	7. Productivity is reviewed and maximised to ensure efficient delivery and use of resources
Outcomes	8. Outcomes drive commissioning and service improvement at a strategic and operational level including the use of Routine Outcome Measures (ROMs) to evaluate effectiveness, lead service improvement, inform interventions and help determine endings
Data Quality	9. Quality data is being recorded and flowed which ensures clinical quality is maximised
Culture	10. There is a person first empowering culture which embraces collective ownership, positive risk taking and innovation.

Focus on Access & Waits

- Understanding what helps to manage waits
- What you find supports management of waits
- Process of funnelling to the detail from **Domain -> GPI -> Elements -> Key Lines Of Enquiry's (KLOE)** to give a **score** we can use to see what works
- Collaborative approach to develop the Elements which make up the full picture for managing Access and Waits
- Building robust Key Lines Of Enquiry to help us think about the detail
- Scoring system…

Scoring Definitions

0 = nothing in place (no evidence)
1 = Fair (limited evidence of implementation or impact, document available)
2 = Good (significant evidence of implementation, limited impact)
3 = Very good (full implementation, clear evidence of demonstrable impact),
4 = Best practice (evaluated, approach refined, maximum impact)

From Self Assessment

Domain		Access & Waits
CYP MH Good Practice Indicator Statement		Support to CYP who have concerns regarding emotional and mental wellbeing is commissioned and provided in a way that is easy to access, responsive and requires minimal waits.
Element	**1**	**There is a clear understanding of the allocation of the Access Target for all commissioned services within the locality**
KLOE's		**Is activity related to the Access Target clearly specified for each provider? Are these activity numbers consistent with the nationally expected increases?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**2**	**There is a published, high quality patient access policy in place which is consistent with national rules.**
KLOE's		**Has the access policy been signed off by trust board and commissioners? Is the policy reviewed at least annually? Is there a clear coordinated offer, clear referral routes and pathways into services delivered by different organisations working well collaboratively?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**3**	**A patient-friendly summary of the access policy is available.**
KLOE's		**Is the access policy published on the trust's website? Has this been generated in collaboration with CYP and their families?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**4**	**There are documented standard operating procedures (SOPs) in place that underpin the access policy.**
KLOE's		**Are SOPs reviewed and updated annually or sooner in the event of any national rule change? How have SOPs been implemented? How is adherence to SOPs monitored (eg through audit)?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**5**	**There are documented booking processes for activity which provide for a flexible, efficient and timely use of resources.**
KLOE's		**Do booking processes aim to maximise the availability of patient choice of dates/times? Are they structured to promote dialogue with patients (i.e. interactive booking as opposed to issuing predetermined appointments via letter)? Are booking processes implemented consistently across the organisation?**
Scoring	0	Nothing in place (no evidence)
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Element	**6**	**CYP and their families are informed of the expected and maximum waiting times for appointments and treatment and risks linked to deterioration is managed proactively.**
KLOE's		**How does the service assure the clinical risk of people waiting? Is there a waiting list management policy? Is there a consistent approach about actions to take in case of deterioration? How is that shared with CYP and families? Is there evidence of this working in practice?**
Scoring	0	Nothing in place (no evidence)
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Element	**7**	**CYP are treated in order of clinical priority. Patients of the same clinical priority are treated in date order.**
KLOE's		**Is there clear guidance to this effect within the access policy and SOPs? Is adherence to this principle monitored? Are exceptions to the rule (eg where operational issues prevent compliance) understood and recorded?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**8**	**There are clear systems in place to manage CYPMH access and waiting times.**
KLOE's		**Are waiting lists proactively managed along with governance processes (PTL, meetings, escalation)? Are there documented terms of reference and standard agenda for access meetings? Do access meetings monitor trajectories and progress? Is there continuous monitoring of demand and capacity balance at weekly meetings and identification of capacity shortfalls and other issues that may affect delivery?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**9**	**Patient Tracking List's (PTL) are in place and are understood by all**
KLOE's		**Is there a patient tracking list in place that shows numbers waiting by time band, and upcoming breaches? Are PTLs 'live'? If not, are they refreshed frequently enough to support operational use? Is there an ability to drill down in reports to identify those waiting longest and the reasons? Are reports available and understood by the staff team?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**10**	**Trend analysis reports are made available to support management of CYPMH services.**
KLOE's		**Are trend analysis reports available for referrals, clinical activity (both new and follow up), clock stops and discharges, as well as for size of waiting list, and Access Target performance?**
Scoring	0	Nothing in place (no evidence)
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Element	**11**	**A range of key performance indicators (KPIs) for CYPMH are agreed and monitored.**
KLOE's		**Are KPIs tailored to key challenges or risks within the trust? KPIs might include wait for first appointment, contribution to overall Access Target, wait for treatment pathway (internal waits), size of waiting list against maximum sustainable waiting list size, number of planned patients beyond their clinically determined discharge date.**
Scoring	0	Nothing in place (no evidence)
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Element	**12**	**Review of the numbers receiving care and the discharge rates (including review of dosage/ length of stay/treatment) is completed proactively**
KLOE's		**Are patients on caseload / pathways actively managed and in line with expected duration (in line with NICE evidence base and local pathway SOPs)? Do all such patients have a documented expected discharge date? Internal waits for pathways do not exceed 6 weeks to face to face appointment?**
Scoring	0	Nothing in place (no evidence)
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Element	**13**	**Breach analysis is regularly reported and monitored.**
KLOE's		**Is breach analysis monitored through Access meetings and local performance meetings? Are trends and themes reported? Are bottle necks for specific pathways monitored so workforce can be flexed?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**14**	**There is a systematic process for carrying out root cause analysis of breaches.**
KLOE's		**Is there evidence of learning from root cause analysis? How is learning fed into future planning or local change? Is there understanding of comparisons of local % demand to National Benchmarking?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**15**	**There is a process for local, trust-wide and STP analysis and mitigation/remedial action planning to resolve common causes.**
KLOE's		**Is there evidence of action being taken based on outputs from breach analysis to prevent future breaches of the waiting time standards? How does analysis link to investment plans?**
Scoring	0	Nothing in place (no evidence)
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Element	**16**	**Clinician and room capacity utilisation is maximised.**
KLOE's		**Is there frequent (at least annual) review of room bookings? Is this linked to job planning? Are utilisation rates monitored? Is compliance with booking rules monitored?**
Scoring	0	Nothing in place (no evidence)
	1	Fair (limited evidence of implementation or impact, document available)
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Element	**17**	**All required outsourcing of capacity (eg for clinical capacity through agency/external provider for potential breaches) is proactively managed according to an agreed process.**
KLOE's		**Is this linked to outputs from demand and capacity analysis? Is there clarity of responsibility for outsourced patients? Are their RTT waits still monitored by the trust? How is data flowed from external agencies?**
Scoring	0	Nothing in place (no evidence)
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Feedback

How did everyone score?

NHS England and NHS Improvement

Contact

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North Staffordshire Combined Healthcare NHS Trust

The transformation of ADHD management and alignment with primary care within Stoke on Trent and North Staffordshire: a shared care approach.

Ann Cox, Clinical Lead CAMHS & NMP Lead
Sue Ford, Independent Nurse Prescriber North Staffs CAMHS
Rachel Bullock, Independent Nurse Prescriber South Stoke CAMHS

Healthy London Partnership Conference 3rd July 2019

3 years ago…..a need for change:

North Staffordshire Combined Healthcare NHS Trust

- Lengthy wait lists for ADHD assessments.
- No formalised structure or pathway in place.
- High prescribing costs associated with prescribing for long periods of time.
- Retention within CAMHS was high.
- No throughput/ discharges.
- Working in isolation.
- Variation in practices across CAMHS teams.
- Poor communication between CAMHS and primary care overall.
- ADHD formed up to 50% overall CAMHS caseload.
- CYP's having to attend a secondary mental health service regularly.

A snapshot of 2017

Area	No of open cases on Lorenzo	Number of identified ADHD	Percentage of ADHD case load
North Staffs	629 (-25%*)= 471.5	217	46%
North Stoke	766 (-25%*)= 574.5	86*	15%
South Stoke	442 (-25%*)= 331.5	168	50%

* This does not include those children and young people in the assessment phase

*25% deducted from the total number of open cases as a low estimate of those cases being joint worked, this would include group work, secondary workers, those CYP'S in therapy and have an allocated care coordinator.

* Taken from an internal database in June 2017, this figure is likely to have risen by at least 20 CYP's. Amount of open cases is not representative of geographical area in comparison to other service areas.

Where were we?...

- High caseloads for Psychiatry for YP's with ADHD.
- Effective Shared Care Agreements (ESCA) agreed locally from 2015. Uptake was minimal prior to 2017.
- High caseload of stable CYP's retained who were suitable for ESCA criteria.
- No drive forward from a CAMHS perspective.
- No ownership or lead for ADHD.

North Staffordshire Combined Healthcare NHS Trust

Building a case for change…

- NICE advocate for **primary and secondary care providers to** "produce local protocols for shared care arrangements with primary care providers.."

- point 1.8.1.4 of the guidance: "Following titration and dose stabilisation, prescribing and monitoring should be carried out under locally agreed shared care arrangements with primary care".

Transforming Children's and Young People's Mental Health Provision: a Green paper (DoH, Dec 2017)

So how did we start to change?...

North Staffordshire Combined Healthcare NHS Trust

- New working practices initiated and led by NMP Sue Ford, North Staffs CAMHS in September 2016 utilising tracking and MDT model. This was rolled out in South Stoke CAMHS, mid 2017.
- Effective Shared Care Model launched by South Stoke CAMHS NMP Rachel Bullock building on North Staffordshire initiatives from February 2018.
- A full review of Psychiatry caseload identified a high proportion of stable CYP's and transferred to the clinical care of NMP's.
- Initial assessments indicating strong potential for ADHD are completed by NMP's.
- All stable diagnosed clients had an ESCA completed and sent to GP's. Improved links with primary care.
- NMP Rachel Bullock and CAMHS Service Manager met with the practice manager at pilot GP site in April 2018 and a clinical needs led, shared care protocol was written and operationalised in partnership, in line with the transformational objectives and commissioning remit.
- **First CAMHS shared care clinic started at Belgrave Medical Centre in June 2018 by Rachel Bullock, South Stoke CAMHS.**
- **A further practice has been identified as a second phase at North Staffordshire CAMHS. Estimated start date September 2019.**

PROUD TO CARE

safe • personalised • accessible • recovery focused spar

How was this achieved?

North Staffordshire Combined Healthcare NHS Trust

North Staffordshire Combined Healthcare NHS
NHS Trust

CAMHS – South Stoke
Blurton Health Centre
Ripon Road
BLURTON
Stoke on Trent
Tel 01782 652670
Fax 01782 343908

Ref: RB

12 November 2018

Private & Confidential

Re:

Please find attached Enhanced Shared Care Agreement which has been discussed and agreed by the parent/carer.

I would like to reinforce that we will continue to hold overall responsibility for the outlined medications.
We will continue to maintain a minimum of a 6 monthly contact, by where we will continue to:
• monitor height, weight, blood pressure and pulse. Also we will routinely carry out blood and ECG investigations.
• review both the efficacy and effectiveness of the medication in relation to the named diagnosis.
• monitor for any unwanted side effects and/or adverse drug reactions.

We will continue to feedback to you with our review findings at each clinic appointment.

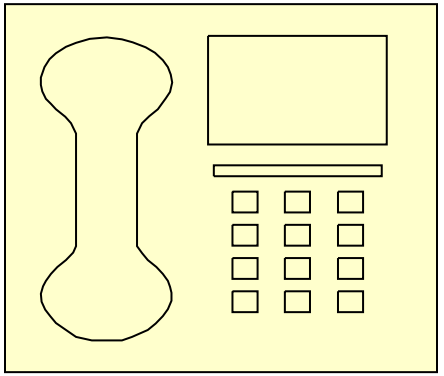
If there are shared care agreements in place for 6 or more South Stoke CAMHS children we would be more than happy to provide a 6 Monthly Clinic at your surgery if this supports future partnership working arrangements.

Please feel free to contact myself or my colleague Rachel Bullock, Nurse Prescriber if you would like to discuss further.
I would like to take this opportunity to thank you for your ongoing support and partnership approach for the above named.

Yours Sincerely,

Dr Lubna Latif
Consultant Psychiatrist in Child and Adolescent Mental Health

Chairman: Mr David Rogers
Chief Executive: Mrs Caroline Donovan
www.combined.nhs.uk
Follow us on Twitter: @CombinedNHS
Follow us on Facebook: www.facebook.com/NorthStaffsCombined



ESCA

North Staffordshire Combined Healthcare NHS Trust

University Hospital of North Staffordshire NHS Trust | North Staffordshire Combined Healthcare NHS Trust | Staffordshire and Stoke on Trent Partnership NHS Trust | North Staffordshire Clinical Commissioning Group | Stoke-on-Trent Clinical Commissioning Group

Private and Confidential

EFFECTIVE SHARED CARE AGREEMENT

THIS FORM IS TO BE USED ONLY WHEN THERE IS A LOCALLY APPROVED SHARED CARE AGREEMENT

A consultant wishing to invite a GP to participate in an effective shared care agreement should complete this form and forward to the patient's GP. Sharing of care assumes communication between the Consultant, GP and patient. The intention to share care should be explained to the patient by the Consultant initiating treatment. It is assumed that by completing this form, the Consultant has obtained the patient's consent for shared care of their treatment.

If a consultant asks the GP to participate in shared care, the GP should reply to this request as soon as practical by completing the GP section of this form. A copy should be retained by the GP and the original form should be returned to the Consultant, for filing in the patient's hospital notes. If the GP is not confident to undertake these roles, then he or she is under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition will remain with the Consultant.

The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

TREATMENT FOR SHARED CARE

DRUG NAME: [STATE DRUGS]	**PATIENT'S NAME:** / **DATE OF BIRTH:**
	ADDRESS: ADDRESSOGRAPH LABEL
FOR TREATING: [STATE CONDITION]	**NHS NO:** / **HOSPITAL UNIT NO:**

CONSULTANT TO COMPLETE

CONSULTANT NAME: **SPECIALITY:**

TELEPHONE NUMBER: **FAX NUMBER:** **EMAIL:**

SIGNATURE: **DATE:**

The full Effective Shared Care Agreements (ESCAs) and supporting information should be accessed via the following links:

- ***Secondary care:*** UHNS Intranet: http://uhns/clinicians/support-services/pharmacy/joint-formulary-related-documentation/ *then select ESCAs & RICaDs.*
- ***Primary Care:*** Stoke-on-Trent CCG website: http://www.stokeccg.nhs.uk/effective-shared-care-agreements
  North Staffordshire CCG website: http://www.northstaffsccg.nhs.uk/escas.

GP TO COMPLETE

ACCEPT SHARED CARE AGREEMENT: YES ☐ NO ☐

GP NAME: **PRACTICE ADDRESS:**

TELEPHONE NUMBER: **FAX NUMBER:** **EMAIL:**

SIGNATURE: **DATE:**

Approved by North Staffordshire & Stoke-on-Trent Area Prescribing Committee (date): 23/10/13 Review Date: 23/10/14 Version number: 2

PROUD TO CARE

spar

Key national drivers:

- Trusts Transformational objectives.
- 5 Year forward document.
- Green paper- Transforming Children's services (Dec 2017).
- Revised NICE guidance for management of ADHD (March 2018).
- NHS Institute for Innovation and Improvement: Going Lean in the NHS (November 2017)

Objectives met:

- Improved quality and efficiency
- Improved CYP care and experience
- Improved/ safer prescribing practice
- Reduce length of stay in CAMHS
- Significant cost improvement
- Timely assessments- MDT led
- Improved staff understanding and competence
- Nurse-led pathway

What has the impact been?

- Over **300** (and growing) CYP's on Effective Shared Care Agreements (+ 70% of prescribing).
- Encompasses a strengths based, recovery focussed approach.
- Improved response times for Psychiatry within CAMHS.
- Improving quality of wider service.
- Costs will still be retrieved for those where GP has declined ESCA.
- Those on shared care to be reviewed 6-12 monthly where appropriate.
- Builds in a step up/step down process in line with the ADHD RAG model implemented in April 2017.

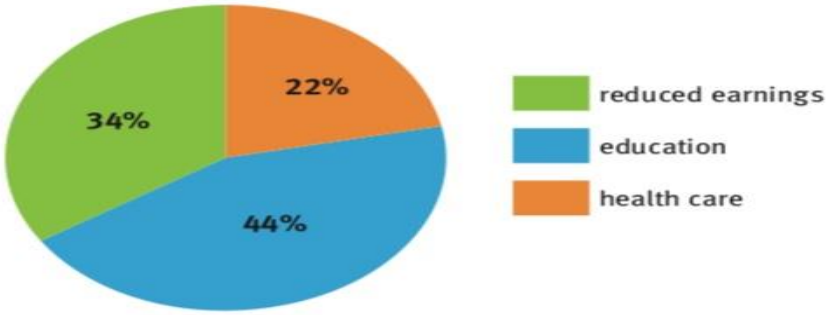
Overall prevalence of 1.5%

2.6% of boys and 0.5% of girls are diagnosed with ADHD

10,500 new cases a year

Costs of ADHD

Total **£102,135** per case, consisting of:



Total long-term cost of ADHD for each year's children: £1,070 million

What have we learnt?...

- Dispels the myths that GP's were not in support of a partnership approach.
- GP's were reassured by the support and guidance of NMP's .
- Improving the quality of the service for Children and Young People and their experiences.
- NMP's have proved to be ideally placed to progress with this pathway.

Our advice to others is*:*

"Have the conviction to question practice, listen to the voices of our CYP's and families, and nurture a culture of progress and nurse-led innovation."

What our GP partners say…

- “The practice are extremely pleased with the way the pilot is currently running, GPs have the opportunity to discuss with you the patients directly when you are in the practice and equally you can liaise with the GP about other aspects of the patients care when necessary. Making direct entries into the patient record in the practice also aids the GPs and other practice clinicians when seeing the patients regarding their health.”
- GP surgery CQC report highlighted partnership approach as good practice (2019).

What our CYP's say…

It's a lot closer to home when I see you here

I like coming to the surgery as no-one knows why I am here

I don't have to miss a day of school now

Future in mind…

- Future plans to roll out the shared care model throughout the service. (>400 CYP's or 80% of prescribing).
- Roll out to more GP surgeries.
- Mentorship to further NMP's.
- Nurse prescribers to drive forward initiatives such as STOMP/STAMP within CAMHS prescribing practices.
- To ensure social prescribing agenda is embedded within ADHD pathway.

Visions for the future….

- As advanced nursing roles we would play a key part in this primary care liaison work, strengthening relationships with primary care.
- We ensure a consistent streamlining of process and oversight.
- De-prescribing in our practice supports options such as non-pharmacological interventions, social prescribing and self-help within our approaches under the national initiatives of STOMP/STAMP.


Certificate of Acknowledgement
Awarded to
Nurse Prescribers & ADHD - North Staffordshire Combined Healthcare NHS Trust
Winners
Partnership Working/Co-Production
National Children & Young People's MH Awards
Professor Heather Tierney-Moore OBE
Patron
POSITIVE Practice
Mental Health Collaborative
Recognising excellence in mental health and mental health services
NHS England
NHS North Staffordshire Combined Healthcare NHS Trust
Tony Russell
Co Founder

Sharing the learning…

- Published in the Atlas of Shared Learning.
- Winner of the CYP Positive Practice in Mental Health Award for partnership.
- We have been shortlisted for 2 Nursing Times 2019 Awards for Nursing in Mental Health and Children and Young People services.
- Our Trust has achieved ‘OUTSTANDING’ from CQC 2019.

Ann Cox, Clinical Lead/ Consultant Nurse/NMP Lead,
Ann.cox@combined.nhs.uk
North Staffordshire Combined Healthcare NHS Trust

Rachel Bullock, Independent Nurse Prescriber:
rachel.bullock@combined.nhs.uk
South Stoke CAMHS, Blurton Health Centre, Ripon Road, Blurton, Stoke on Trent. ST3 5BS Tel: 0300 123 0977

Sue Ford, Independent Nurse Prescriber, North Staffs CAMHS
susanm.ford@combined.nhs.uk
North Staffordshire CAMHS, Dragon Square, Chesterton, Newcastle under Lyme. ST5 7HL. Tel: 0300 123 1153

References

- Trust transformational objectives (2018)
- Transforming Children's and Young People's Mental Health Provision: a Green paper (DoH, Dec 2017).
- NICE Guidance for Attention Deficit Hyperactivity Disorder: diagnosis and management (NICE, 2018).
- Next Steps for the 5 Years Forward View.

- https://www.stokeccg.nhs.uk/stoke-governance/policies/medicines-optimisation/effective-shared-care-agreements

The Brighton & Hove Wellbeing Service: Our Waiting List Journey

Cat Pritchard, Wellbeing and Therapeutic Services Manager - cat.pritchard@nhs.net

Tom Bostock, CYP Brighton & Hove Wellbeing Service Clinical Manager - tom.bostock@nhs.net

Presentation can be found using the link below:
https://prezi.com/view/CeBBlB7Qsa1yLOlH4hwn/

Some data can be found on the proceeding slides

Wellbeing Referrals

2957

number of referrals

Date filter

31/05/2018 31/05/2019

Contract

Community Wellbeing...

Service type

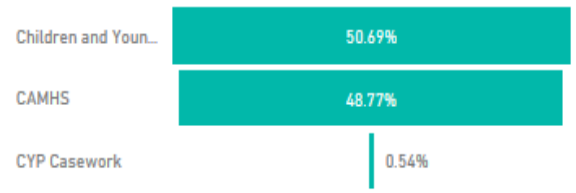
Multiple selections

Filter referral source

Multiple selections

Therapy type

All



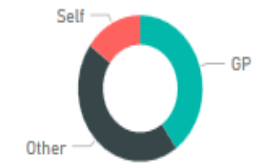
First GAD7

First PHQ9

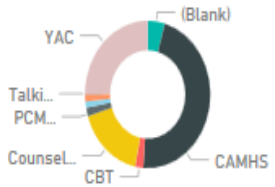
Sexual Orientation

Ethnicity

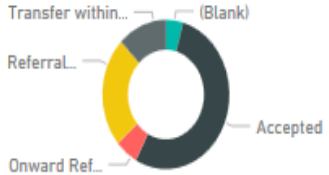
Referral source



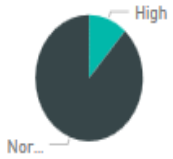
Triage decision



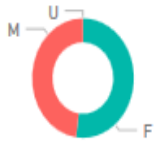
Triage outcome



Referral priority



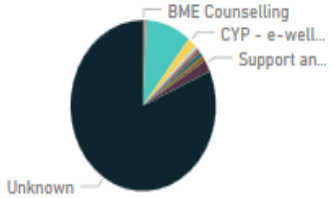
Gender



Filter by staff team

All

Therapy type



Registered Practice (use focus mode)

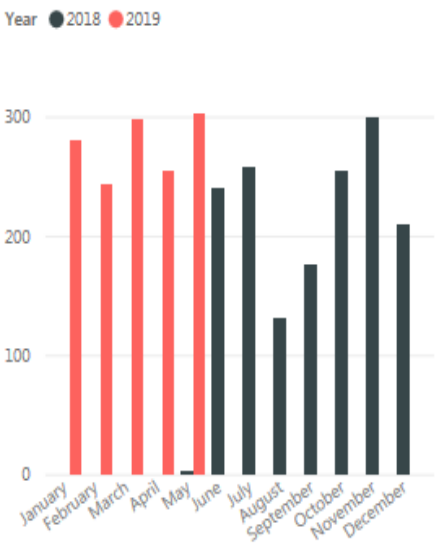
Age distribution

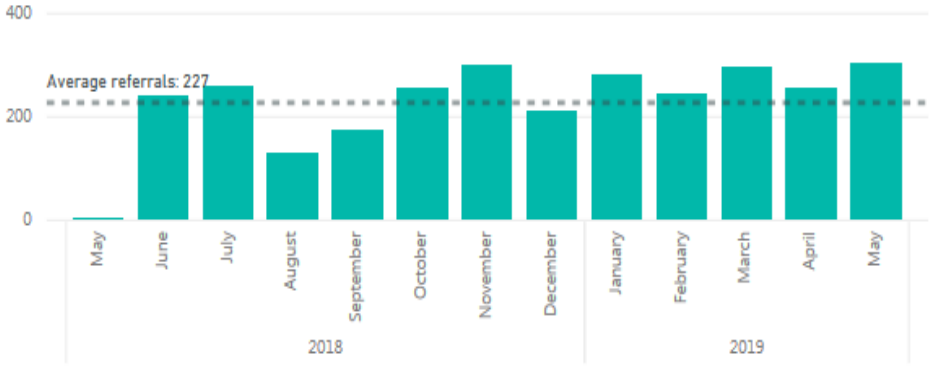
Filter by age

All

2
3
4

Referrals by partial postcode





Waiting Lists - Currently Waiting

Contract
- [x] Community Wellbeing Service

Complex Patient Pilot
- [ ] Not in Complex Patient Pilot

Service type
- [x] Children and Young People
- [ ] PCMHP

Patient in contract backlog
- [ ] No

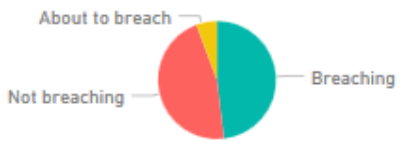
Appointment type
- [ ] (Blank)
- [x] Assessment
- [ ] First Treatment
- [ ] Treatment

Appointment method
- [ ] 1-1

Therapy type
- [ ] (Blank)
- [ ] Counselling
- [ ] e-motion

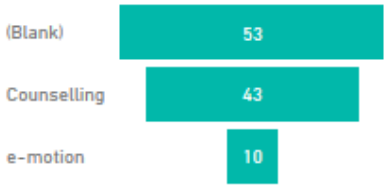
106

People currently waiting

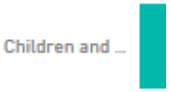


Waiting list
- [ ] Select all
- [ ] CYP CBT Assessment (Under 18)
- [ ] CYP Counselling Assessment List (13-25 Y...
- [ ] CYP e-wellbeing Online Counselling Asses...
- [ ] CYP Primary Counselling Assessment List...

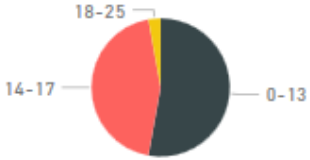
Therapy type



Service type



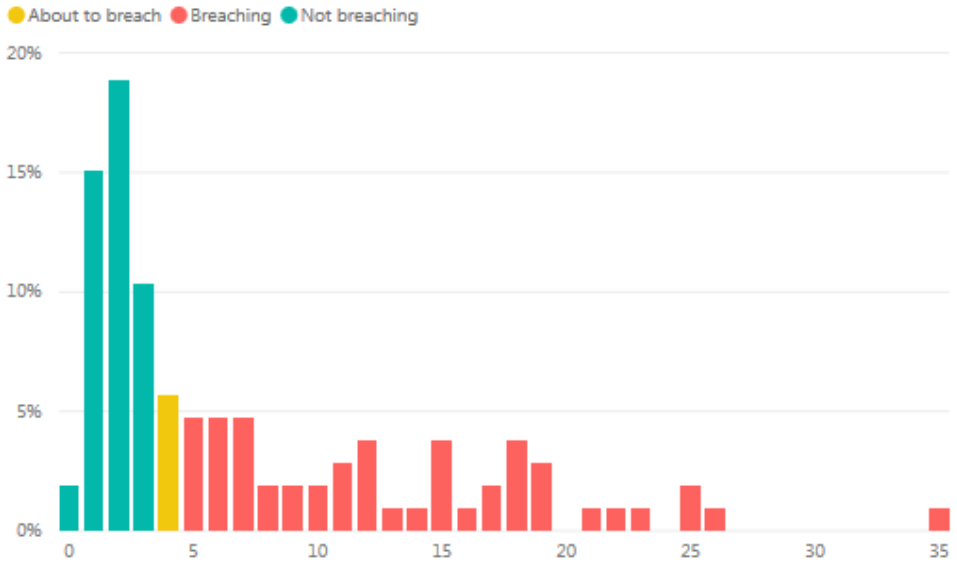
Age at referral



Appointment type

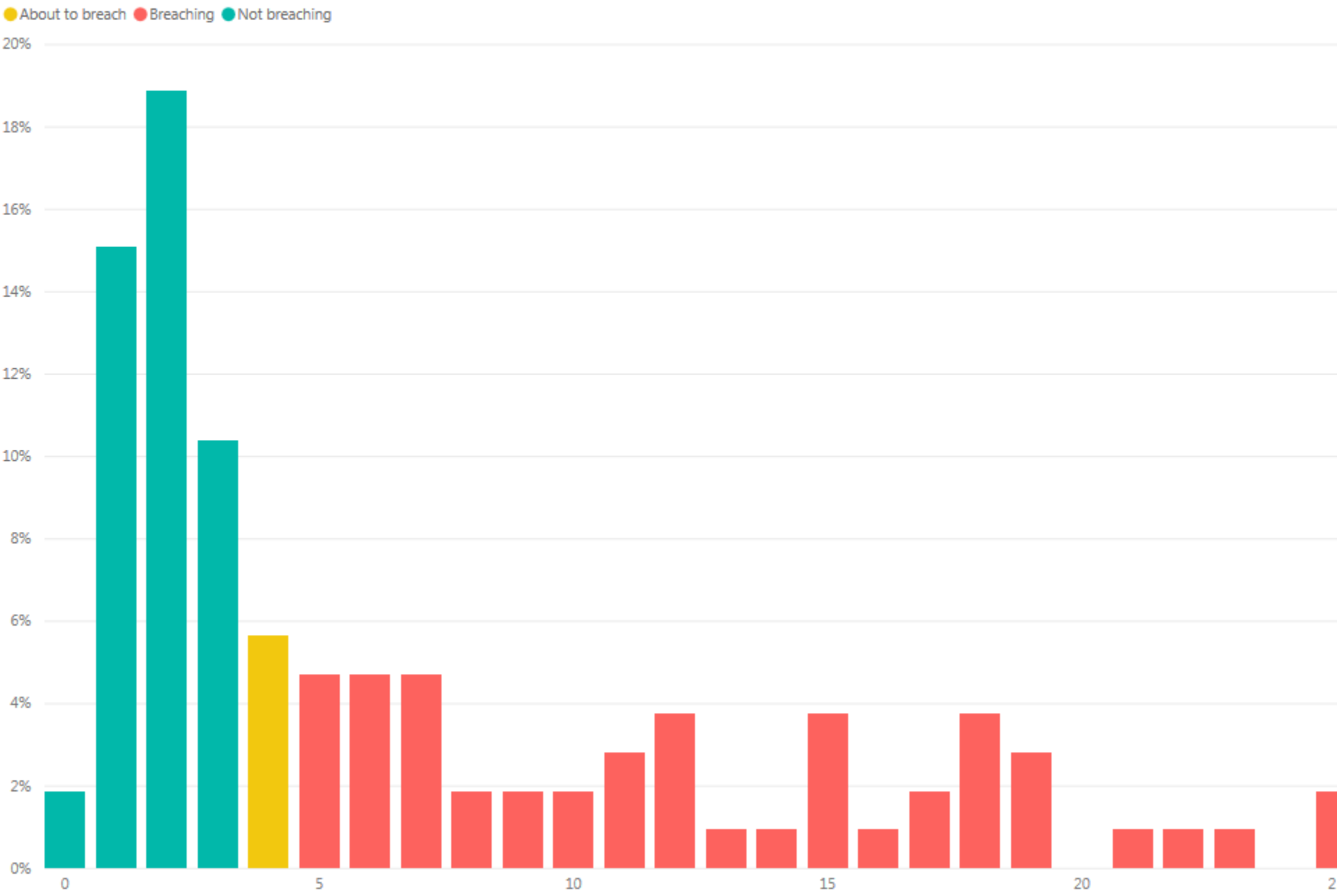
Appointment met

Weeks waiting



Back to report

WEEKS WAITING

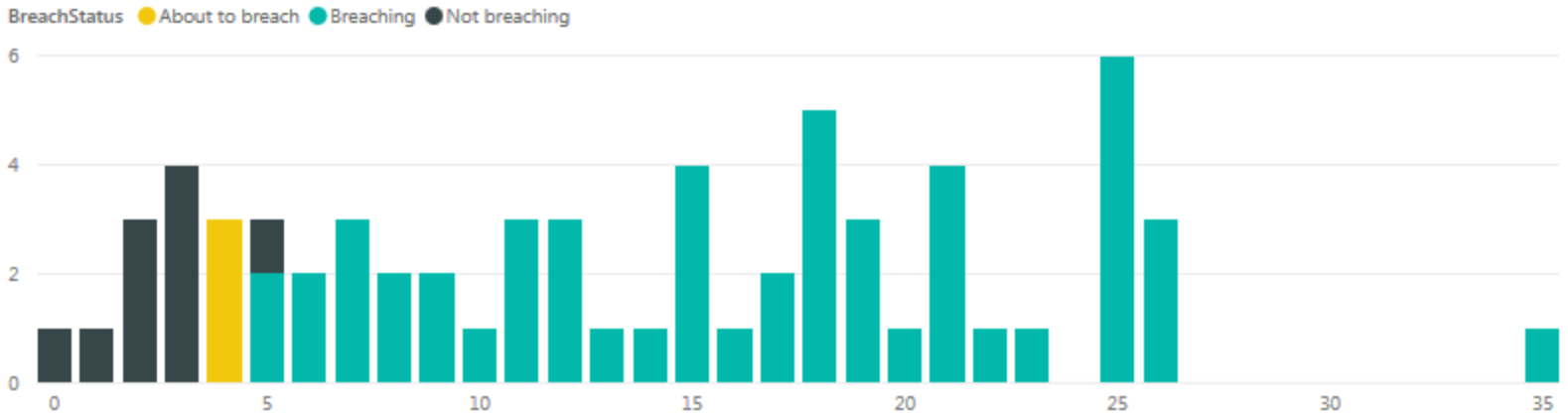


PtCount by DataSource

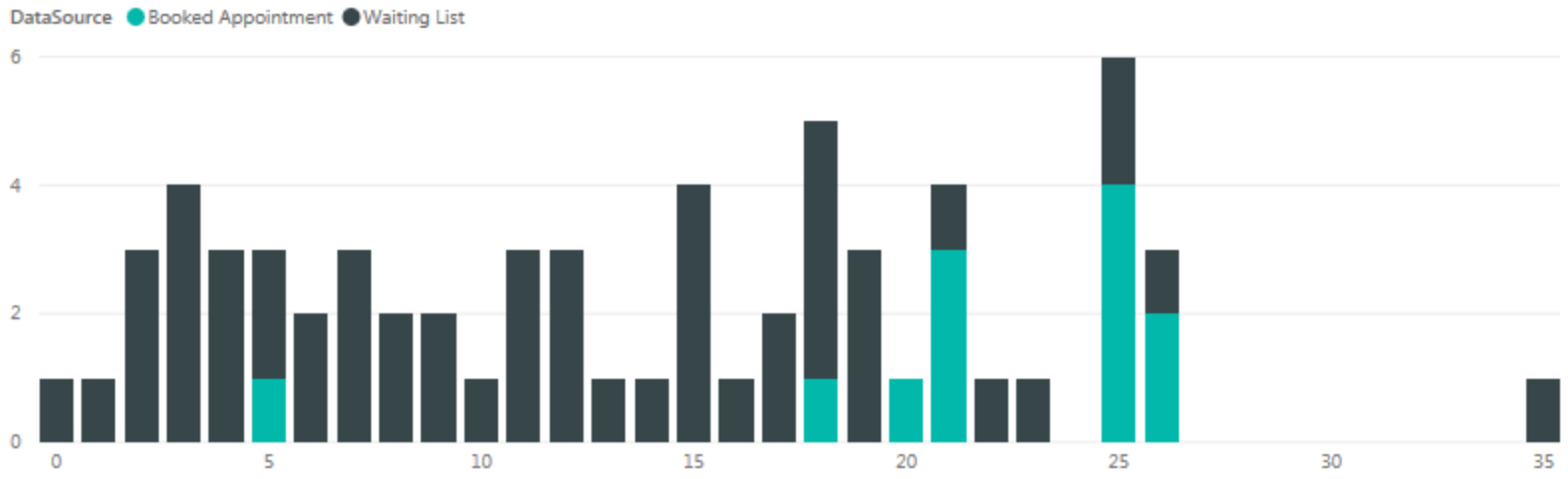
(Blank)

Total booked appointments from unknown waiting list

PtCount by WeeksWaiting and BreachStatus



PtCount by WeeksWaiting and DataSource



Date filter

31/05/2018 31/05/2019

Service

Children and Young People

Manager

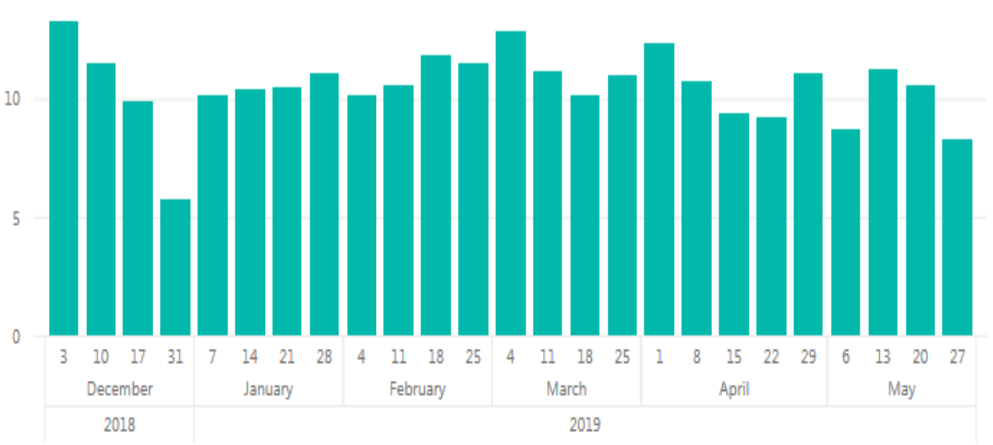
All

10.81

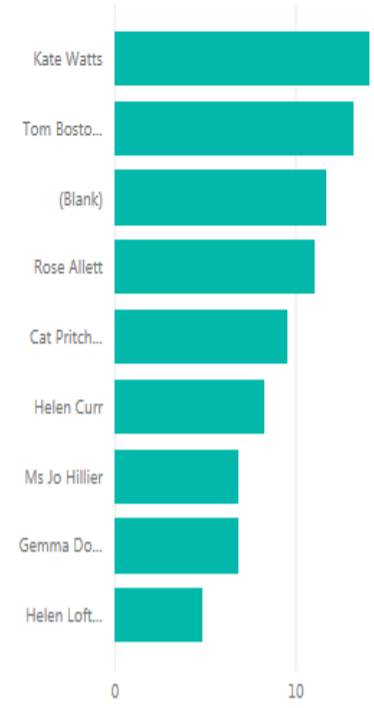
Hours Per WTE per Week per Staff

Includes triage and supervision slots, does not include DNAs or cancellations

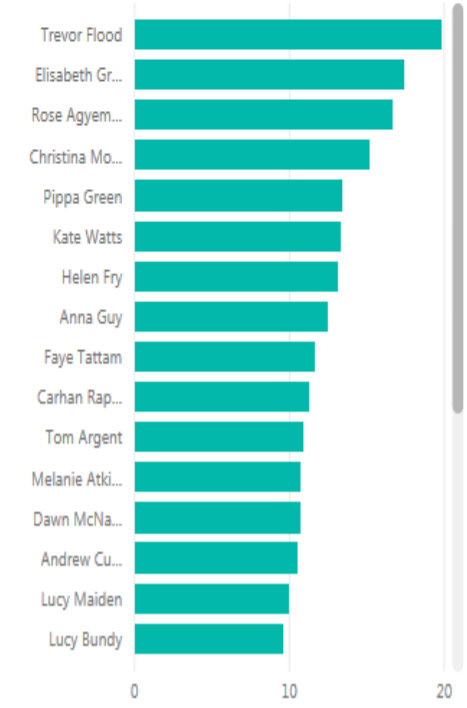
Average through time



Average per Manager



Average per Staff



	Year	2018				2019						
	Month	December				January				February		
Staff		3	10	17	31	7	14	21	28	4	11	18
Abi Matson-Phippard	Hours	5.33	8.50	1.00	2.67	7.50	4.67	9.50	1.00	8.50	9.50	6.
	WTE	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.
	Hours Per WTE per Week	6.67	10.63	1.25	3.33	9.38	5.83	11.88	1.25	10.63	11.88	7.
	% DNA	0 %	11 %	0 %	50 %	11 %	0 %	10 %	0 %	0 %	14 %	17
	% Cancelled by us	0 %	0 %	50 %	0 %	0 %	0 %	0 %	86 %	0 %	0 %	67
	% Cancelled by Patient	14 %	20 %	0 %	40 %	0 %	38 %	0 %	67 %	25 %	8 %	0
	Triage Hours	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.
	Supervision Hours	0.00	1.00	0.00	0.00	0.00	0.00	1.00	0.00	1.00	0.00	1.
Andrew Cummings	Hours	11.83	9.92	9.83	4.50	10.00	9.33	9.17	10.00	7.58	8.83	11.
	WTE	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.
	Hours Per WTE per Week	13.15	11.02	10.93	5.00	11.11	10.37	10.19	11.11	8.43	9.81	12.
	% DNA	7 %	25 %	14 %	38 %	14 %	8 %	8 %	14 %	18 %	8 %	19
	% Cancelled by us	0 %	14 %	0 %	0 %	0 %	0 %	0 %	0 %	10 %	15 %	7
	% Cancelled by Patient	13 %	8 %	33 %	38 %	14 %	8 %	21 %	25 %	10 %	21 %	19