Healthy London Partnership

CAMHS access targets (standards) in London

Rapid audit of commissioners' views

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Contents

Abbreviations

CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCGs	Clinical Commissioning Group
CJS	Criminal Justice System
CQC	Care Quality Commission
CYP	Children and young people
LA	Local Authority
LAC	Looked after children
MHSDS	Mental Health Services Data Set
NHSE	NHS England
NHSI	NHS Improvement
ONS	Office for National Statistics
SCIE	Social Care Innovation and Excellence
SDCS	Strategic Data Collection System
STP	Sustainability and Transformation Partnership areas (five in London)
TAMHS	Targeted mental health in schools
YOS	Youth offending services

Executive summary

Nationally and regionally, there have been problems with access to specialist children's and adolescent mental health services. While ten per cent of children nationally have a mental health condition requiring access to mental health services, only three per cent are able to do so[1]. Rising demand, lengthening waiting times and high thresholds for access to services have been highlighted for some time.

The purpose of this report is to try to compare areas meeting and not meeting the CAMHS access targets, and explore whether there are themes of good practice that influence success. We also wanted to hear from commissioners about the challenges affecting demand and delivery of services.

The national literature identified nine factors which may affect performance:

Voluntary and community services (VCS) 'flowing data' (either to NHS digital or their commissioners)
VCS providing Tier 2 services
Having a directory of local support services
Having a single point of access
Schools work
Digital platform for support either at Tier 1 or Tier 2, or as follow up support
Work with the local authority on commissioning or provision of services
Bespoke support for at risk children
Availability of mental health crisis services 'out of hours'

In exploring **local issues with areas meeting the targets**, we found the following themes:

In terms of **strengths**:

- All boroughs meeting the targets had: VCS providing Tier 2 services, a single point of access, and robust schools work, as well as joint working/commissioning with the local authority;
- Most had good provision for children in at risk groups.

Even boroughs meeting the 30% access target[2] felt that system **weaknesses** were the need for increased emergency/crisis services.

The **recent peer reviews of crisis services** delivered by HLP found a number of key themes across the system which affected children:

- Accident and emergency (A&E) departments being used as a crisis point due to inability to access CAMHS services
- Pressure on A&E due to closure of departments and the subsequent impact on other hospitals
- Lack of a standardised approach of each trust serving a number of boroughs
- A cut off of 3-4pm in A&E with dependence on A&E or liaison psychiatry after that time

Commissioners also felt that there was a need for strengthened Tier 2 interventions in order to reduce pressure on Tier 3 CAMHS. **Interviewing commissioners** from five different CCG areas, and ***using a survey of all CCGs*** to compare areas meeting and not meeting the targets, we found that ***only two factors differed between areas meeting or not meeting the targets***:

- Having VCS providing Tier 2 services for children's mental health

[1] Transforming children and young people's mental health provision: a green paper. December 2017.

[2] Target is synonymous with standard – the standard is more commonly referred to as a target.

- Having a local directory of services and support

From the national (and London) comparisons, we saw areas with excellent practice. Those areas had investment in crisis care, and investment in frontline council services by the NHS, to reduce demand. They also had a whole system approach to children's mental health, with joined up and responsive services. **Our recommendations** are as follows:

Recommendation	Suggested owner	Suggested timescale
CCG commissioners to be supported to ensure all VCS providers can 'flow' data	NHSI, NHSE, HLP, NHS Digital	1 January 2019 – short term
Consider use of VCS to reduce demand on specialist services	CCGs and councils together	1 January 2019 – short term
Ensure that a local up to date service directory is available for each borough/CCG	CCGs and councils	1 January 2019 – short term
Ensure crisis care for CAMHS is available 24/7 across London	STPs	31 March 2019 – medium term
Review needs across London and consider collective commissioning across the NHS and councils to create seamless offer across Tiers 1-4, and reduce demand on specialist services, aged 0-25 years	HLP and STPs	31 December 2019 – long term

Aims

To identify key themes for improving access to child and adolescent mental health services (CAMHS) in London.

Objectives

- Describe the key issues which may be affecting CAMHS access[3] in London by:
    - Collating **key themes** that may affect access
    - Reviewing **performance data** from ad hoc (SDCS) and routine (MHSDS) data sources
    - Conducting **semi-structured qualitative interviews** with commissioners
    - Surveying **information on services in CCG areas**
    - Reviewing evidence from areas in England with good access to services
- Triangulate the key factors which may be affecting CAMHS targets in London
- Make recommendations for change (short / medium and long term)

[3] CAMHS refers to NHS specialist children and young people's mental health services (CYP MHS) rather than that which is outside the NHS

1 Background

Access to children's mental health services (child and adolescent mental health, CAMHS) has been highlighted as a national problem by the **Children's commissioner** for England and Wales[4]. A 2017 report noted that 60% of areas are failing NHSE benchmarking standards. An overall theme is of NHS services solely dealing with severe illness, with reduced scope for earlier intervention[5].

The Care Quality Commission (**CQC)** reviewed the quality of children and young people's mental health services in ten health and wellbeing board areas in the report 'Are we listening?' (2018)[6]. The report found 'long waiting lists, inappropriately high eligibility criteria, and gaps in service provision', with a fragmented commissioning system.[7]

CAMHS waiting times - national

Nationally, waiting times have increased for CAMHS services. The **NHS benchmarking and good practice for CAMHS conference**[8] (2017) analysed data from the last few years, finding that demand had increased 56% in the four years prior to 2017. The mean waiting times for emergency appointments had increased from ten days in 2015/16 to 25 days in 2016/17. The latest (2017) waiting times for non-urgent care are seven weeks for a routine appointment nationally[9].

An interesting statistic **nationally** is the **conversion rate of referrals to acceptance** into treatment. In 2012/13 for CAMHS this was 81%, and then in 2016/17 (4 years later) this was down to 65%. It is difficult to speculate on the reasons – CAMHS criteria may have been narrowed to cope with rising demand, or referrals may include less severely unwell children who are then screened out of treatment.

Complex commissioning

The **fragmented commissioning and providing landscape** for children's mental health is an issue nationally. Services are still described in terms of **tiers** (described below), ranging from the least to the most severe. Multiple commissioners may lack the ability to achieve a 'whole systems' look at children's mental health.

Tier	Brief description	Commissioners	Key problems
Tier 1	Prevention and health promotion	LA public health	Sustained funding cuts since 2015, non-statutory responsibility (not mandated services)
Tier 2	Mental health trained professionals working with children with mild to moderate problem (voluntary and community sector, school counselling, mental health workers)	LA children's social services; CCGs	Sustained funding cuts – in face of continued statutory responsibilities for child safeguarding. Youth work and early intervention funding in councils significantly cut with austerity measures.
Tier 3	Mental health professionals working together in a team	CCGs	Poor measurement of quality measures – some areas historically underfunded
Tier 4	Inpatient and highly specialist provision	NHSE	Distant from local provision

Funding

The commissioning landscape is one part of a complex picture. Another is the distribution of NHS spending by children's mental health services, which is **skewed** towards the more severe end of the

[4] Briefing. Children's mental healthcare in England. Children's commissioner (October 2017).
[5] Briefing. Children's mental healthcare in England. Children's commissioner (October 2017
[6] https://www.cqc.org.uk/publications/themed-work/are-we-listening-review-children-young-peoples-mental-health-services
[7] https://www.cqc.org.uk/sites/default/files/20180308b_arewelistening_report.pdf
[8] Powerpoint presentation, personal communication. Benchmarking and good practice conference for CAMHS 2017.
[9] Powerpoint presentation, personal communication. Benchmarking and good practice conference for CAMHS 2017.

spectrum, perhaps as a historical reflection of LA spend on earlier interventions, or an NHS focus on illness rather than early intervention. We see from the table below that 84% of NHS mental health spend is on specialist, rather than earlier intervention services.

Area of NHS spend	Per cent
Universal services (children not accessing CAMHS)	16%
Community CAMHS services	46%
Inpatient	38%

Earlier interventions are cheaper and prevent more severe illness from developing. We know that half of all mental illness develops before the age of 14[10], giving opportunities for earlier identification. Comparing the costs of different interventions at different stages, the earlier interventions are the cheapest, see below from the **Children's commissioner**[11].

- £5.08 per student – the cost of delivering an emotional resilience program in school
- £229 per child – the cost of delivering six counselling or group CBT (cognitive behavioural therapy) sessions in a school
- £2,338 – the average cost of a referral to a community CAMHS service
- £61,000 - the average cost of an admission to an in-patient CAMHS unit

The Government's **green paper on children's mental health**, published in December 2017[12], identified ways of addressing the surge in demand, with a strong focus on schools-based activity.

High risk groups

The national prevalence for children in the general population is that 'one in ten young people has some form of diagnosable mental health condition'[13]. This can be contrasted with the high risk groups described below - looked after children, those in contact with the criminal justice system, children with learning disability and those attending pupil referral units (PRUs).

Looked after children

Given that 45% of looked after children (LAC) are thought to have a 'diagnosable disorder', and 70-80% have 'recognisable problems'[14], early, targeted support for this group would be an obvious choice for intervention.

Local authorities have often paid for bespoke mental health support for this cohort, although this **funding is vulnerable** in funding settlements as it is not statutory. **The Institute for social care innovation and excellence** (SCIE) looked at ways to improve looked after children's mental health. It made recommendations including that 'every school should have a designated teacher with the training and competence in identifying and understanding the mental health needs of all their pupils who are

10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf: 6.

11 Briefing. Children's mental healthcare in England. Children's commissioner (October 2017)

12 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf last accessed 30.7.18.

13 Transforming children and young people's mental health provision: a green paper. December 2017.

14 https://www.nice.org.uk/guidance/ph28/evidence/ep22-the-mental-health-of-looked-after-children-under-5-years-joe-sempik-pdf-430133293 last accessed 30.7.18.

looked-after'. This would echo the role of virtual heads, who have been crucial in raising LAC educational performance and aspirations[15].

Children in contact with the criminal justice system

Hagell (2002) reviewed the existing international evidence, showing that 46-81% of young offenders had mental health problems. The most common issues for such children were conduct and oppositional disorders, followed by substance misuse, anxiety and depression[16].

2 Introduction

In 2016, 200,000 children accessed CAMHS treatment in England -2.6% of the population. This is lower than children who need treatment – estimated at 1 in 10 children[17]. The Department of Health **'Future in Mind'** report estimated that only **25 to 35 per cent of children** who needed CAMHS services actually received help[18]. Children need to access evidence based mental health care, which may be delivered by a range of different providers.

In terms of workforce development, 11 London boroughs have **children's wellbeing practitioners in place**. This scheme was developed in partnership with the Anna Freud Centre to deliver different models of children's mental health support in schools, CAMHS services, local authorities or the third sector. This aims to develop improving access to psychological therapies (IAPT) for children and young people. As this programme is at the early stages, it will not be considered as a current factor with a direct impact on achieving the access target.

This paper seeks to consider the **key factors that may affect CAMHS access**, by drawing on a number of sources outlined below.

3 Methods

Describe the key issues affecting CAMHS access (tier 2 and above) in London by:

- drawing out **key themes** using national and expert sources
- summarising **performance data** from ad hoc (SDCS) and routine (MHSDS) data sources
- conducting semi-structured **qualitative interviews** with CAMHS commissioners
- distributing an online **survey** to all of the CAMHS commissioners in London (separated by those meeting/not meeting the targets) – testing the themes identified above
- reviewing evidence from **areas in England** with good access to children's mental health services

- **triangulating the evidence** above, and making **recommendations** for change.

[15] https://www.scie.org.uk/children/care/mental-health/report last accessed 1.8.18
[16] Hagell (2002). The mental health of young offenders. Bright futures: working with vulnerable young people.
[17] Transforming children and young people's mental health provision: a green paper. December 2017.
[18] Department of Health and Social Care and NHS England, Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing, 2015.

4 Results – key themes from the national evidence

The nine key themes outlined in the background and introductory sections above include the following factors that support improved access, which can be broadly divided into data and service configuration factors:

- **Data factors**:

VCS 'flowing data' (either to NHS Digital or their commissioners) - The CQC '**Are we listening'** report identified examples of good practice around data, where 'voluntary sector partners were granted access to some NHS information systems, which made it easier to share information effectively and efficiently'. It would make sense for that to be standard practice.[19]

- **Service configuration factors**:

VCS providing Tier 2 services
Having a directory of local support services
Having a single point of access
Schools work (Tier 2 provision in schools)
Digital platform for support either at Tier 1 or 2, or as follow up support
Work with the local authority on commissioning or provision of services
Bespoke support for at risk children –those in contact with the criminal justice system, looked after children, and those attending pupil referral units (all of whom have higher levels of need than other children)
Availability of mental health crisis services 'out of hours'

These then informed both the commissioner discussions and survey described below.

5 Results – performance targets in London

There are specific definitions of access to CAMHS:

- **2a**
  Total number of individual children and young people aged under 18 receiving treatment by NHS funded community services in the reporting period;
- **2b**
  Total number of CYP under 18 with a diagnosable mental health condition[20].

The NHSE targets for access each year are set out below:

Annualised access rate per cent			
2017-18	2018-19	2019-20	2020-21
30%	32%	34%	35%

In many areas, **voluntary and community sector** (VCS) organisations may provide Tier 1 or 2 services to children and young people.

[19] https://www.cqc.org.uk/sites/default/files/20180308b_arewelistening_report.pdf

[20] https://www.healthylondon.org/wp-content/uploads/2017/11/Guide-to-available-datasets-and-reports-for-children-and-young-people-April-2017.pdf last accessed 29.8.18.

Their activity, if they are funded or part funded from NHS monies, needs to be captured as part of the access target.

However, **not all VCS organisations have the ability to input data** into MHSDS, leading to perceived inaccuracies in national reporting of access. As of October 2017, only two London VCS organisations were doing so – the Brandon Centre (Islington) and the Bromley Y. It is thought that **48 VCS in London** are delivering services to CYP but **not** 'flowing data' to MHSDS. This risks national under reporting of performance to the national access target.

5.1 Bespoke data collection

Due to the issues with data collection, a **one off** collection nationally, using the SDCS) was carried out in June 2018 to gain a more accurate picture. The following London CCGs met the CAMHS access using the SDCS (one off) measurement. The red denotes CCGs meeting the SDCS only (but not the MHSDS target), indicating difficulties with data flow to MHSDS.

CCG	SDCS access rate	MHSDS access rate Mar 2018 (Q4)
Barnet	33%	33.2%
Haringey	30.6%	25.1%
Islington	52.8%	13.1%
City & Hackney	39%	29%
Havering	33.9%	30.5%
Tower Hamlets	47.2%	35.3%
Brent	31.7%	28.9%
Hounslow	43.7%	33%
Hammersmith & Fulham	46.5%	37.2%
Harrow	33.7%	26.5%
West London (Kens & Chelsea)	82.6%	78.1%
Central London (Westminster)	31.7%	31%
Kingston	34.1%	18.2%
Richmond	37.1%	24%
Merton	33.3%	29.2%
Sutton	34%	33.5%
Wandsworth	32.5%	28%

For the SDCS collection, the providers that submitted the most activity data for 2017/18 are shown below (although not adjusted per head of population).

CCG	Provider
Croydon	**Croydon Drop in**
Tower Hamlets	**Step Forward (tower hamlets)**
Croydon	**Off the record counselling Croydon**
Enfield	**London Borough of Enfield**
Hounslow	**Hounslow Youth Counselling**
Islington	**Mind Connect**
Richmond	**Off the Record**
Croydon	**Croydon Youth Information and Counselling Service Ltd**
Kingston	**Relate KCCG**
Kingston	**Achieving for Children**

5.2 Analysis of local transformation plans (LTP) with CCG performance

We then compared the target performance with CCGs' **local transformation plans** to see whether clues could be found to relate to performance.

No clear themes emerged from these comparisons other than shared providers in particular areas where targets were not being met, although this is highly biased in terms of having very limited information in many LTPs.

For detail see **Annex A**.

6 Results – Qualitative interviews

Commissioners in CCGs which either were/ were not meeting the CAMHS targets were contacted, to ask for their views using a semi structured interview format. Interviews were conducted in person or by phone. Only those meeting the targets responded, and had interview set up.

Results were compiled and then common themes derived, summarised below. Further detail is found at **Annex B**. This represents a more robust method than using the LTP plans as a proxy for actual systems design. We took a looser view of target achievement, using any borough which achieved the SDCS only, **or** both the SDCS and MHSDS.

Borough	Data flow from VCS	VCS	Single point of access SPoA	Schools	Digital platform	Pooled budget/ joint work with LA	Looked after children - LAC, pupil referral unit - PRU and criminal justice system - CJS	Crisis services
Wandsworth	no	yes	yes	yes	no	yes	yes	Yes being incr
Merton	Yes manual	yes	Yes	Yes	limited	yes	No LAC, yes CJS	yes
Tower Hamlets	no	yes	yes	yes	no	yes	yes	Yes being incr
Central (Westminster)	yes	yes	yes	yes	Just started	yes	yes all	yes
West (K&C)	yes	yes	yes	yes	Just started	yes	yes all	yes
Hammersmith & Fulham	yes	yes	yes	yes	Just started	yes	yes all	no

We also collated **the questions on strengths**, and found that:

- Not all the boroughs meeting their targets had VCS providers 'flowing' data so we would expect a step change increase from Q3 of 2018-19;
- All boroughs meeting the targets had: VCS providing Tier 2 services, a single point of access, and robust schools work, as well as joint working/commissioning with the local authority;
- Most had good provision for children in at risk groups: those looked after, in pupil referral units, and those in contact with the criminal justice system.

Even boroughs meeting the targets felt that **system weaknesses were**:

- The need for increased emergency/crisis services
- Strengthened Tier 2 interventions in order to reduce pressure on Tier 3 CAMHS

7 Results – Online survey of commissioners

In order to differentiate what factors might be separating boroughs meeting/not meeting the targets, we distributed a survey monkey to all commissioners in London – those meeting and not meeting the targets had the same questions administered but in two separate cohorts. Four meeting the targets and eight not meeting the targets completed the survey using the questions described in **section 4**.

We then focussed on those where the results differed between those CCGs meeting/not meeting the targets, as a **possible explanation for performance**.

	Meeting target	Not meeting	Prelim finding
VCS	All	Not in all	Could be factor
VCS flowing data	All have	Not in all	Could be a factor
Directory	All	Not in all	Could be factor
SPoA	*** (see below)	Not in all	No diff
Schools	All	all	No diff
Digital platform	Not in all	Not in all	No diff
Work with LA	Yes or limited	Yes or/limited	No diff
Bespoke for at risk	All	All	No diff
Crisis services 9-5	More than 9-5 or 24/7	9-5 or slightly more or 24/7	A slight difference

If we look at the **factors that differ** between boroughs meeting and not meeting the targets, these are narrowed down as follows:

- VCS providing Tier 1 and 2,
- VCS flowing data (although with qualitative interviews this wasn't optimised even in boroughs meeting the targets),
- Having a directory of services, and
- Having crisis services with longer than 9-5 (though this is a slight difference only).

8 Results – combining the interview and survey results

We then triangulated the survey results with 1-1 interviews from boroughs and found that the differences narrowed even further. We could then refine the table as follows:

	Meeting target	Not meeting	Prelim finding
VCS	All	Not in all	Could be factor
VCS flowing data	Not in all	Not in all	No difference
Directory	All	Not in all	Could be factor
SPA	Not in all	Not in all	No difference
Schools	All	All	No difference
Digital platform	Not in all	Not in all	No difference
Work with LA	Yes or limited	Yes or/limited	No difference
Bespoke for at risk	All	All	No difference
Crisis services 9-5	9-5, More than 9-5 or 24/7	9-5 or slightly more or 24/7	No difference

This means the **only differences seen between those CCG areas meeting/not meeting the targets** are:

- Having VCS providing Tier 2 services for children's mental health
- Having a local directory of services and support

8 Results - What are high performing areas of England doing?

8.1 Bradford

Bradford (population 580,000 people) has radically transformed the approach to children and young people's mental health by taking an integrated, early intervention approach. Long CAMHS waiting lists of 18 months underpinned the main case for change, prior to service transformation.

The basic premise was a **youth worker led model in Phase 1**. This offered support to children already on the CAMHS waiting lists. Phase 2 opened the offer to children referred from other sources, and Phase three (the current phase) opened support to *any child* needing assistance.

This **youth worker model** was provided by NHS vanguard funding for 12 whole time equivalent Band 3 or 4 youth workers to provide a **'health buddy'. This comprises support** and intervention for a defined 12 week period. This is then complemented by a longer period of **youth mentoring** with access to a digital tool for staff and children to communicate with each other. Crisis care has also been transformed, with a 'safe space' house (with playroom and a kitchen) staffed by mental health workers and run by a housing association, for **Section 136** placements. **CAMHS waiting times** in Bradford are now **8 weeks** (down from 18 months) – although they are slightly increasing due to raised awareness in the community.

8.2 Birmingham

This model is known as '**Forward thinking Birmingham'**[21]. The programme was commissioned by four CCGs for children and young adults aged 0 to 25 years, and designed to reduce system fragmentation. A 'Pause centre', to provide a drop in resource in the city centre was created, as well as a 24/7 phone number for parents or children to phone to get help/advice. There is a single point of access known as the 'Assess centre' – this provides a single front door for all services. New crisis inpatient facilities for 18-25 year olds, to create a new therapeutic environment are a feature. Another is the digital linkage to create a 'state-of-the-art integrated patient management system so that people no longer get 'lost in the system'.

8.3 North Yorkshire 'no wrong door'

This service is designed to be holistic, and addressed the needs of higher risk children. It is described as 'an integrated service to support children living in care and children at risk of being taken into local authority care. This approach was intended to support children and young people in a joined-up way, so they could access a single service rather than find themselves bounced between different agencies for psychological support, speech and language therapy, youth offending services and social care.[22]' It is interesting that the model was designed and commissioned by the council.

8.4 Durham and Tees crisis model

[21] https://www.forwardthinkingbirmingham.org.uk/
[22] https://www.cqc.org.uk/sites/default/files/20180308b_arewelistening_report.pdf

The new integrated service from two crisis services performs well, with 60% of CYP referred to crisis services seen within 1 hour of a referral being made and over 75% were seen in 4 hours. Other key features were:

•Dedicated CYP crisis resolution model identified substantial cost reductions (over £400k and £700k per annum for each hospital). CYP crises were effectively managed in community settings with less recourse to ambulance transport, A&E attendance and inpatient admission.

•Dedicated CYP crisis telephone support, advice and triage improved access, response times and provides flexible/individualised support.

The cost of providing the crisis services from 8am to 10pm daily across the three CCGs was estimated at £414k per year[23]. The population covered by the three CCGs[24] is almost 450,000 people. This is important benchmarking information for the London boroughs and could be used when planning across mental health provider areas.

8.5 North Lincoln crisis and intensive home intervention team[25]

This area radically reshaped its offer to cut out all the fragmented crisis service lines and create a 'one team' for CAMHS. North Lincolnshire had classic issues common to deprived areas such as substance misuse, domestic violence, teenage pregnancy and unemployment. The average waiting times for CAMHS were between 9-18 months. There were many different teams including for Tiers 3, LAC, LD and ADHD. They created one team for 24/7 access. They have a strong focus on prevention, having trained all their school nurses and YOS in CBT techniques. All these staff also have formal CBT supervision weekly, a key component of robust practice.

8.6 Norfolk model

Norfolk is currently reviewing its mental health provision for children and young people. This work is being done in partnership between the county council and the NHS. Norfolk estimates that only 36% of children with 'diagnosable mental health conditions' are accessing help, and demand is increasing by about 10-15% every year. [26]

8.7 London pilots/changes

We know that changes have been made in certain London boroughs, either as a result of individual CCG commissioning, or funded by NHSE specialist commissioning (South West London and St George's mental health trust). NELFT has an assertive outreach service which has avoided almost 200 inpatient admissions over one year, SLAM a supported discharge service and specialist crisis care. Tavistock and Portman have delivered a child and adolescent assertive outreach service. These models will need to be evaluated and potentially scaled up to ensure equity of access across London.

9 Discussion

From the qualitative interviews, we see that even high performing boroughs were not all sending in ('flowing') their VCS data. We would expect better performance in those areas, from the end of 2018/19, as they are currently meeting targets without their VCS providers sending data in. All the areas meeting their targets did express a need for greater Tier 2 services, and for greater crisis cover.

[23] https://democracy.durham.gov.uk/documents/s59684/CAMHS%20Crisis%20and%20Liaison%20Service%20Evaluation%20Report%20-%20Final%2027%2005%202015.pdf
[24] North Durham, Durham Dales and Darlington CCG
[25] Crisis presentation slide pack Dr T Urquhart Clinical Psychologist Lincs Partnership NHS Trust.
[26] https://www.norfolk.gov.uk/care-support-and-health/health-and-wellbeing/childrens-health-and-wellbeing/mental-health-camhs/childrens-mental-health-transformation accessed 28.8.18

The crisis cover issue is important, as CAMHS access is only the first part of the pathway. If children in acute need are struggling to get help out of hours, this type of emergency provision needs to be addressed as part of a whole system view.

From the online survey of commissioners we see that the only factors that seemed to differ between boroughs meeting and not meeting the targets were having VCS providing Tier 2 services for children's mental health, and having a local directory of services and support. For those reasons, it may indicate that VCS providers of Tier 2 services are crucial in helping the system function well. Having the local service directory similarly may help signpost parents, carers and children to other community support to help children at early stages of need.

From the **comparative section**, we see that some of the most radical changes defining success are shifting investment from specialist to community support, as in the Bradford model. This requires close working and cross investment between the NHS and local authorities. In the Durham and Tees crisis model, investment of over £400,000 was made to provide 24 hour cover for a population of 450,000 people. Extrapolated to London, this may mean that investment of £8.3m is needed to provide 24 hour crisis cover for the whole city. It may be worth exploring this as a London venture, rather than for individual CCG clusters to arrange, as gaps clearly exist.

10 Conclusions

Short term

In the short term, all VCS providers need to be supported to 'flow' data, so that we have an accurate picture of access. This involved secure data connections and robust information governance arrangements.

Given that the differences between CCGs meeting /not meeting their targets rested only on use of the VCS, and having a directory of services, we would suggest that CCGs not meeting targets could explore use of VCS to reduce demand on specialist services. CCGs (in a related point) could also ensure – working with their councils - that a local up to date service directory is available.

Medium term

Crisis care needs a collective approach (linked in to the HLP children and young people's **crisis peer review process**, completed in 2018). Taking the lessons from Durham and Tees, we need to map need across the city and ensure that crisis care over 24 hours does not vary between areas and is safe and immediate. This will need mature partnerships between the NHS and councils, with pooling of budgets and planning and provision for crisis care on a London wide rather than provider footprint basis. The recent **crisis peer reviews** delivered by HLP found a number of key themes across the system which affected children:

- Accident and emergency (A&E) departments being used as a crisis point due to inability to access CAMHS services
- Pressure on A&E due to closure of departments and the subsequent impact on other hospitals
- Lack of a standardised approach of each trust serving a number of boroughs
- A cut off of 3-4pm in A&E with dependence on A&E or liaison psychiatry after that time

Long term

Transforming access to CAMHS will require more than simply scaling up existing services for children with mental health issues. It will require a radical re-think of interventions and services, a more integrated and responsive model, and an acknowledgment that infinite acute services will not be able to service the levels of rising demand in the population.

Given the funding cuts to councils, and the fact that the NHS relies on good Tier 2 services to reduce demand for Tier 3, pragmatic conversations need to take place so that all commissioning is joined up, and take a collective ownership of need. Here the lessons from Bradford, about the NHS funding local authority youth work is a powerful example of forward thinking and innovation.

CCGs and councils could explore the use of public health funding, where appropriate, to support delivery of Tier 2 services.

11 Recommendations

- CCG commissioners to be supported to ensure all VCS providers can flow data
- Use of VCS to reduce demand on specialist services
- Ensure that a local up to date service directory is available (usually provided by VCS or councils)
- Ensure crisis care for CAMHS needs out of hours is 24 hours across London
- Review needs across London and consider joint commissioning across the NHS and councils to boost Tier 2 provision and reduce demand, using a new 0-25 year old model

Annex A – Review of local transformation plans (LTPs)

CCGs not meeting any target

	Data flow	SPA Flexible pathway no silos	Schools work	Online data resources	Pooled budgets with LA/cuts	LAC bespoke	Crisis and A&E
Camden	Mentioned as improving	No	Has link pilots in place	No	No	Not mentioned	OOH support mentioned
Enfield	Not mentioned	Yes	Yes	No	No, and cuts to LA mentioned	No	Planned NCL OOH
Croydon	Yes VCS submit to MHSDS	Stated aim	Yes – conference	No	No, budget issues for CCG	High UAC mentioned	GP access mentioned
Barking and Dagenham	Not known	Not known	No	Yes Kooth	Not known	Not known	Not known
Havering	Not known	Not known	Yes from ARC	Yes Silent Secret	No	No	Crisis vanguard 2016/17
Redbridge	Not known	Not known	Not known	Yes Kooth			Crisis vanguard model
Southwark	No	No – cite lack of funding	yes	No	No	No	Not known
Greenwich		Not known	Planned	Not known	No	No	Not known
Lewisham	No	Not known	Yes	Not known		Yes	SLAM reviewing this

Looking at the CCGs not meeting any targets, there are **no clear themes** to be derived from the LTPs. Some CCGs however lack a single point of access (SPA), lack joint working with councils and also do not explicitly mention provision for LAC. There seems to be a **provider theme**, with SLAM boroughs and NELFT the providers featured in CCGs not meeting targets.

CCGs >30% met on SDCS but not the MHSDS

	Data flow	SPA Flexible pathway no silos	Schools work	Online data resources	Pooled budgets with LA	LAC bespoke	Crisis services and A&E
Islington	Brandon centre has N3 access	Planned	Yes well established	Not stated	no	no	NCL initiative underway
Haringey	Aim to integrate all end 17/18	Planned with Barnet and Enfield	Link pilots yes	None stated	yes	Not mentioned	Planned to improve
Kingston	No mention	yes	yes	Yes Kooth	no	no	Increased use of A&E
Merton	No mention	yes	yes	No?	no	no	Not known
Richmond	No mention	yes	yes	Planned	no	no	Not known
Wandsworth	Seems good	no	yes	no	no	no	No mention

Looking at the CCGs meeting the one off SDCS but not the MHSDS targets, they all seem to have established schools work, but lack the features of others not meeting targets such as dedicated LAC provision and lack of joint working with their councils. The **provider theme** here seems to be SWLStG in SWL.

CCGs >30% met on both SDCS and MHSDS

	Data flow issues	Use VCS	SPA Flexible pathway no silos	Schools work	Online data resources	Pooled budgets or joint work with LA	LAC bespoke	Crisis services and A&E
Barnet	2016-17 over-reporting issues 20%		no	Yes	Yes Xenzone	Yes with Families first, YOS and PRU	Not mentioned	Stated aim
Sutton	Off the record? data		no	Training underway	no	Yes with schools	no	Added nurse St Helier
Central/Westminster				Yes CAMHS located there	Yes Kooth	no		
West/K&C				Yes trained	Yes Kooth			NWL collective
Tower Hamlets				Yes link pilots				

Looking at the CCGs meeting their targets, the providers seem truly mixed, so systems rather than providers may be the more dominant factor.

Annex B - qualitative interview details

More detailed information from **boroughs meeting the targets** - set out in the table below

Borough	CAMHS criteria strict?	Data flow from VCS	VCS	SPA	Schools	Digital platform	Good joint work with LA	LAC and CJS and PRU	Crisis services	Strengths	Possible gaps
Wandsworth SWL (SDCS only)	Yes, difficult for on the cusp i.e. high needs Tier 2. Trying to find added underspend to fund this grey area.	No. will do so by the end of 2017/18. This means that the current data cuts are likely to underestimate access. Place2Be to flow by end of year, Catch 22 too small. Place2be will flow direct to NHS digital and quarterly also to commissioner	Yes, Place2Be in primary schools and Catch 22 secondaries **Have a full directory** kept up to date of community resources	yes	Yes – see VCS.	Not yet, but meeting soon to discuss trailblazer funding	Yes. Strong links with educational psychology, work underway to make staff teams across CAMHS and council more effective and work together better. There is also an under 5s CAMHS service staffed by SWL StG and funded by the LA	There is dedicated LAC provision comprising clinical psychology and primary mental health as well as intensive intervention. Yes, joined up provision for YOS has MH liaison workers. Embedded in the LA.	Yes being increased. Currently have CAMHS liaison from 9am to 8pm, adult MH covers from 8pm to 9am. There is also adolescent specialist outreach who can provide home treatment. And divert children from Tier 4.	They have mapped all the community resources to direct people to if they aren't eligible for CAMHS – increases the option for children (2000 refs per year, of which 350 accepted) – this describes tiers 1-3 and emergency department.	Need more Tier 2 work: children developing harmful sexual behaviours, more in special schools, and for children in contact with CJS Crisis system good but could be slightly better joined up.
Central (Westminster) NWL	-	yes	Yes	Yes	Yes MIND	Yes Kooth	Yes although LA budgets reduced	all	Yes	Good schools work	Need incr crisis provision
West (K&C) NWL	-	yes	Yes	Yes	Yes MIND	Yes Kooth	Yes although LA budgets reduced	all	yes	Good schools work	Need incr crisis provision
Hammersmith & Fulham	-	yes	Yes	Yes	Yes MIND	Yes Kooth	Yes although LA budgets reduced	all	none	Good schools work	Need crisis services (none currently)
Tower Hamlets NEL	Reasonable, and helped by 'Tier 2.5' service by VCS	not to NHS digital, planned for end of 2018 calendar year	Yes, Step Forward and Docklands two main providers	Yes, provided by ELFT. No self refers to CAMHS	Yes incl CWP	none	Yes, robust S75, and joint commissioning framework planned, good co-location	Yes to PRU, CJS and LAC	Currently 9-5 (9-7 one day), with hospital RAID team covering OOO. Plans to increase	Good work and relationships with council, good VCS esp Poplar Hasra, and Tier 2.5 services	Digital, and no self refers to CAMHS
Merton	yes	Not electronically. Flow to commissioner manually who enters into system. Due for re-commissioning so nfa until then. Off the Record plan to do anyway	Yes, several. Off the Record, Wish Foundation (self harm), NSPCC for CSE. **No directory yet but planned**	Yes well regarded, well resourced team 8.30am to 5pm, plan to extend hours.	Yes, have TAMHS in n=18 schools. Further mitcham cluster plan commission Place2Be	Some online via Off the Record counselling	Yes, joint work and embedded Tier 2 posts in council. Integrated commissioning pilot planned	Yes, L&D forensic role No specific LAC post Good PRU provision	Could be increased	SPA fully staffed and do assessment (1 SPA, 0.8CBT, 0.4 SpR, 0.6 VC, 1WTE psychologist)	Slightly fragmented arrangements with schools not communicating their plans

Common themes from qualitative interviews in areas meeting the targets

- Directory of community resource for children not meeting thresholds, increasing the options
- Need increased crisis services to cover a 24 hour period (not just 9-5pm)
- Need more capacity inTier 2 interventions
- Commissioning oversight needs to link all parts of system incl schools
- Even boroughs meeting their targets aren't all 'flowing' data so would expect a step change increase from Q3 2018-19 when those systems will come into force.