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.

1.3. 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.

1.4. 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)
- 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).

1.5. 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.

1.7. 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.

NCL Prevalence Data

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] Cavendish Square Group

[2] Centre for Mental Health and London School of Economics

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. We have agreed a shared dataset in order to provide a consistent approach across NCL to facilitate benchmarking and data aggregation to support planning across the Sustainability and Transformation Plan (STP) area.

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 have agreed 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 (Achieved)
- Agree a set of KPIs to form an NCL CAMHS dashboard to support monitoring of the impact of Transformation Plans.
- Agree a methodology for recording RTI and RTT waiting times from the perspective of the Child/Young Person based on NICE Guidelines and pending national guidance.

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. We are currently awaiting publication of national guidance which will hopefully provide a consistent methodology across England.

Key Milestones

- Development of Dataset (Completed)
- Agreement of Dataset with Providers (Completed)
- Implementation of Dataset (Partially Completed)
- Reporting on Dataset (Initiated but not currently full implementation with all providers)
- Development of an NCL CAMHS Dashboard (2017/18)
- Waiting Time Reporting (Pending national guidance)

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 two Mental Health Trusts and an Integrated Care Organisation 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 NHS 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.

3.5 This piece of work will also facilitate a timely discussion across NCL commissioners as CYP IAPT funding tails off and CCGs will need to identify funding locally to continue to support and embed CYP IAPT training.

Key Milestones

- Secure funding – July 2017 ***completed***
- Appoint resource to conduct mapping – August 2017 ***completed***
- Completed mapping to be produced for NCL Commissioners – December 2017 ***on track***
- Wider stakeholder engagement – January 2018
- Completed workforce plan – January 2018

Funding

3.5 Commissioners have secured funding from the STP workforce work stream with some additional funds from the STP Mental Health Work stream to fund this piece of work.

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

4.1 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. In July 2015 NHS England published "Access and Waiting Time Standard for Children and Young People with an Eating Disorder". The initial phases of transformation for NCL focused on improving data recording and reporting, investing in additional specialist staff to meet gaps in capacity and reducing waiting times.

4.2 Summary of Progress against priorities identified in Transformation Plans 2015.16 and 2016.17:

Table 1

	Priority	Summary of Actions to Progress	RAG Rating
1.	Increase capacity and reduce waiting times to meet key requirements of NICE Guidance	Additional staffing across MDT achieved-see below Waiting Times Targets	**Achieved**
2.	Outreach education training for eating disorders to primary care health and education staff	Two training sessions held – one for primary Care and one for Schools-30 attendee's Requires additional focus	**Partially achieved**
3.	Offer telephone support for General Practitioners	Is available but requires further evidence of wider knowledge by GP's	**Partially achieved**
4.	Improved performance monitoring and management	Quarterly performance reports and contract meetings taking place Disaggregation of Urgent and Non-Urgent cases Outcomes data routinely captured and reported Length of stay in Intensive Eating Disorder Service reported	**Achieved**

Performance against Eating Disorders Service Waiting Times and Access Targets:

Table 2

CCG	Year of Performance	NCL Targets for Eating Disorders Service-Waiting Times RTT Non-Urgent/Urgent	Performance < 4 weeks RTT non-urgent	Performance RTT < 1 week urgent
All NCL CCGs	**2014.15**	Baseline Year	54.0%	Not Known
	2015.16	60%	69.2%	No Target
	2016.17	80%/95%	85%	100%
	2017.18 Q1	90%/95%	100%	100%

Summary of Service Activity

Table 3

Referrals for all five boroughs 2015.16, 2016.17 and 2017.18 Q1		
CCG	**Number of referrals received**	**Number of referrals accepted**
All NCL	181	171
All NCL	141	127
All NCL	37	36

<u>Phase 3 of Eating Disorders Transformation</u>

4.3 We have engaged with our provider and identified key themes from patient/family feedback user feedback (children and families) in order to refresh our understanding of current baseline of provision and move the transformation planning beyond waiting times standards. As a result of this and findings from 2017 CQC inspection of RFL EDS has now relocated to new premises with additional clinical rooms, a larger waiting area and additional office space.

4.4 To support our planning process and identify the next phase of transformation Healthy London Partnership (HLP) asked hospitals and community providers to complete a self-assessment tool to reflect the eating disorder service they provide. The outcomes for NCL covering eight themes reported in July 2017. This along with discussion with providers, clinical partners and families have informed our new priorities as set out in Table 4:

Table 4

RFL Eating Disorder Service	RAG	NCL Local Transformation Plan-Priorities 2017.18
Co-morbidities management		Links with community paediatrics to be improved Care pathways with generic CYPMH
Needs and provision		
Evidence based care		Primary Care partnership working
Community model		Additional training for schools and primary care

NICE Concordant treatment standard		Engage with peer review through QNCC
Engagement with CYP, families and carers		Self-referral for families to be considered Signposting and navigation for families and professionals to access support
Demonstration of evidence based care		Engage with peer review through QNCC
Transition and partnership working		

Appx 1: Workforce

Workforce Capacity NCL/RFL Eating Disorders Services: Roles	***Grade***	***+Transformation Funding additional WTE Eating Disorders***
Clinical Psychologist	***7***	***0.30***
Clinical Psychologist	***8a***	***0.60***
Family therapist	***8a***	***0.60***
Psychotherapist	***7***	***0.50***
Reception/Med sec	***3-5***	***.40***
Dietician	***7***	***.40***
Staff Grade Doctor		***.60***
Nursing outpatient	***6***	***.27***

Priority 4 - Perinatal Mental Health and Children's Social, Emotional and Mental Health

A Rationale for joint priority across NCL

5.1 The Five Year Forward View for Mental Health3 is clear in its objective that specialist perinatal mental health services should be available for all women and their families who need them. One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have long-standing effects on children's emotional, social and cognitive development. Costs of perinatal mental ill health are estimated nationally at £8.1 billion for each annual birth cohort, or almost £10,000 per birth.

5.2 The commissioners and providers in North Central London Sustainability Transformation Plan (STP) for Barnet, Enfield, Haringey, Camden and Islington, have been working in partnership to deliver a specialist community perinatal mental health service to provide care for women with severe or complex mental ill health during the perinatal period.

5.3 Specialist perinatal mental health services are established to serve the needs of women who are likely to require management of their mental illness during pregnancy or in the postpartum period (usually up to one year post-delivery).

5.4 Commissioners and providers worked together to secure funding for a specialist perinatal mental health service that will provide equity of access and consistency of provision across the five boroughs. North London Partners' vision is that all women and their families in North London Partners who experience mental health problems during pregnancy or the postnatal period will have access to appropriate, timely, consistent, high quality, universal and specialist health care. These services will be integrated into existing mental health, local authority, women's and children's services.

B. Our Ambition:

5.5 It is therefore important for children services, particularly CAMHS services (parent and infant) and early support services (Homestart, Family Nurse Partnership, etc.), link with their perinatal mental health services, health visiting and children's centres and other children services to identify women with low to moderate mental health difficulties.

5.6 Overall our ambition is to improve the perinatal mental health service in NCL in order to establish:

- An NCL wide perinatal mental health service,
- Provision of perinatal mental health services that ensure equitable access across the STP footprint.

C. What we are aiming to achieve across NCL:

5.7 The perinatal recommendation in the Five Year Forward View for Mental Health is that NHS England should invest to ensure that by 2020/21 at least 30,000 more women each year access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

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[3] Mental Health Taskforce report to NHS England (2016) The Five Year Forward View for Mental Health

5.8 Around 2,000 – 3,000 women in NCL experience less severe illnesses whilst around 1,000 women a year in NCL are likely to have a complex or severe mental health condition for example psychosis, chronic serious mental illness, severe depressive illness or post-traumatic stress disorder. These conditions have a potentially serious impact on mothers, babies (including their future development) and their families.

5.9 The North Central London (North London Partners) Partnership was successful in bidding to NHS England's Perinatal Mental Health Community Services Development Fund. The partnership brings together the three mental health providers in the North Central London (North London Partners) Sustainability and Transformation Plan (STP) area - Barnet Enfield and Haringey NHS Mental Health Trust (BEH), the Tavistock and Portman NHS Foundation Trust (T&P), and Camden and Islington NHS Foundation Trust (CIFT) - to provide services across the five North Central London (North London Partners) boroughs of the STP (Camden, Islington, Barnet, Enfield, Haringey). BEH and CIFT will deliver clinical services; T&P will support training.

5.10 An important priority for all CAMHS services is to have links with NCL Perinatal Mental Health Team and relevant early year's children services in order to improve the care pathway for women experiencing mental health problems during the perinatal period.

D. Current picture:

5.11 Approximately one in five mothers experience mental health problems (4,000 women in NCL) during pregnancy and the first year after child birth. Whilst this is an adult service the mental health of the mother has a profound impact on the baby and its future social, emotional and mental health. The following table shows the number of births by borough and the estimated rate of mental health conditions.

2016/17 Births		**Barnet 5382**	**Enfield 4545**	**Haringey 4281**	**Camden 2658**	**Islington 3093**	**NCL 19959**
Disorder	% women affected	Expected cases	Expected cases	Expected cases	Expected cases	Expected cases	Expected cases
Postpartum psychosis	0.2%	11	9	9	5	6	**40**
Chronic serious mental illness	0.2%	11	9	9	5	6	**40**
Severe depressive illness	3%	161	136	128	80	93	**599**
Mild-moderate depressive illness	10-15%	538-807	455-682	428-642	266-399	309-464	**1996-2994**
Post-traumatic stress disorder	3%	161	136	128	80	93	**599**
Those who require SCPMH support	5%	269	227	214	133	155	**998**

5.12 There is a limited specialist perinatal mental health community service offer across NCL. In the northern boroughs of NCL no specialist team exists; in the southern boroughs

there is some provision but it is below national standards, in terms of length of treatment available and type of care available. Most women with complex needs currently access support through parent infant mental health services, psychology services and non-specialist liaison mental health services in the acute hospitals. They receive care from non-specialist teams, which is outside of best practice and guidance, due to this the numbers seen in these services is also difficult to quantify.

E. Key Stakeholders

5.13 We are working with a wide range of key stakeholders including:

- Mother and Baby Units
- Child & Adolescent Mental Health services e.g. parent and infant mental health services
- Health Visiting services
- Adults and Children's Safeguarding services
- Children's and Family Social Care
- Children's Centres/Family Hubs/Early Years Centre
- Early Help Services
- Service Users organisations
- Voluntary sector e.g. Homestart, Coocoon
- Accredited faith organisations

F. Model of Service Provision

5.14 The service aims to focus on women with severe or complex mental illnesses, equating to around 5% of women giving birth in NCL. However, this service is currently only resourced to reach approximately 3% of the target population, plus consultation work to improve the response of other health services to women affected by perinatal mental illness. This therefore equates to an estimated 630 women per year in NCL being supported when the service is fully implemented.

5.15 The service will undertake triaging, signposting of referrals, psychiatric assessments, treatment and care of individuals with severe mental illness during the antenatal period and for up to one year postnatally.

5.16 The table below shows the number of women expected to be seen by the service each quarter.

	2017/18					2018/19				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Number of women seen	50	100	125	125	**400**	150	150	150	150	**600**

G. Funding

5.17 The new NCL Perinatal Mental Health Service is funded by a mix of the CSDF allocation CCG monies. The following sets out two potential approaches to CCG funding of Wave 1 service and if the NCL partnership is successful in Wave 2 CSDF bid.

5.18 Option 1 Divide costs equally between the five CCGs, the additional annual cost to each CCG from 20/21 becomes £98,904.

Funding Source	2019/20 Wave 1 costs	20/21 Wave 2 costs	20/21 Combined wave 1 and wave 2 costs
Barnet CCG	£206,054	£98,904	£304,958
Camden CCG	£206,054	£98,904	£304,958
Enfield CCG	£206,054	£98,904	£304,958
Haringey CCG	£206,054	£98,904	£304,958
Islington CCG	£206,054	£98,904	£304,958
NHSE Perinatal Fund	£466,338 (wave2)	£0	£0
Total	**£1,496,608**	**£494,522**	**£1,991,130**

5.19 Option 2 divide the costs by predicted births is followed, the additional annual cost to each CCG from 20/21 becomes:

Funding Source	2019/20 Wave 1 costs	20/21 Wave 2 costs	20/21 Combined wave 1 and 2 costs
Barnet CCG	£277,815	£133,349	£411,164
Camden CCG	£137,204	£65,857	£203,061
Enfield CCG	£234,610	£112,611	£347,221
Haringey CCG	£220,982	£106,070	£327,052
Islington CCG	£159,658	£76,635	£236,293
NHSE Perinatal Fund	£466,338 (wave2)	£0	£0
Total	**£1,496,607**	**£494,522**	**£1,991,130**

H. Key Milestones

1. Each CCG to ensure that all relevant children's' stakeholders are known to the new NCL Perinatal Mental Health Team.
2. Each CCG to identify gaps in early years support e.g. Parent Infant Mental Health Services.
3. Close programme work in March 2018.

I. Link to Key Policy

Mental Health Taskforce Report to NHSE (2016) Five Year Forward View for Mental Health.

Prevention in mind: All Babies Count. NSPCC. 2014.

Bauer, et al. Costs of Perinatal Mental Health Problems. LSE. 2014.

Priority 5a: Crisis and Urgent Care Pathway

6.1 **Rationale for joint priority across NCL:**

CAMHS crisis care is a focus area within Future in Mind, the Five Year Forward View, the Crisis Concordat, the HLP Children's Programme and expected national guidance currently in DH gateway:

- NHSE required assurance from CCGs that refreshed CAMHS Transformation Plans include a plan for extended hours community provision, to be available from April 2017, as phased implementation of 24/7 cover for children and young people
- FYFV requires NHSE to deliver effective 24/7 mental health crisis resolution and home treatment teams to ensure a community based mental health crisis response is available in all areas and are adequately resourced to offer intensive home treatment as an alternative to acute admission. An equivalent model for CYP (children and young people) should be developed within this expansion programme
- Provision of crisis response is closely linked to the implementation of the all age Health Based Place of Safety specification and section 136 pathway as stipulated by the Crisis Concordat
- Healthy London Partnership children's programme issued guidance setting out a pathway for rapid response and de-escalation of crisis not solely reliant on acute hospitals
- National guidance is setting out requirements for progress to 24/7 crisis response is to be issued shortly

The development of out of hours crisis has been included in the CAMHS work stream of the NCL mental health STP programme as it is a service which, to achieve sufficient economies of scale and maximised effectiveness and efficiency, would work best across an NCL-wide population.

6.2 **Our ambition**

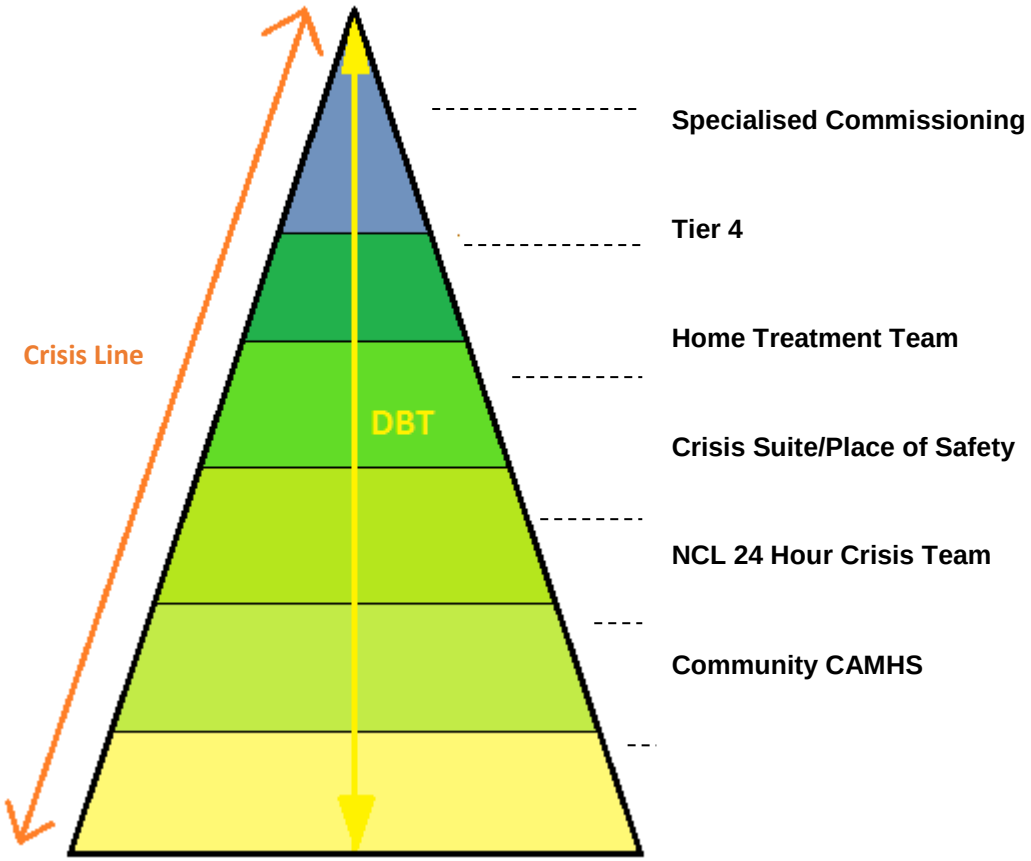
- To improve the service to young people in crisis in the NCL area i.e. to:
  - Improve access to care; and
  - Improve experience of care
- To meet the national guidelines and best practice guidance for crisis as much as practically possible
- To provide a service within budget
- To provide a safe service both for patients and staff
- To provide a service that integrates with the ST rota, paediatrics, A&E departments and local CAMHS in a co-ordinated way
- To have a service that covers the whole STP area
- To have an equitable service across the STP area
- That assessments are completed in partnerships with relevant providers e.g. the LA and at a time and place that ensures a safe and consistent assessment throughout the 24 hour period.

6.3 **What we are aiming to achieve across NCL:**

NCL will develop a local integrated pathway for children and young people with higher tier mental health needs which includes rapid community-based and out-of-hours responses to crisis. There will be an investment in training for the crisis response team, with a focus on Dialectical Behaviour Therapy (DBT) as the core treatment modality. 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. NCL will work closely with Specialised Commissioning and jointly with Health & Justice Commissioners to develop local integrated pathways including transitioning in or out of acute, specialist and secure settings. Over the lifespan of the LTP programme until March 2021, the aspiration of NCL is to develop a comprehensive acute care pathway for children and young people experiencing a mental health crisis. The development of the acute care pathway will occur in phases as additional LTP investment comes on stream and savings are realised through Tier 4 devolution. This is an iterative programme of work due to long term ambitions of services to meet the needs of those young people in crisis.

CAMHS Acute Care Pathway – a whole system approach to crisis care



6.4 **Current picture**

In NCL there is variable day time crisis care with some CCGs having active outreach services into A&E and the community, and others less able to provide outreach, often for complex reasons such as funding, staff recruitment and retention. Additionally the out of hours crisis response across the sector is extremely variable with the hospitals in the south of the borough having access to a comprehensive psychiatric registrar rota, but the service in the north unable to access this level of support. Commissioners and providers from across NCL have therefore been collaborating closely to develop a model based on new guidance and drawing on good practice examples from elsewhere.

6.5 **Key Stakeholders**

- Young people and their families
- Accident and Emergency departments
- Paediatrics
- CAMHS
- Senior Psychiatric trainees on the rota
- Social Care / Emergency duty teams
- Bed managers

6.6 **Possible models of service provision**

In order to develop a model that meets as much of the vision as possible, the proposed model will need to work within a set of parameters, which include:

- The financial envelope
- Keeping staff and patients safe
- Having a service that is accessible to the whole NCL
- Having a service that has the capacity to ensure that children and young people are enabled to be kept safe and secure until the morning or when a full and timely assessment can be completed if not possible immediately
- Interface with current, and any new arrangements for the collaborative commissioning of local CAMHS Tier 4 provision

Commissioners and providers have developed six possible service models. Further work will be undertaken to cost each of the models, following which the NCL CAMHS Project Board will agree on three models to take to wider consultation. This will ensure that all the risks and challenges as well as the opportunities each model provides have been considered, and provide a greater understanding of all stakeholders' preferences in order to reach the most viable model to take forward. The overview of the models set out below identifies initial risks and benefits as a starting point to invite comment, challenge and support to take this process forward. To ensure that proposals are developed in a timely manner, local discussions to agree lead or consortium provider arrangements will run concurrently with the consultation. Once the consultation process is complete, the preferred model will be fully developed, with a view to a service launch in April 2018.

Alongside the development of the NCL-wide crisis service, opportunities to further enhance the model will be explored. This includes through the HLP-led work on health-based Places of Safety and opportunities provided through the Crisis Care Concordat 'Beyond Places of Safety' capital funding programme.

The role of the NCL CAMHS Project Board in overseeing this work ensures that commissioners and providers work collaboratively with service users and that there is service user challenge and oversight as proposals are developed.

6.7 **Key milestones**

- Costing of six service models – October 2017
- Selection of three service models for wider consultation – October 2017
- Consultation on three possible service models – November to December 2017
- Agreement of preferred service model – December 2017
- Development of service and recruitment of staff – January to March 2018
- Proposed launch date – April 2018

6.8 **Funding**

The five NCL CCG's have identified a total budget of £500k to invest in an NCL-wide out of hours CAMHS crisis service and have invited providers to work closely with them to develop a service.

	Description	Benefits	Risks	Recommendation
Model 1	Increase investment to all outreach services and then they commit to staffing an out of hours cover that is central. Investment in each team would be in region of £100k which would allow for provision of additional Band 7 and Band 6 sessions with associated overheads Cost: £100K investment would allow for a 0.75 band 7 and a 0.7 band 6 per CCG area	• The service would be very well linked in with current CAMHS provision, with existing members of staff providing the cover • Staff would be likely to have a good understanding of services available locally for onward referral and liaison The provision would be within budget • Could be relatively quick to implement	• Currently the daytime crisis services across NCL are all different, with some understaffed and unable to provide daytime cover or outreach consistently • If the whole team are to be included, including existing staff there will need to be significant changes to terms and conditions and there will need to be a budget for unsociable hours for existing staff • Spreading the shifts across 24 hours may reduce daytime cover in some areas • One service would need to take on the rota and governance aspects which will require additional funding • The team would draw on a large number of potential staff across the NCL region which makes it more difficult to create a cohesive team (team meetings, training etc.) • The service would be disjoined and not an NCL service • There is currently such inequity across the day time services it would be very difficult to implement	• Not Viable - would not provide an NCL wide service
Model 2	Out of hours cover staffed by nurses and in a central base, which would require eight Band 7s and eight Band 6s to provide adequate cover for the	• This is the most comprehensive model and it meets the NHS E and HLP recommendations • The team will function as a proper team, as they will all be dedicated to the service	• The model is beyond the budget • The team may feel isolated from the day time crisis cover arrangements, though over time these would develop • There may be recruitment and retention difficulties owning to the unsociable hours	• Not Viable - too expensive, but remains something that we could aspire to achieving if we are able to reinvest Tier 4 savings following devolution of T4 budgets

	16 shifts needed across the week Cost: £1,295,230.66	• The team would develop a good knowledge of the local crisis pathways • The team will develop good working relationships with the ST group and the A&E departments Could be relatively quick to implement but not as quick as model 1	• Setting up a first class service during the night is too expensive and will encourage use of out of hours rather than day time	
Model 3	Twilight out of hours cover only i.e. 4pm to midnight plus weekends would need four Band 7s and four Band 6s Cost: £647,615.33 for clinical staff only	• The team would be able to develop as a coherent team The model is affordable • Could be relatively quick to implement but not as quick as model 1	• The model does not meet the NHSE and HLP guidelines for 24 hours cover • There may be recruitment and retention difficulties owing to the unsociable hours	• Recommendation: take forward to consultation
Model 4	Model 3 plus a nightshift person providing telephone advice to get through the night safely Cost: £734,583.37 for clinical staff only	• The team would be able to develop as a coherent team • The model is affordable • The model would meet the current guidance • Could be relatively quick to implement but not as quick as model 1	• There would be a member of staff on their own from midnight to 9 am, who would have access to the ST rota, but would be working on their own • There may be recruitment and retention difficulties owing to unsociable hours and the lack of team for the later shift • It may be difficult to find cover for illness and leave • There would need to be a service who organised the rotas and managed this process	• Not Viable - too expensive
Model 5	Bring together the resources dedicated to	• The model is affordable	• It's a radical change and would need sign up from all providers and CCG's	• Not Viable – not costable

	crisis and outreach across all 5 CCGs and invest in this team, to be able to cover 24 hours and have them located in one base in the NCL region Cost: not possible to cost	• Staffing the night shifts would be easier as there would be a larger pool to draw upon • The team would have good knowledge of the services available right from the start • It would be a fully 24 hour support rather than an 'add on' which would better ensure that the service YP receive would be the same whatever time of day they access it • This model would allow the service to respond more flexibly to spikes in need arising across the footprint, both in and out of hours	as it could be experienced as a loss in some areas. The team would need to be physically located in one of the CCG areas and this may cause tension across the services • It would mean significant changes to terms and conditions as one provider would need to host it • It might take longer to configure owing to the nature of the changes proposed • Degree of change is too great to achieve in the timescales.	
Model 6	Twilight and weekend (9am to midnight) cover provided by Band 6s with Band 7 leadership, integrated into Paediatric Liaison team. Nightshift covered by on-call junior doctor. Costs £647,615.33 for clinical staff only	• The team would be part of an established team within a pre-existing base • The model is affordable (1 shift covering each twilight shift and 2 shifts covering each weekend day shift - 11 shifts needed across the week)	• There is no nursing cover on the nightshift • There may be recruitment and retention difficulties owing to the unsociable hours and the lack of team for the twilight shift	• Recommendation: take forward to consultation

Priority 5b: Collaborative Commissioning proposal of Tier 4 beds and Place of Safety.

Rationale for a joint propriety across NCL

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.

Our ambition

- Improve quality and reduce variability of Tier 4 experience for our patients
- Reduce distress to young people
- Reduce length of stay for a significant proportion of young people
- Smooth transition in and out of Tier 4, including reduced waits for CYP to access Tier 4 beds when required
- Improve Outreach/Crisis team quality and efficiency

Current picture

6.2 During 2016/17 two bids were submitted to NHSE under the New Models of Care programme for the development of NCL-wide arrangements for the co-commissioning of CAMHS Tier 4. Unfortunately both bids were unsuccessful, with feedback from NHSE indicating that the proposed models were not sufficiently ambitious or transformative and that a wider footprint, beyond NCL boundaries should be considered.

6.3 Looking beyond NCL, North East London (NEL) is the only other STP area that has not developed local commissioning for Tier 4, therefore it is logical to consider the development of a proposal that covers both areas. In addition, between both STP's there are a full range of Tier 4 beds including PICU and low secure, improving the sustainability of localised plans; in NCL there two NHS general adolescent CAMHS Tier 4 units (The Beacon and Simmonds House) and a NHS regional unit (GOSH / Mildred Creek); in the NEL there are two NHS Tier 4 units (Brookside and The Coburn), one of which also includes provision of new additional PICU beds for London. NHSE have indicated that private units within the STP footprint are out of scope; Priory North London is already covered within the NW London New Models of Care arrangements and Ellern Mede is a highly specialised provider meeting specific needs at a national level.

Updated CAMHS specialised inpatient service review analysis data for NCL STP

6.4 Following the London region CAMHS specialised inpatient services review which took place in 2017, the following usage analysis for 2016/17 has been shared with NCL commissioners:

NCL Tier 4 CAMHS Admissions

Data Source	NHS E					HLP			NHS E		
Year Location	2013-14 London	2014-15 London	15-16 London	15-16 Out of London	15-16 Total	15-16 London	15-16 Out of London	15-16 Total	16-17 London	16-17 Out of London	16-17 Total
Barnet est popn 2016 aged 0-18 **90,336**(ONS 2017)											
Admission	**33**	**39**	34	7	**41**	35	6	**41**	24	38	**62**
LOS London	**1,923**	**2,220**	2,740	749	**3,489**	2,852	735	**3,587**	2,994	2,013	**5,007**
Cost	**£958,686**	**£1,007,955**	£1,595,878	£467,354	**£2,063,232**	£1,597,062	£459,307	**£2,056,369**	£1,706,293	£1,435,152	**£3,141,445**
Av Cost	**£499**	**£454**	£582	£624	**£591**	£560	£625	**£573**	£570	£713	**£627**
Camden est popn 2016 aged 0-18 **47,642** (ONS 2017)											
Admission	**5**	**19**	9	14	**23**	11	10	**21**	11	19	**30**
LOS London	**650**	**1,218**	701	1,064	**1,765**	1,049	1,021	**2,070**	1,290	1,839	**3,129**
Cost	**£143,739**	**£601,102**	£630,340	£663,904	**£1,294,244**	£631,263	£645,020	**£1,276,283**	£717,112	£1,202,571	**£1,919,683**
Av Cost	**£221**	**£494**	£899	£624	**£733**	£602	£632	**£617**	£556	£654	**£614**
Enfield est popn 2016 aged 0-18 **83,773** (ONS 2017)											
Admission	**20**	**23**	5	6	**11**	4	5	**9**	8	12	**20**
LOS London	**1,187**	**1,165**	185	213	**398**	473	207	**680**	1,543	1,039	**2,582**
Cost	**£663,675**	**£625,566**	£291,389	£132,906	**£424,295**	£291,389	£174,103	**£465,492**	£1,137,356	£679,074	**£1,816,430**
Av Cost	**£559**	**£537**	£1,575	£624	**£1,066**	£616	£841	**£685**	£737	£654	**£703**
Haringey est popn 2016 aged 0-18 **61,480** (ONS, 2017)											

Admission	**22**	**16**	10	4	**14**	9	2	**11**	11	23	**34**
LOS London	**1,331**	**1,532**	435	151	**586**	833	148	**981**	1,383	2,343	**3,726**
Cost	**£679,371**	**£821,833**	£500,394	£94,219	**£594,613**	£500,394	£90,018	**£590,411**	£896,881	£1,533,881	**£2,430,762**
Av Cost	**£510**	**£536**	£1,150	£624	**£1,015**	£601	£608	**£602**	£649	£655	**£652**
Islington est popn 2016 aged 0-18 **40,819** (ONS 2017)											
Admission	**13**	**17**	7	2	**9**	7	3	**10**	12	18	**30**
LOS London	**697**	**1,591**	857	81	**938**	1,234	81	**1,315**	2,607	1,661	**4,268**
Cost	**£142,332**	**£810,165**	£786,502	£50,542	**£837,043**	£786,502	£53,600	**£840,102**	£1,606,839	£1,088,294	**£2,695,133**
Av Cost	**£204**	**£509**	£918	£624	**£892**	£637	£662	**£639**	£616	£655	**£631**
NCL est popn 2016 aged 0-18 **324,050** (ONS 2017)											
Admission	**93**	**114**	65	33	**98**	66	26	**92**	66	110	**176**
LOS London	**5,788**	**7,726**	4,918	2,258	**7,176**	6,441	2,192	**8,633**	9,817	8,895	**18,712**
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**	£6,064,481	£5,938,972	**£12,003,453**
Av Cost	**£447**	**£500**	£774	£624	**£727**	£591	£649	**£606**	£618	£668	**£641**

Nb. The numbers of admissions includes where an individual child / young person was admitted to multiple units as a result of changing need; the total number of placements will consequently be higher than the total number of children and young people placed in Tier 4.

What we are aiming to achieve across NCL

6.5 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 with 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.

6.6 NCL have been asked by NHSE to consider developing a proposal outside of the new care model programme, and they have indicated that they are supportive of local providers and commissioners commencing discussions regarding this, ahead of formal joint working on a proposal with Specialised Commissioning from April 2018.

6.7 NHSE have suggested that NCL providers and commissioners develop a plan to run the service for the first one or two years as a shadow arrangement with NHSE, which would limit the financial risk. Any proposals should be developed in the context of improved outreach and crisis care arrangements with the aim of reducing the number of Tier 4 beds that were needed; NCL commissions and providers are keen to ensure that a proportion of any savings achieved in a reduction in Tier 4 admissions and/or lengths of stay are reinvested in local crisis and outreach services.

6.8 As with crisis care, the role of the NCL CAMHS Project Board in overseeing this work ensures that commissioners and providers work collaboratively with service users and that there is service user challenge and oversight as proposals are developed. A working group of providers, commissioners and service users will be convened to take this work forward and interim project management support will be provided to support this

Funding

6.9 The project would need to be administered and managed and NHSE have indicated that a budget of £200k is required for this. NHSE have stated that they would be prepared to contribute 50% of the funding on a match-funding basis; the remaining £100k would be funded by the participating CCGs, which would amount to approximately £8.3k per CCG for the 12 CCGs in the combined NCL/NEL STP footprint.

Key Milestones

- Build relationships with providers and commissioners across the wider NCL/NEL footprint; align NEL and NCL STP priorities in relation to CAMHS Tier 4; establish levels of need and activity baselines across the wider footprint; begin options appraisals of possible alliance / consortium models; commissioners and providers develop outline proposals across the NCL/NEL STP footprint in preparation for formal project development – October 2017 to March 2018
- Commence formal project development with NHSE Specialised Commissioning – April 2018
- Commence delivery of shadow place-based commissioning of CAMHS Tier 4 – April 2019

Links to key policies and initiatives

Linked to key policies and initiatives:	Aims
Five Year Forward View	• By 2020/21 in-patient stays for CYP will only take place where clinically appropriate with minimum possible LOS and close to home. • NHS England will transform the model of commissioning so that general IP units are commissioned by localities on a place basis (e.g. STP or ACO?) • Total bed days in CAMHS tier 4 per CYP population will be a metric monitored in IP paediatric wards

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, Education and Treatment Reviews (CETRs) 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, Education 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 has been 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 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 becomes 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, Education 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. In order to support this, we are looking at developing a joint post across NCL to facilitate the CETRs.

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. We are currently completing a full workforce audit of 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 is quite rare, providing an ability to call on a wider workforce mean that specialist expertise is 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 CETR processes.

VIII. Capital and Housing

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

IX. Transition

7.12 Children's Commissioners will be working with adult commissioners to improve transition arrangements and joint planning where CETRs are requested for young people approaching adulthood, and young adults.

Key Milestones

- Establish consistent process for admission avoidance register (Completed)
- Improve data through work with providers to record LD/ASD and through better use of and profile of admission avoidance register (Partially Completed)
- 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 (Partially Completed)
- 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

7.13 We are awaiting feedback from our Transforming Care bid for the development of an intensive behaviour support service, we are also looking at investing local CAMHS Transformation funding in this area in the event that the bid is unsuccessful. 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, Education and Treatment Review: Policy and Guidance - https://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf

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

Our ambitions

9.1 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.

9.2 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

9.3 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.

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

9.4 The partnership brought together clinicians together from existing services, identifying resources to ensure CAMHS and Advocacy support was 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 was viewed as the first step in improving available support DH made funding available to support a one year pilot of providing CAMHS and Advocacy into these pathways ending in April 2017.

- **Development of the Child House Model**

[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

9.5 The ambition is to build on existing good practice both local and international, to pilot a Child House in NCL. Following the development of this initiative, we would envisage a reduction in service demand on tier three CAMHS, and reduced wait times, through early intervention to minimise the risk of severe and enduring mental health 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

9.6 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.

9.7 Early intervention emotional support services were 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.

9.8 In the North Central Sector:

- CSA medical examinations are being provided by two CSA Hubs at University College Hospital and St Ann's Hospital.
- CAMHS Commissioners (previously DH) funded an early intervention emotional support service for all children and young people accessing the CSA Hubs. The service is provided by the Tavistock and Portman and Solace Women's Aid, consists of 1 WTE CAMHS clinician and 0.8 WTE Child Advocate.
- A multiagency co-design workshop ran in March 2016 with more than 50 professionals attending. A smaller multiagency group developed the detail of the Child House model for the sector
- Engagement with children and young people is ongoing with consultations conducted with Barnet Youth Board, Enfield Youth Parliament, and Islington In Care Council

9.9 Funding secured from MOPAC to support the development of two Child House Pilots in London has been reviewed and the project has been significantly delayed. NCL CAMHS Commissioners agreed to extend funding to this pilot using CAMHS transformation grant funding to bridge the gap between the end of the pilot and start of the NCL Child House pilot to ensure that there would be a seamless transition between service provision for this vulnerable cohort.

9.10 Having given consideration to the level of funding available and the demand and capacity modelling, it has been advised that the Child House Pilot project should proceed with a single Child House and NCL is the preferred location. Procurement documents are being prepared for the capital works and for a lead provider and it is envisaged that the service would go live in May 2018.

9.11 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 2017 – Invitation to tender for lead provider released
- October 2017 – Capital works start
- January 2018 – Contract award and implementation period
- July 2018 – NCL Child House opens

Funding

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

9.13 We are awaiting a confirmation of the final costed model for a single NCL Child House and assurances that costs for this pilot will be met with the allocated budget.

9.14 Work will need to be undertaken in consultation with NCL Commissioners to develop plans for sustainability should the pilot offer positive outcomes for Children and Young People.

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 Work stream

[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

Review of Progress 2017.18

10.1 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.

10.2 NCL has made significant progress in providing timely assessments and diversion from the CJ system and fast track into treatment or support. Supporting the mental health of young people coming to the attention of the Criminal Justice system is a priority identified with the local STP plans.

10.3 Each CCG area in NCL has a mental health Liaison and Diversion (LD) worker or is in the process of recruiting to an LD post based on the London model and recommended role description. In addition Barnet CCG has used targeted funding to recruit a WTE 0.8 Psychologist directly into the YOS team with clinical supervision provided through our local CAMHS service. NCL CCG's now have in place a

- Single local point of access for all YOS/CAMHS referrals
- Service design based on 'in-reach' and enhanced pathways to CAMHS for YOS and strengthening pathways into specialist CAMHS

10.4 By the end of 2017.18 we are confident that we will be offering a mental health assessment to every young person at second appointment in YOS to support a reduction in re-offending and/or escalation of offending behaviours. We are measuring outcomes using YJS performance indicators but some areas still need to make progress in reporting outcomes through the MHMDS, this will be in place by end of March 2018 to ensure full reporting for 2018.19

Our LTP Ambitions 2018.19

- Strengthening collaboration and knowledge exchange between NCL YOS Teams regarding mental health and interventions
- Reporting and monitoring of outcomes using Routine Outcomes Monitoring tool and CAMHS minimum data set
- Benchmarking reported outcomes across NCL by end of 2017.18
- Development of Specialist Child and Adolescent Mental Health support for High Risk Young People with Complex Needs.

10.5 To help achieve the final ambition above each CCG will allocate funding to jointly commission specialist provision for sexually harmful behaviours training and liaison support for each area including CAMHS, children and family services and YOS.

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.

Conclusion

11.1 As an STP, we have made significant progress in delivering their ambitions for CAMHS transformation as set out in the documents published in 2017. Of note is the development of a perinatal service focussing on provision for women with severe or complex mental illness which constitutes 5% of our population. The service is doing well and meeting its key performance indicators. We will however need to apply for further funding to sustain this level initial funding that we successfully bid for will only meet the needs of 3% of the target population.

11.2 We also successfully delivered a shared reporting framework across NCL to support cross pollination best practice and benchmarking. The increase of capacity to our eating disorders services coupled with improved performance monitoring and management has started to have an impact on our waiting time targets and has enabled NCL to have more robust data that informs more targeted commissioning decisions.

11.3 We do however have some work to do in relation to engaging CYP families and carers in some of our planning and implementation and developing greater scope for partnership working with Primary care. An important element of what we have to deliver is contingent on us gaining greater knowledge of our workforce measured against the needs of the local CAMHS population. The workforce mapping that we are currently undertaking will inform the development of our multi-agency workforce plan. We hope that it will enable us deliver care in alternative setting to healthcare i.e. schools, community centres and through the Third Sector.

11.4 We have also made progress in relation to our commitment to improve services for young people in crisis and will be submitting a bit to enable us to take this work forward. In anticipation of this we have already developed and proposed six operating models, three of which will go out to consultation with stakeholders. The model that we end up implementing will be set within the parameters of the financial envelope, the outcome of the consultation and interface with current and new arrangements for the collaborative commissioning of local Tier 4 provision. The Tier 4 work will be taken forward by developing stronger relationships with North East London to ensure critical mass across the service area having previously been unsuccessful in the bidding process. We believe that given the shared geography, prevalence and that NEL are the only other STP without robust Tier 4 provision, it will put the STPs in a stronger position to deliver this in a sustainable way.

11.5 We have also made strides by integrating the Transforming Care Partnerships plan into our planning and they are supporting delivery of a PBS service and bringing young people closer to home to be cared for in the least restrictive care option.

11.6 In conclusion the NCL CAMHS plan is on track to deliver local ambitions and meaningful transformation to enable us to respond better to the needs of the local population of young people and their carers. This will not come without its challenges, particularly, constraints to the financial envelop within health and social care in the context of health QIPPs and Local authority CIPs. This couple with the very real challenges of working cross organisationally with services and organisations that are guided by sometimes conflicting statutory requirements, will test what we deliver. Our ambition despite all these challenges still remains that we aim to address variation in provision and improve care for our population in a sustainable way.