Enfield Children and Young People’s Mental Health Transformation Plan
2015 – 2020

Art work by Katie-Alice Contant (CAMHS Young People’s Participation Group)

October 2018 Refresh
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1. Foreword

In March 2015 the Government published *Future in Mind – Promoting, protecting and improving our children and young people’s mental health and wellbeing*. The report sets out a national ambition to improve mental health services for children and young people, with each CCG required to submit a Local Transformation Plan. Our first plan was submitted in October 2015, and was the result of close engagement with partners including children and young people, and their parents and carers. The plan detailed our local commitment to implementing the *Future in Mind* vision.

In our original Local Transformation Plan submission we stated that the plan is iterative and will continue to be developed over the timeframe of the five year plan, in response to changing need, analysis of activity and outcome data, and service reviews.

Both the London Borough of Enfield and Enfield CCG recognise that changes to the original submission of the plan are required not least due to the financial positions of each respective organisation.

Notwithstanding this, as a system we have worked together to refresh our *Future in Mind Local Transformation Plan* for 2016/17, 2017/18, and 2018/19 with the aim of ensuring that we have modern sustainable children and young people’s mental health services in place by 2020. It is our intention that this is maintained from 2021 and into the future. We welcome the commitment to whole system improvement in mental health services for children and young people included in the recently published NHS 10 Year Plan, and look forward to implementing the recommendations.

The Health and Wellbeing Board is equally committed to ensuring that mental health is everyone’s business and to putting in place a whole system response to the problems we face. Our new Joint Health and Wellbeing Strategy, currently in development, recognises the links between physical ill-health and mental ill-health and will seek opportunities to connect physical and mental health provision. Mental health resilience will also remain an embedded priority

Stuart Lines

Director for the Public’s Health (on behalf of the Health and Wellbeing Board)

Enfield Council
2. Executive Summary

We want all children in our borough to realise their full potential, helping them to prepare from an early age to be self-sufficient and have a network of support that will enable them to live independent and healthy lives. This means that every child must have the best start in life, regardless of where they live in Enfield. This is our overarching vision for children and young people and promoting, protecting and improving mental health and wellbeing is fundamental to delivering this.

We want to break down the barriers between services and develop, deliver and commission a range of high quality and accessible mental health support based on the THRIVE model. Effective universal services based on the Healthy Child Programme and Early Years Foundation stage must be supported by targeted services that have a lasting impact particularly on the most vulnerable, in order to prepare for the responsibilities of adulthood and build up resilience for the future. We will ensure there is mental health support through all stages of childhood, pre-birth, infancy, pre-school and through school, with the aim of releasing the potential in all children. Educational attainment is recognised as being a key to achievement of long-term health and wellbeing.

In our original Transformation Plan we noted that many of the elements of Future in Mind were already in place, our main CAMH service is well thought of, and is a joint service across the Council and Barnet, Enfield and Haringey Mental Health NHS Trust (BEH MHT) with good working relationships with schools and staff embedded in social care, youth justice, the looked after children team and children’s centres. However we noted that there had been increased pressures on the services, including more complex referrals and, an increase in numbers of young people admitted to hospital with deliberate self-harm. We also remain concerned about the number of pupils excluded from schools with undiagnosed needs.

As a partnership we are committed to ensuring that we have modern sustainable children and young people’s mental health services in place by 2020. The Children and Young People’s Mental Health Partnership Group has engaged with children and young people, schools, the voluntary sectors and other stakeholders and identified the following priorities set out in this plan.

LTP achievements since October 2017 refresh

- The Care Quality Commission (CQC) carried out a thematic review of Enfield CAMHS in the summer of 2017. It noted a number of challenges in Enfield, including funding and out of hours support for CAMHS, but equally recognised a number of positive areas including demonstrably effective integrated working, the provision of CYP centered care, strong CYP participation and a commitment to a collaborative culture.

- Co-production is more embedded in our work and there are active young people and family participation groups co-facilitated by BEH MHT and the Council which
are used to support service improvement. A CYP mental health awareness event was held in Enfield Town Park, and there was a development day for ADHD.

- **Destigmatisation campaigns** have included successful events planned and delivered by the Mental Health Partnership across the Enfield community to mark World Mental Health Day (October 2017 & 2018) and Mental Health Week (May 2017/18). These have been well advertised and well attended by the school and wider community.

- **Early Help Family Hubs** are being implemented across Enfield, incorporating the existing Children’s Centre’s programme, local troubled families team, and the Parent Support Service. To include evidence based parenting programmes and a multi-agency early years panel for SEND.

- **The Health and Wellbeing Offer for Schools** was developed and launched by Public Health this year. The Health Enfield Website was also developed this year [https://new.enfield.gov.uk/healthandwellbeing/](https://new.enfield.gov.uk/healthandwellbeing/) - it has a Healthy Youth section and Healthy Schools section and includes emotional well-being and mental health

- **Mapping Exercise Regarding Mental Health Support in Schools** (Healthy London Partnership) was carried out by Enfield’s CYP Mental Health Partnership in July 2018. This provided a comprehensive and current whole system overview of what is provided in schools for children’s mental health.

- **The Healthy Schools London Award** has been taken up by over 80% of Enfield schools. As part of this an audit of all areas in the school that lead to a healthy school takes place and many schools continue to a silver action plan which can include emotional health and wellbeing of students.

- **The Haven** - for secondary school pupils was launched this year and is open Mon, Tues, Wed, in the area of Edmonton. The Haven is quiet place to go that is calm and restful. Youth workers are on hand if they need a chat. There are no age restrictions but it is aimed at secondary school age children who don’t need to be in school at lunchtimes and for young people.

- ‘**Attachment Lead in Schools training**’ was run in 2016/17. This was delivered by Louise Michelle Bomber (Attachment Support Teacher, Therapist and Author). Ten mainstream schools and one SEMH special school participated alongside PBSS staff, an Educational Psychologist and a School Standards and Support Service member. A senior member of staff and a key support worker from each school took part in all sessions, in order that they could lead and disseminate attachment informed practices and understandings across their school. Attachment Lead Network meetings are now in place to support sharing of related practices and promote ongoing development of staff skills and awareness. More recently, these have been combined with Mental Health Champions Network meetings, and the combined forum is now being opened out to all interested parties.
Access to CAMHS services has improved, and whilst we did not meet the CAMHS Access target in 2017/18, sustained work by the CAMHS teams and additional investment in a CAMHS Access Pilot, which will extend eligibility, should mean that we meet the target in 2018/19. There has been a sustained focus on recruitment and retention and team managers have been successfully recruited across generic and SAFE/Alliance services to enhance operational oversight and support clinical delivery.

Focus on Quality improvement, as the specialist CAMH service is participating in BEH MHT’s Haelo/quality improvement programme and has for example successfully reduced DNAs so that the service has a low rate compared with the national and regional average.

Admissions to inpatient facilities continue to be low, as Enfield has used its resources effectively to appropriately support young people with severe mental health problems in the community and The Royal Free Hospital and the Adolescent Team co-manage young people with eating disorder difficulties and mental health.

Positive Behaviour Support Training has been commissioned from the British Institute of Learning Disabilities (BILD) and been delivered to a network of teams in schools, community health services and children’s with disabilities services.

The STAY (Supporting Team Around You) Project is now up and running and is working with young people with special needs and behaviour challenges and for whom there is a risk of home or special school breakdown and admission to hospital or a residential school/placement, and is starting to have an impact on outcome.

THRIVE implementation is ongoing, and will build on the history of strong partnership working in Enfield and the whole system approach which is embedded in provision. There are regular interface meetings between BEHMHT and Enfield Council’s CAMHS emotional wellbeing services to support effective information sharing and a collaborative approach to CPD and workforce training opportunities.

LTP priorities for this refresh

The Enfield plan remains as ambitious as ever and we are committed to continuing with the implementation of a range of initiatives and projects.

Continue with the implementation of a THRIVE type model of integration

- Establish a system wide data set/outcome measures framework to monitor Thrive implementation
- Start to structure local pathways to deliver care according to five THRIVE needs based groups
- Pilot use of i-THRIVE Grids to support shared decision making
- Thrive needs based groups recorded for all cases

Continue with **co-production initiatives** to develop services that meet the needs of children and young people and their parents and carers

Educational Psychology and Schools Emotional Well-Being Service to lead the pilot of **SEMH Hubs** in a special school and across several primary schools to provide a coherent partnership approach to planning for children’s mental health in schools, accessing guidance and signposting and identifying the help that children in schools need in relation to promoting good mental health. Children’s Well-Being Practitioners will be embedded into these Hubs.

Roll out the **Whole School Well-Being Sandwell Charter Mark** to all schools that have expressed interest. This is a joint action research project led by Public Health and the Educational Psychology Service with partnership involvement from colleagues in Education.

To re-launch the **Critical Incident in Schools protocol** under the Children’s Safeguarding Board.

Develop and sustain the **CYP IAPT Children’s Well-Being Practitioner** roles which will deliver low intensity mental health input within Specialist Community CAMHS in schools via the Educational Psychology and Schools Emotional Well-Being Service.

To roll out **Family Outcome Star** as an outcomes tool to identified services so there is a consistent outcome measure across the system, e.g. Educational Psychology, Schools Emotional Well-Being Service, STAY, Parenting Groups. Training is planned.

**Reduce waiting times for assessment and treatment** for specialist multi-disciplinary CAMHS services, with 92% of CYP waiting no more than 13 weeks for an initial assessment.

**Improve access** to services and ensure that at least 32% of CYP with a diagnosable mental health condition receive treatment from an NHS-funded community mental health service. In 2018/19, and 35% in 2019/20.

**Extend access**, particularly for vulnerable young people who may be reluctant to engage with services, by making it easier to get an appointment at different locations including availability out of school hours

Review **transition arrangements**, including for children with complex needs

**Pilot an NCL Out of Hours service** as part of plans to improve CAMHS crisis care across with a view to ensuring a robust response is in place across NCL
- Ensure access to **NICE compliant Early Intervention in Psychosis (EIP) services**

- Embed the **Liaison and Diversion (L&D)** work with the wider work of the Youth Offending Team, and continue the collaborative commissioning of Youth Justice Liaison and Diversion Service with NHSE

- Extend the work of the **STAY project**, including the development of a forum to support the network of staff who have been trained in Positive Behaviour Support.

- Continue to align programmes of work that **address health inequalities** particularly in those groups of CYP who are over-represented:
  - Look After Children (LAC) or Unaccompanied Asylum Seeking Children (UASC)
  - Temporarily or permanently excluded, or at risk of, exclusion from school;
  - Entering or at risk of entering the criminal justice system;
  - Higher risk of entering the crisis pathway including deliberate self-harm or eating disorders
  - Special Educational Needs and Disabilities (SEND)
# Risks, issues and mitigations for 2018/19

The table below details several risks that have been identified and how these will be mitigated.

<table>
<thead>
<tr>
<th>No.</th>
<th>Risk</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Risk Rating</th>
<th>Mitigation</th>
<th>Residual rating</th>
</tr>
</thead>
</table>
| 1   | There is a risk that there may be delay in recruitment due to competition for CAMH staff                                                                                                                 | 3      | 4          | 12          | Main provider has a good record of staff retention  
There is good history of effective partnership working in Enfield and services have a good reputation                                                                                                 | 9               |
| 2   | There is a risk that the main provider, CCG and Council’s financial positions have a detrimental impact on partnership working                                                                             | 4      | 2          | 8           | There is a good history of effective partnership working in Enfield and awareness that this mitigates the impact of the respective financial positions                                                              | 5               |
| 3   | There is a risk that limited management capacity to support increased demands of transformation programme may lead to delays in scheme and imitative implementation                                            | 3      | 3          | 9           | Two year funding for a service manager has been included in the LTP.  
Funding for a dedicated CAMHs Commissioning Manager has been agreed                                                                                                                                            | 5               |
| 4   | There is a risk that there will be an increase in the number and complexity of children and young people presenting with mental health problems impacting on service delivery                                      | 3      | 4          | 12          | Ongoing commitment to early identification and intervention  
Additional clinical staff approved in April 2018 by the CCG’s Executive Team                                                                                                                              | 5               |
<table>
<thead>
<tr>
<th>No.</th>
<th>Risk</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Risk Rating</th>
<th>Mitigation</th>
<th>Residual rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>There is a risk of non-achievement of the 32% access target during 2018/19</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Undertaking regular monitoring of performance to proactively identify any potential areas of underperformance</td>
<td>6</td>
</tr>
</tbody>
</table>
| 6   | There is a risk that the expansion of early identification and intervention work dependent on schools buying into the traded service offer at a time when there are competing pressures on budgets | 3      | 3          | 9           | There is good understanding within the system of the importance of early identification and intervention, and sign up to the traded offer is good  
Voluntary sector engagement and participation is good.  
Working with schools in a partnership/hub model that will provide an effective structure to develop the workforce.                              | 5               |

### 3. Alignment with the Sustainability and Transformation Plan and local CYP Local Transformation Plans

This plan does not operate in sole isolation within the county boundaries of Enfield, but is closely linked with the LTPs of the other four CCGs in North Central London as well as the work undertaken through the collective STP footprint. This collaboration and alignment takes place through a formal partnership group between local authority members and health providers, commissioners and regulators with strong clinical representation that meets on a monthly basis. The group oversees the planning and delivery of a range of local and national initiatives designed to improve CAMH services across the five boroughs in North Central London. For example, the group recently was successful in bidding for money to support targeted training programmes to upskill registered professionals and others to take on extended and advanced roles in A&E and paediatric departments where CYP may present with a mental health condition. This project will closely align with North London Partnership (HLP) workforce high level objectives and Health Education England (HEE) priorities.
4. Transforming children and young people’s mental health provision: A Green Paper

This paper sets out a commitment to expand support for children and young people’s (CYP) mental health services and build on the commitments already set out in implementing the Five Year Forward View for Mental Health\(^1\). The ambition is to create a network of support for children and young people, and their educational settings.

There are three key proposals in the Green Paper which are:

1. To incentivise and support all schools to identify and train a Designated Senior Lead for Mental Health with a new offer of training to help leads and staff to deliver whole school approaches to promoting better mental health;

2. To fund new Mental Health Support Teams (MHSTs), supervised by NHS CYP mental health staff, to provide specific extra capacity for early intervention and ongoing help within a school and college setting; and

3. As the new Support Teams are rolled out, NHS England will trial a four week waiting time for access to specialist NHS CYP mental health services. This builds on the expansion of specialist NHS services already underway.

NHSE will trial all three elements in new trailblazer areas, identifying the first wave to be operational by the end of 2019. The partnership in Enfield were disappointed not to be invited to bid to be a trailblazer but we will be looking at how we can operationalise key elements of the plan with schools and key stakeholders. We are on target to meet the CAMHS Access Target for 2018/19 and would welcome the opportunity to become a trailblazer in 2019/20.

5. **Vision and Roadmap**

Mental health has been defined as ‘a state of well-being in which the individual realises his or her own abilities can cope with the normal stresses of life, can work productively and make a contribution to his or her community.’

World Health Organisation (2001)

Emotional wellbeing has been defined as a positive state of mind and body, feeling safe and able to cope with a sense of connection with people communities and the wider environment.

World Health Organisation (2007)

We want to ensure that mental health is ‘everyone’s business’ and to co-produce a whole system approach to emotional wellbeing and mental health in Enfield, which transforms provision by 2020. Key elements are:

- Co-production with children, children young people and families
- A stronger focus on prevention, self-help, peer to peer work and community support networks
- Early identification and intervention, through implementation of the Healthy Child Programme, the Family Resilience Strategy, and work in schools
- Implementation of a THRIVE type model which is more responsive to needs including children and young people in crisis
- Additional targeted support where necessary for children and young people who are more vulnerable
- A workforce motivated and equipped to deliver accessible and responsive services
- A common understanding of the support and services available with access through the Single Point of Entry

Implementing NICE and best practice guidance and an ongoing focus on outcome measures will be embedded as part of CYP IAPT implementation.
CAMHS Local Transformation Plan Roadmap 2015/16 – 2020/21

- IT SUPPORT PACKAGE: ICAN etc.
- DEMAND & CAPACITY INITIATIVE
- PROVIDER FORUM
- REDESIGN OF ORIGINAL LTP IN RESPONSE TO SYSTEM FINANCIAL
- CYP IAPT COLLABORATIVE
- CYP ANTI-STIGMA WORK
- LAC CAMHS
- EATING DISORDERS
- TRANSFORMING CARE: STAY TEAM; PBS TRAINING; AT-RISK MEETINGS
- ALL AGE MENTAL HEALTH JSNA
- HEALTH INJUSTICE
- AUTISM
- EARLY HELP
- WHOLE SYSTEM TRAINING

- THRIE UPN
- THRIVE-TYPE MODEL IMPLEMENTATION
- OUT OF HOURS CRISIS PATHWAY
- EXTEND SEMH PROVISION IN ALL
- MENTAL HEALTH CHAMPIONS
- RESPONSE TO THE CHILDREN’S MENTAL HEALTH GREEN PAPER
- INTEGRATED PROVISION FOR CHILDREN WITH ADDITIONAL NEEDS
- PERINATAL MENTAL HEALTH
- SCAN AND STAY TEAMS DEVELOPMENT
- FAMILY RESILIENCE STRATEGY / EARLY HELP
- WHOLE SCHOOL MODEL INCLUDING CHARTER MARK
6. Understanding local need

Good emotional health in childhood has important implications for both health and social wellbeing in adult life. One in ten children and adolescents between the ages of one and fifteen has a mental disorder. Research suggests that 20% of children have a mental health problem in any given year and about 10% at any one time. *Future in Mind*, 2015, highlighted the following:

- Fewer than 25%-35% of those with a diagnosable mental health condition access support\(^2\)
- Bullying is reported by 34-46% of school children in England with those experiencing persistent bullying have higher rates of psychiatric disorder\(^3\).
- Bullying is also associated with elevated rates of anxiety, depression and self-harm in adulthood\(^4\).
- 12.5% of children and young people have medically unexplained symptoms, one third of whom have anxiety or depression\(^5\).
- An estimated 60-70% of children and adolescents who experience clinically significant difficulties have not had appropriate interventions at a sufficiently early age\(^6\).

Enfield is the fourth largest London borough, with 91,444 children and young people aged from 0 to 19 yrs. in Enfield which makes up 27.59% of the population. This is high compared with both the London and England average. The Enfield 10-19 yrs. population is expected to increase at a greater rate than both London and England, with variable impact across the borough. Enfield is a diverse borough and 65.4% of children and young people are from BME backgrounds.

\(^2\) Green, et al, Mental health of children and young people in Great Britain, 2004

\(^3\) Copeland WE, Wolke D, Angold A. Costello EJ (2013). Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. JAMA Psychiatry 0(4):419-426


\(^6\) Enfield is the fourth largest London borough, with 91,400 children and young people aged from 0 to 19 years which makes up 27.5% of the population (ONS Estimates 2017). This is high compared with both the London and England average. The Enfield 10-19 yrs. population is expected to increase at a greater rate than both London and England, with variable impact across the borough. Enfield is a diverse borough and 65.4% of children and young people are from BME backgrounds. *Children's Society (2008)* The Good Childhood Inquiry: health research evidence. London: Children’s Society
Although Enfield is located in Outer London it has many inner-city characteristics. Changes to rent levels, the Benefit Cap and other reforms may have had an effect upon demand for services. Welfare reform is implicated in tenancy instability, increased poverty (despite more people being in work), migration from inner London boroughs to outer boroughs and neighbourhood ‘churn’. The borough has the 7th highest number of households in temporary accommodation in England (December 2013), and unemployment levels consistently above both London and National averages (at September 2013, Enfield’s rate was 9.3% compared to 8.7% for London). Overall, Enfield is the 12th most deprived borough in London and the 64th nationally. Under the Income Deprivation Affecting Children Index (IDACI), Enfield is now the fifth most deprived borough in London and the 13th in England (out of 326 Local Authority areas. Most of the deprivation is concentrated along the eastern and southern corridors of the borough, resulting in significant inequalities across Enfield as a whole.

Changes in benefit rules are having an anecdotal impact on the population profile and on the increase in complexity of children and young people seen by CAMHs. Child poverty is a significant risk factor for mental health problems.

It is well known that some children and young people are more vulnerable to developing mental health problems.

To note that the Joint Strategic Needs Assessment is currently being incrementally updated and improved – the last “Deep Dive” intelligence and data assessments on the mental health and wellbeing of the population in Enfield, including the mental health of children and adolescents, was undertaken in 2016. This is due for review and update in the next year. This may be found here:

https://new.enfield.gov.uk/healthandwellbeing/topics/mental-health/

The Public Health Intelligence team, as part of the Children and Young People’s Mental Health Partnership Group (CYPMHG), is committed to ongoing outreach activities and have confirmed that they will engage with children, young people, and families as part of the next iteration of the JSNA. The Young People’s Participation Space has been instrumental in for example: developing the proposals for LCBTQ groups, the celebration of Black History Month in waiting areas for CAMHS and in the design of an inclusive charter for young people.

Key statistics

The graphic on the next page shows the most recent data available for Enfield compared to other peer groups.
In 2015, 17.4% of children are living in out-of-work households. In London, 14.4%, and England, 14.0%.

22% of all dependent children in Enfield are in low-income families. *

In May 2015, Enfield was the 12th most deprived local authority in England (14th five years earlier). Income Deprivation Affecting Children Index: Enfield is the fifth most deprived borough in London.

Permanent exclusions from school - 54

Secondary schools - 47

Primary schools - 7

Looked After Children per 10,000 population aged 18 and under - Enfield average: 39

England average: 62

Children Protection Plan per 10,000 population aged 18 and under - Enfield average: 39.9

England average: 56.2

Physical abuse: 28 (10%)

Emotional abuse: 96 (33%)

Neglect: 157 (55%)

The unemployment rate in Enfield is only 4%, lower than the London average.

In London, 21% of workers do not earn a living wage.

In Enfield, 17.4% of children are living in out-of-work households.

The definition of 'low income' in this case is receiving 60% or less of median income or on out-of-work benefits (HMRC)
Child poverty is a significant risk factor for mental health problems, with most of the deprivation being concentrated along the eastern and southern corridors of the borough, resulting in significant inequalities across Enfield as a whole. The map shows this variation in each ward.
The degree of risk of developing mental health problems

It is well known that some children and young people are more vulnerable to developing mental health problems. The table below highlights individual risk groups and the degree and prevalence of each risk type.7

<table>
<thead>
<tr>
<th>Risk group</th>
<th>Degree of risk</th>
<th>Prevalence of risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with a learning disability</td>
<td>6.5 fold increased risk of mental health problem</td>
<td>2.6% of pupils have learning disabilities</td>
</tr>
<tr>
<td>Children with physical illness</td>
<td>2 fold increased risk of emotional/conduct disorders over a 3 year period</td>
<td>5-6% of children (600,000) report/are reported by parents as being in &quot;fair or poor&quot; health</td>
</tr>
<tr>
<td>Homeless</td>
<td>8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation</td>
<td>Between 35,000 to 52,000 homeless young people in England</td>
</tr>
<tr>
<td>Young people</td>
<td>7 fold increased risk of suicide attempts in young lesbians</td>
<td>Estimated 6% of population are LGBT</td>
</tr>
<tr>
<td>Young LGBT</td>
<td>18 fold increased risk of suicide attempts in young gay men</td>
<td>160,000 children and young people per year have a parent in prison</td>
</tr>
<tr>
<td>Children of prisoners</td>
<td>3 fold increased risk of antisocial-delinquent outcomes</td>
<td>Over 6,000 children aged under 18 entering custody during a year – the vast majority are boys. 10% of 10–25 year olds report committing a serious offence in previous year</td>
</tr>
<tr>
<td>Young offenders</td>
<td>40 fold increased risk of suicide in women in custody age &lt; 25</td>
<td>64,400 children (0.5% of under 18 year olds) are 'looked after' in England</td>
</tr>
<tr>
<td>LookedAfter Children</td>
<td>18 fold increased risk of suicide for men in custody age 15–17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 fold increased risk of a non-English depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 fold increased risk of mental disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 fold increased risk of any childhood mental disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 – 7 fold increased risk of conduct disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 – 5 fold increased risk of suicide attempt as an adult</td>
<td></td>
</tr>
</tbody>
</table>

A table below taken from Public Health England\(^8\) data details the identification of need for Enfield and compares this to London and England.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Enfield Count</th>
<th>Enfield Value</th>
<th>London Value</th>
<th>England Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated prevalence of mental health disorders in children and young people: % population aged 5-16</td>
<td>2015</td>
<td>5,298</td>
<td>9.9%*</td>
<td>9.3%</td>
<td>9.2%*</td>
</tr>
<tr>
<td>Estimated prevalence of emotional disorders: % population aged 5-16</td>
<td>2015</td>
<td>2,067</td>
<td>3.8%*</td>
<td>3.6%</td>
<td>3.6%*</td>
</tr>
<tr>
<td>Estimated prevalence of conduct disorders: % population aged 5-16</td>
<td>2015</td>
<td>3,278</td>
<td>6.1%*</td>
<td>5.7%</td>
<td>5.6%*</td>
</tr>
<tr>
<td>Estimated prevalence of hyperkinetic disorders: % population aged 5-16</td>
<td>2015</td>
<td>893</td>
<td>1.7%*</td>
<td>1.5%</td>
<td>1.5%*</td>
</tr>
<tr>
<td>Prevalence of potential eating disorders among young people: estimated number aged 16 - 24</td>
<td>2013</td>
<td>4,850</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of ADHD among young people: estimated number aged 16 - 24</td>
<td>2013</td>
<td>5,111</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cause for concern - Looked after children where there is cause for concern: % of looked after children</td>
<td>2016/17</td>
<td>56</td>
<td>37.1%</td>
<td>35.5%</td>
<td>38.1%</td>
</tr>
<tr>
<td>Hospital admissions as a result of self-harm: DSR per 100,000 population aged 10-24</td>
<td>2016/17</td>
<td>93</td>
<td>151.2</td>
<td>197.2</td>
<td>404.6</td>
</tr>
<tr>
<td>Hospital admissions as a result of self-harm: Crude rates per 100,000 (10-14 yrs)</td>
<td>2016/17</td>
<td>20</td>
<td>93.8</td>
<td>102.1*</td>
<td>211.6*</td>
</tr>
<tr>
<td>Hospital admissions as a result of self-harm: Crude rates per 100,000 (15-19 yrs)</td>
<td>2016/17</td>
<td>47</td>
<td>232.8</td>
<td>305.2*</td>
<td>619.9*</td>
</tr>
<tr>
<td>Hospital admissions as a result of self-harm: Crude rates per 100,000 (20-24 yrs)</td>
<td>2016/17</td>
<td>28</td>
<td>129.2</td>
<td>188.6*</td>
<td>393.2*</td>
</tr>
<tr>
<td>School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Primary school age)</td>
<td>2018</td>
<td>1,018</td>
<td>3.0%</td>
<td>2.2%</td>
<td>2.2%</td>
</tr>
<tr>
<td>School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Secondary school age)</td>
<td>2018</td>
<td>585</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (School age)</td>
<td>2018</td>
<td>1,672</td>
<td>2.8%</td>
<td>2.4%</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

\(^*\) Indicates modeled data or synthetic estimates

The data indicates that Enfield has a higher prevalence, or occurrence, of mental health disorders in children and young people, but lower levels of hospital admissions due to self harm. The SAFE and Alliance teams provide psychological assessment and review services for young people presenting to the local A&E department in crisis,

\(^8\)https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/1/gid/193B133090/pat/6/par/E12B00007/ati/102/are/E09B00010
who may be admitted to a general paediatric ward at North Middlesex University Hospital or Barnet Hospital. The number of assessments carried out by the team has increased as has acuity.

Enfield CYP Hospital Assessments

Across all school ages, the data indicates a higher percentage of children with social, emotional and mental health (SEMH) need than the other 31 boroughs in London or the England rate.

Whilst the values for eating disorders are estimates, Enfield ranks sixth highest out of all the 32 London boroughs.

Priority

Through the JSNA, to maintain oversight over whole system capacity and demand for children and young people’s mental health services

Our actions

✓ Children, young people and families to be involved in the refresh of the JSNA

✓ The Public Health Intelligence Team to support development of a system wide data set/outcome measures framework
7. Commissioning arrangements

BEH MHT is our main provider of specialist multidisciplinary CAMH (Tier 3) services, including adolescent outreach, provision for looked after children and services for children and young people with social communication and neurodevelopmental issues. The Trust works very closely with other services including the Council's Educational Psychology and Emotional Wellbeing Service. A Memorandum of Understanding (MoU) has been developed to underpin the joint working arrangement, and has been signed off. We also commission a community eating disorder service from the Royal Free London NHS Foundation Trust based at the Hampstead site as well as elements of specialist provision from the The Tavistock and Portman NHS Foundation Trust based in northwest London. Work is supported by a wide range of services at Tier 1 and 2 although we know that we could do more and that provision could be more comprehensive.

There is a Section 75 agreement in place to support the joint commissioning of children's services, and the CCG and Council work in partnership to both commission and performance manage CAMHs. Schools and public health colleagues are engaged in these arrangements.

NHS England commission Tier 3.5 and inpatient or Tier 4 Services. The CCG and Council are committed to working with NHS England to co-commission these services, and use Section 75 arrangements to further develop partnership working. We are also keen to involve the NHS England Health and Justice Team in the work of our Enfield Targeted Youth Engagement Board.

As is stated in the original Future In Mind Transformation Plan, many of the elements of Future in Mind are already in place, our main CAMH service is well thought of, there are good working relationships with schools and CAMHS staff embedded in social care, youth justice and the looked after children team. However there have been increased pressures on the service, waiting times have grown, and some parts of the service are experiencing more pressure than others. We are also concerned about the increase in children and young people presenting with self-harm and in crisis.

That said, admissions to Tier 4 inpatient beds, and lengths of stay, have remained relatively low compared with other CCGs, which reflects the impact of the proactive work carried by the Alliance Team which is part of our adolescent outreach service. However Enfield young people have been placed in out of area inpatient beds because there were no London beds available, and there have been NCL STP discussions with providers about how best to co-commission inpatient beds with NHS England. NHS England has pledged £100k to co-commission services with NCL CCGs. Both Tier 4 mental health placements and complex care/three way funded residential placements are proactively monitored through the Complex Care Panel. Work to align this to, and ensure compliance with, Transforming Care requirements has been prioritised.
The Health and Justice work is co-commissioned with NHS England. This has allowed Enfield to increase speech and language support into the Youth Offending Service and improve links with other community health services.

**Transforming care for people with learning disabilities and/or autism**

A Better Care Fund proposal was approved in October 2015 to fund an Intensive Behaviour Support Service, known locally as the STAY (Supporting Team Around You) Project to work with young people with special needs and behaviour challenges and for whom there is a risk of home or special school breakdown and admission to hospital or a residential school/placement. Small scale community based services are more likely to bring about positive outcomes for this group of young people rather than isolated out-of-area services (Jones, 2013), and a similar model in Ealing, which combined intensive behaviour support with respite, was able to demonstrate reduced levels of behaviour that challenges, and a reduction in use of residential schools/placements. There were delays in start up of the project in Enfield because of difficulties in the recruitment of suitably qualified and experienced staff. But this has finally been resolved, and the service has been delivered by the Joint Adult Learning Difficulties Team since January 2018. This has meant closer working relationships between children’s and adults services, including a joint monthly meeting to review the at risk register, and improved decision making around transition. The STAY project works closely with the CAMHS SCAN (Social Communication and Neuro-disabilities) service, and there are obvious synergies between the two services.

The decision to fund the STAY project predated the extension of the national Transforming Care programme to children and young people, but has meant that Enfield is ahead of other areas in terms of implementation. STAY is supported by a multi-agency steering group and the monthly at risk meetings, and in addition to the project we are looking at a positive behaviour support training programme for the children’s workforce, at developing early identification and interventions, and are working with colleagues in North Central London STP to try and identify a crash pad and possible overnight respite option. There is potential for capital funding. In addition North Central London STP has been invited to be an accelerator area for Transforming Care and submitted a bid which focusses on the development of the key worker/support worker role and a parent worker, which will increase the capacity of the STAY Project. Both the accelerator pilot and the STAY project will be externally evaluated.

The following outcomes have been identified by the partnership:

- Young people remain connected to their support network
- Access to learning locally
- Avoid “cliff edge” at 18 / point of transition to adult services
- Reduce admission and re-admission rates
Achieve measurable improvement in mental health outcomes

Ensure effective coordination of statutory and voluntary services to the young person

Improve outcomes for education and employment

Achieve high satisfaction ratings with the service

Reduce offending rates, where young people are known to Youth Offending Service/Police

Put in place support for family and friends, which will in turn achieve greater support for the young person

Increased use of a Positive Behaviour Support approach across the system

Young people to experience increased quality of life through increased access to local services and opportunities

Families to feel empowered in supporting their children to remain in the family home

Families and young people to feel supported by Enfield services and professionals working collaboratively

**Priority**

**To continue to develop and embed a whole system approach to transforming care for children and young people**

**Our actions**

 ✓ Ensure effective implementation of the Accelerator Pilot

 ✓ Development of a forum to support the network of staff who have been trained in Positive Behaviour Support.

 ✓ Support external evaluation of the STAY Project and Accelerator Pilot
8. **An integrated model of provision**

**CAMH services in Enfield**

There is an ongoing commitment in Enfield, led by the Health and Wellbeing Board, to a whole systems approach to children and young people’s mental health. We want children and young people’s mental health and emotional wellbeing to be everyone’s business.

The four-tier system of a comprehensive CAMH service was described in standard 9 of the National Service Framework for children, young people and maternity services (Department of Health, 2004) and was based on a solid body of earlier work (Health Administration System, 1995). The tiers as described are neither fixed nor one-directional; a child could be in receipt of services from more than one tier for example and would be likely to move down as well as up, according to need.

Although helpful in its time when differentiating between the forms of support available to children and young people, there is concern that it has emphasised the divisions between services. *Future in Mind* promotes the use of more integrated models of care such as the THRIVE model. This model brings services together to focus on the needs of children and young people, in the context of a system which is struggling to meet increase demand and complexity of need, whilst refocussing on building resilience, personalisation of evidence based and outcome driven care, support for vulnerable groups, and value based service delivery.

The model outlines groups of children and young people, and the type of support they may need, and tries to draw a clearer distinction between treatment and support. It focuses on a wish to build on individual and community strengths wherever possible, and to ensure children, young people and their families are active decision makers in the process of choosing the right approach. The model seeks to identify somewhat similar groups who share a conceptual framework as to their current needs and choices, although it is recognised that there will be large variations in need within each group and the resources they require.

The THRIVE model, developed by the Anna Freud National Centre for Children and Families (AFNCCF) and the Tavistock and Portman Clinic is shown below in Figure 1. The left hand graphic provides a description of the five THRIVE-groups.

These needs based groups are distinct in terms of the:

- needs and/or choices of the individuals within each group
- skill mix of professionals required to meet these needs
- resources required to meet the needs and/or choices of people in that group

The graphic on the right details the inputs offered for each of these groups.
The model provides a distinction between advice/support and evidence based 'treatment', and is based on the following principles:

- Shared decision making at heart of choice
- Acknowledgment of limitation of treatment
- Acknowledgment of limitations of resources
- Distinction between treatment and risk support
- Greater emphasis on how to help young people and communities build on their own strengths

**Implementation of the THRIVE model**

Since the original Local Transformation Plan submission a number of multi-disciplinary sessions have been held to discuss the THRIVE model. Given the history of joint working across Council and NHS services, we feel that we are well placed to progress implementation of a THRIVE type model of integration and this year will be deploying the i-THRIVE model into Enfield.

We have engaged with the AFNCCF to take forward the implementation of the model in Enfield. We have already undertaken an initial mapping exercise to see how a range of services currently provided in Enfield map to the model.
Thriving in Enfield

The majority of young people in Enfield will fall into the ‘thriving’ section of the model. Within the ‘thriving’ section, children and young people with the support of families, peers, schools, and universal services are able to flourish independently.

Key universal services support all children within the borough to have good well-being and provide key opportunities for initial support and early identification include primary care, education (including schools and early years settings), health visiting and school nursing, out of school provision and voluntary sector provision to children and young people.

It is essential that the impact on promoting and maintaining good emotional and mental wellbeing of these universal services is recognised. Additionally, that the work involving increasing wellbeing more generally has (e.g. increasing physical activity) for enhancing mental and emotional wellbeing among young residents.
Priority

To progress the implementation of a THRIVE type model of integration in Enfield

Our actions

- Establish a system wide data set/outcome measures framework to monitor Thrive implementation
- Start to structure local pathways to deliver care according to five THRIVE needs based groups
- Pilot use of i-THRIVE Grids to support shared decision making
- Thrive needs based groups recorded for all cases

Services Provided In Enfield

This section of the plan describes the range of services that are provided in the borough of Enfield, and the diagram illustrates this pictorially as to how we work together with the child or young person at the centre of service provision.
**Multi-disciplinary Teams**

The following section describes a range of teams whose staff employed by BEHMHT and the London Borough of Enfield council.

**Generic CAMH services**

The two multi-disciplinary teams in Enfield have combined and are now accessed through a Single Point of Entry (SPoE). This has improved assessment, consistency of practice and is gradually impacting on waiting times. The team receives referrals from a range of agencies, including self-referrals. They provide a range of interventions according to the clinical needs of each client presenting with severe emotional and behavioural difficulties.

**SAFE Team**

The Service for Adolescents & Families in Enfield (SAFE) team provides a borough-wide service for Enfield adolescents and families in crisis with acute mental health problems or concerns. The team also provides an early intervention in psychosis service for young people to support and stabilise. Although the generic CAMH teams also see adolescents, SAFE specialises in the treatment of adolescents with psychosis and provides a crisis support provision where the emphasis is on outreach work and rapid response. Response times are within one working day to a young person in an acute setting and two working days for other urgent referrals.

The Early Intervention in Psychosis (EIP) service delivers a full age range NICE compliant service including children and young people and all referrals. BEHMHT have been requested to undertake audit work on this area to ensure that the services are NICE compliant. We know that adult presenting with first time psychosis is in line with the expected national prevalence.

The SAFE Team provides the early intervention service for young people who present with signs of early onset psychosis aged 13 to 17 years.

The SAFE team offers interventions that follow the principles of the EIP model and use materials and tools from the NHSE guidance. Interventions are focused on the pathway that encompasses early treatment, intervention and response, support around recovery, and psycho-education around the illness bringing about relapse prevention.

There is good working relationship between CAMHS and the Adult Services and a protocol in place for many years describes how transition will work at 17+. This

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9 https://www.nice.org.uk/guidance/cg155

ensures there is a full pathway in place for all Enfield young people who experience first onset psychosis and require the services of the EIP service. The access rate performance to the EIP service is monitored on a quarterly basis against the annual operational plan submitted to NHSE.

Alliance Team

As an enhanced crisis support team the Alliance team consists of three mental health nurses who have extensive experience in working with young people and their families in crisis. Since July 2010, the Alliance team began to operate alongside the SAFE team and, two generic CAMH teams in Enfield and Enfield Service for Children & Adolescents with Neurodevelopmental disorders (SCAN).

The main aims of the Alliance team are to respond to those young people who are or have been at risk of admission to an acute hospital service.

- To respond to referrals from the CAMHS community teams within 24 hours of referral.
- To engage for a short period (90 days) and disengage having a clear follow up plan within the CAMH services Tier 3 clinic.
- Where a young person is admitted to a Tier 4 facility to engage with the young person whilst in hospital with a view to reduce the length of stay by supporting a transition into the community.
- Where possible, to reduce the need for Tier 4 admission by offering intensive home/ community support.

HEART Team

The CAMHS HEART team is fully integrated within the Local Authority led multidisciplinary HEART (Health, Education and Access to Resources Team). Clinical Governance, supervision and formal line management (for CAMHS staff) comes from BEH, and there is service delivery and management accountability via the Manager of the HEART team.

Referrals are accepted from young people’s social workers or foster carers’ supervising social workers. There is close liaison with the wider HEART team, which includes educational specialists in the Virtual School, physical health services and KRATOS, the young people in care council.

HEART CAMHS provides services at all levels of the THRIVE model:

- Getting advice and signposting: Some LAC children do not get referred to CAMHS, but their wellbeing may be indirectly benefitted as their carers, social workers and teachers may access training and consultation from CAMHS HEART.
Getting help: Referred children can be provided with a consultation only service (e.g. advice to the network about impact of placement change on wellbeing, structured attachment-focused parenting groups for foster carers), or direct psychological and therapy interventions, which may be brief.

Getting more help: Some referred children require specialist mental health assessments and longer term psychological and therapeutic interventions. We currently provide psychodynamic psychotherapy, family therapy, trauma-focused CBT and are developing other NICE approved evidence based interventions for LAC.

Risk support: We have some capacity to conduct emergency risk assessments, and to support those young people at risk of hospital admission we liaise closely with our colleagues in SAFE and ALLIANCE both pre- and post-admission.

Service for Children and Adolescents with Neuro-developmental Disorders (SCAN) Team This is a targeted service for children and young people who have been diagnosed with both a neuro-developmental disorder and mental health needs who attend special schools. It is a multi-disciplinary team made up of psychiatry and clinical psychology which works jointly with colleagues in Enfield Community Services including Paediatricians and a range of health therapies as required.

CAMHS in the Child Development Team (CDT)

This is a dedicated CAMH service provision for assessment and diagnostic services for children under the age of six with neuro-developmental problems, physical disability, learning disability and life-limiting conditions.

Enfield Parent and Infant Partnership (EPIP)

Enfield has developed a Parent and Infant Project in Enfield as part of a wider Parent Infant Mental Health Service. Enfield CAMHS initially worked with the Every Parent and Child (EPC) to secure a grant from PIP UK to support the start-up of EPIP, based on the commitment of the CCG and the LBE to provide match funding. This PIPUK grant has since ended and EPIP is now funded by Public Health and the CCG. EPIP is small specialist service providing therapeutic assessment and support to parents and their babies up to the age of 18 months where there are issues and difficulties around relationships and attachment, as a result of parental mental ill health and/or complex

“What is unique about the HEART team within CAMHS is that we are working alongside local authority colleagues on a day-to-day basis in a multi-agency approach, and our CAMHS clinicians have specialist expertise in the particular needs of Looked After Children.

We’re also able to provide a more timely and responsive service than most CAMHS services nationally, with all referrals being accepted and typical waiting times of two to six weeks”

Senior Clinical Psychologist, HEART CAMHS Team
social difficulties. The team provides assessment and a variety of treatment interventions.

Referrals are taken from midwives, health visitors, GPs, perinatal and paediatric hospital based teams, adult mental health, children's centres, voluntary organisations and social care.

**CAMHS in the Youth Offending Unit**

The Youth Offending Unit (YOU) has an integrated health team consisting of a CAMHS Clinician, Speech and Language Therapist and Nurse. In addition two YOU workers have completed the CYP IAPT training. All clinicians offer evidence based interventions, and can facilitate access to the full range of CAMHS services. The team is completed a new Liaison and Diversion worker funded by the NHSE Health and Justice Team, who undertakes mental health screening for young people held in custody.

There are plans in place to more fully integrate the Haringey and Enfield Liaison and Diversion Posts as there is one Wood Green Custody Suite.

Enfield YOU has a strong focus on prevention when working with children and young people in the youth justice system including those on the edges of youth justice pathways, and processes are in place to ensure mental health and emotional wellbeing assessments are given to all young people in or on the edge of youth justice service. Further detail is set out in the borough’s partnership response to tackling youth crime – Working Together for a Safer Enfield 2017 – 2020 and Enfield Youth Justice Plans, with a strong focus on co-production.

**SEWS (Schools Emotional Wellbeing in Schools)**

The Schools Emotional Wellbeing Service (SEWS) has developed from an offer made to all schools in the borough in 2014. An emotional well-being practitioner (i.e. Family Therapist, CAMHS Practitioner or Educational Psychologist) spends either a day or half day per week in each school providing:

- A direct assessment and intervention service for children young people and families
- Group work
- Consultation to individual or groups of school staff
- Staff training on issues such as attachment, trauma, ADHD, deliberate self harm, exam stress.

Currently this is targeted service and SEWS team members facilitate referral into Community Specialist CAMHS where necessary. New ideas about how to use the SEWS resources have developed and been implemented in each school as the year
has progressed. There has been a strong emphasis on feedback and outcome measures and on evaluation involving staff, students and parents/carers. The feedback so far indicates that schools value this service very highly.

SEWS is revisiting the model so that in the future school partnerships can share the provision of therapeutic intervention through a hub model of delivery. Children’s Well-Being Practitioners are joining this reconfiguration and it is anticipated that this will be the local arrangement for the Mental Health Support Teams.

**Educational Psychology Service (EPS)**

The EPS works with schools and settings through a ‘consultation model’ of service delivery and offer guidance, assessment and intervention for children and young people aged 0 – 25 years across the whole spectrum of special educational needs, including social, emotional and mental health. EPS works in collaboration with schools, partners and the community to promote children’s emotional well-being.

The EPS is funded by the Local Authority to fulfil its statutory duty under the Children and Families Act 2014. This includes providing psychological consultation and assessment in relation to:

- the statutory assessment process for the provision of Education, Health and Care plans for the 0 – 25 age group;

- the Local Authority’s priorities in reviewing of EHC Plans where there is likely to be a change of placement or provision, and

- being an expert witness as requested by the Local Authority for Special Educational Needs and Disability Tribunals.

The EPS is commissioned by the majority of Enfield schools, some services and other organisations to provide psychological involvement that falls outside of the statutory remit. This has enabled the EPs to provide the following:

- support for children and young people in schools without a EHCP;

- a bespoke service to schools based on their individual needs, e.g. psychological consultation/support for individual/groups children and young people, parent groups, staff development;

- a dedicated Early Years EP Team as contribution to a partnership model through children's centres;

- regular psychological support for Nurture Groups;

- psychological consultation for looked after children who have SEND and do not have a statement/EHCP;
crisis support for schools when there are children/young people at risk of exclusion;

- critical incident support for schools following a traumatic event;

- projects across several schools, e.g. Cognitive Behavioural Therapy approaches to support schools/children & young people around exam stress/anxiety;

- contribution to the neurodevelopmental multi-disciplinary assessment/intervention in CDT/CAMHS and as part of the Advisory Service for Autism for schools;

- Contributing to the Incredible Years (IY) parenting offer through children’s centres and for school aged children - as aligned with Children & Young People’s Improving Access to Psychological Therapy services (CYP IAPT) principles.

The EPS is committed to the *Future in Mind* mental health agenda and is part of the Enfield CYPIAPT Learning Collaborative and has successfully trained three EPs on the parenting and CBT therapy modality. Current training involves EPs undertaking CBT (therapy and supervisor arm) and the Leadership and Management Arm.

**Behaviour Support Service**

Behaviour Support Services (BSS), including the secondary Pupil Referral Unit (PRU), work in partnership with schools, parents and the council to support the inclusion of all children and young people, and support remove barriers to learning.

They assist children and young people experiencing social emotional behavioural difficulties (SEBD) and social and emotional mental health difficulties (SEMH) to access successful learning opportunities. The team may also:

- offer preventative interventions to support pupils at risk of exclusion

- provide a support and training services in the primary sector and secondary sector

- refer to the Enfield secondary tuition centre who work with learners in Key Stage three and four to ensure that young people receive a curriculum that enables them to reach their full potential

**Improving Access to Psychological Therapy services (CYP IAPT) Service**

The CYP IAPT Service provides individual and group services for 16 years and over. IAPT practitioners provide stress and wellbeing training in local colleges. The work is being expanded to Sixth Form Colleges. Shortly, there will be other web based services available such as *The Big White Wall*. 
Every Parent and Child

Every Parent and Child works in the community and in schools and delivers counselling services

External Service Providers

As well as the close working relationship between the CCG and the London Borough of Enfield, we also work collaboratively with other local partners who provide specialist services for CYP with more complex needs

The Tavistock & Portman NHS Foundation Trust

Enfield has a small contract with the Tavistock & Portman Trust to provide outpatient Tier 3 CAMH services to Enfield children & young people according to need. This has been useful if parents are employed in Enfield in related professions, or are seeking a second opinion.

The Royal Free London NHS Foundation Trust (RFH)

The RFH Eating Disorder Service is commissioned across NCL and provides a specialist Community Eating Disorder Service (CEDS) for Enfield children and young people. They address anorexia and bulimia but not obesity issues. The CEDS is signed up to NHS England’s national quality improvement programme.

South London and Maudsley NHS Foundation Trust

For second opinions, recommended by a CAMHS consultant or senior clinician, for complex neuro-developmental disorders, including autism.

DAZU Young Carers Project

DAZU offers support to young carers in both community and school settings through group and individual counselling. A new e-counselling phone app is being trialled by DAZU.

Place 2 Be

Place2Be is a children’s mental health charity providing school-based support and in-depth training programmes to improve the emotional wellbeing of pupils, families, teachers and school staff. Place2Be provides a volunteer counselling/therapy service with clinical supervision, and a project manager for schools. This service is funded partly by schools and partly by Place 2 Be’s charitable donations.

The Brandon Centre

The Brandon Centre is commissioned to provide multi systemic therapy to children, young people and families on the edge of care. Eligibility criteria have been extended
to include Multisytemic Therapy (MST) for young people exhibiting worrying sexual behaviour.

Beacon Centre

Commissioned by NHS England and provided by Barnet Enfield & Haringey Mental Health Trust to provide a twelve bed Tier 4 in-patient Acute Adolescent Unit.

Other in-patient beds around the country are used for Enfield young people when the Beacon Centre is full or another unit offers a more appropriate treatment programme to meet the young person’s needs.

Multi-Disciplinary Panels related to CAMHS

There are a number of multi-disciplinary panels related to CAMHS; the adoption panel, complex issues and the early support resource allocation panel.

Information about other local services and resources

Special Educational Needs and Disabilities (SEND) Local Offer

The SEND Local Offer for children, young people and their families was developed as a statutory requirement by Enfield Council under the Children and Families Act 2014. In 2017, a specific section on Social, Emotional and Mental Health was developed with partners and young people. This is aligned with the THRIVE model.

Young people collaborated in the development by producing films for other young people to communicate their experiences of services and SEND issues.


In addition the BEH MHT CAMHS pages have been redesigned in collaboration with young people.

Peer to peer support

There is access to peer to peer support through the phone app Cypher, and the work of the children and young people’s participation group and Kratos, the Looked After Children's Council.

Mental Health Forum

The Mental Health Forum, which includes representatives from VCOs and schools, meets termly and is a networking opportunity for early help services, providing training, FiM updates and opportunities to influence service developments.
The Family Resilience Strategy

A Family Resilience Strategy has been agreed focussing on the development of Family Hubs based around Children’s Centres, and incorporating the Healthy Child Programme, EPIP, Speech and Language Therapy and the CYPIAPT Incredible Years Parenting Programme jointly delivered by the Educational Psychology Service and the Behaviour Support Service.
9. Co-production with children, young people and families and engagement

*Future in Mind* emphasises the importance of co-production that is providers and commissioners working in tandem with children, young people and families to agree priorities and develop the services they want in the way the best meets their need. As part of the development of the original plan there was a web based survey of children and young people and families and all users of Enfield CAMHS, and an independent piece of work with young people commissioned by Health Watch. This was in addition to work with Enfield CAMHS young peoples’ engagement and parents’ engagement groups and feedback received from individual services which are recorded throughout the strategy.

Since the publication of the original strategy both the parents and the young people’s participation groups have expanded and are becoming increasingly important in the way we develop and monitor services. For example young people are regularly working with the Anna Freud Centre’s youth engagement group, are now involved in the appointment of staff members for the Council and BEH MHT, helped develop the SEMH local offer and design the new CAMHS BEHMHT website, were included in Reported Outcome Measure training, and have influenced the introduction of deferred discharges.

Young People were also involved in the development of the mobile phone app, ‘Cypher’, which has been promoted at various events and via social media in Enfield. Over the last year nationally 10,000 new Cypher users have supported one another, and at any one time about 60 regular users are from Enfield.

In addition in 2017, schools have focused on World Mental Health Day on 10th October 2017, and young people were involved in the design of the posters advertising events. A similar event is planned for 2018.

Work on the annual refresh of the local *Future in Mind* Transformation Plan has been carried out with a wide range of stakeholder groups, including schools, the Head Teachers forum, the voluntary Sector, GPs and other stakeholders, who are well placed to respond proactively to the priorities that have been identified. The establishment of the Provider Forum, now known as the Mental Health Forum, has extended this involvement. In addition work has continued with the Head Teachers Forum and as a result one of Enfield’s largest secondary schools has been involved in promoting the Cypher app. Head Teacher engagement has been critical to working on the Transforming Care agenda and improving the collaboration between SCAN, the Disability Services and families with young people, who are autistic or have learning disabilities and mental health or challenging behaviour problems.

In the original plan additional funding was put aside as part of our investment plans to support the development of a peer engagement programme. We wanted to build on the work of Kratos, the Looked After Children Council, which has been successful in engaging looked after children in a wide range of activities. Whilst we remain

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committed to this idea, and the initial programme was successful more recently investment in the CAMHS multi-disciplinary community service have had to be prioritised.

**Priority**

**To further develop the model of co-production with children, young people and their families.**

**Our actions**

✓ Continue to develop participation groups, with a view to a further extension of existing activity:
  - Service user feedback and participation in developing care planning at a user level
  - Participation Group and CYP inclusion on interview panels

✓ CYP to participate in staff training, e.g. use of outcome measures

✓ Ensure 'Our Voice' are substantive members of the CYP MH Partnership Group, and that service user participation is a regular standing agenda item (future developments as well as a feedback mechanism)
10. Encouraging a whole system approach

There is an ongoing commitment in Enfield, led by the Health and Wellbeing Board, to a whole systems approach to children and young people’s mental health. We want children and young people’s mental health and emotional wellbeing to be everyone’s business.

Since the original submission:

- Work on destigmatisation has included successful events planned and delivered by the Mental Health Partnership across the Enfield community to mark World Mental Health Day (October 2017 & 2018) and Mental Health Week (May 2017/18). These have been well advertised and well attended by the school and wider community.

- The Health and Wellbeing Offer for Schools was developed and launched by Public Health this year. The Health Enfield Website was also developed this year https://new.enfield.gov.uk/healthandwellbeing/- it has a Healthy Youth section and Healthy Schools section and includes emotional well-being and mental health

- A Provider Forum, now known as the Mental Health Forum has been established and is very well attended. The forum is a space where providers, including schools and the voluntary sector, can network with each other, get involved in the development and implementation of our Future in Mind plans, are provided with support and training. The Forum is steered by a multi-agency group comprising representatives from CAMHs, Schools, the Educational Psychology Service, Enfield Council, and NHS Enfield CCG.

- The CYPIAPT Learning Collaborative has been extended and now involves the Youth Offending Unit. There are plans in place to continue the programme and a commitment for workforce to access further training across the therapy, supervision and leadership arms across Enfield Council and NHS staff. The CYPIAPT principles are starting to be embedded in strategic developments, e.g. parenting programmes.

- Enfield Council, through the Educational Psychology Service is committed to developing a charter mark for schools well-being being, i.e. Sandwell Charter Mark.

- The EPS and SEWS are planning to develop a social and emotional well-being hub model. This has potential to align therapeutic services offered by the voluntary sector organisations and have a coordinated response for a group of schools in relation to responding to social, emotional and mental health needs. The innovation team comprises Senior Educational Psychology, Senior Family Therapy, Head Teacher, parent and young person representation.
The Haven for secondary school pupils was launched this year and is open Mon, Tues, Wed, in the area of Edmonton. The Haven is quiet place to go that is calm and restful. Youth workers are on hand if they need a chat. There are no age restrictions but it is aimed at secondary school age children who don't need to be in school at lunchtimes and for young people.

20 Peer Mentors have been trained by the Youth Service to deliver PHSE lessons and schools assemblies on the subject of good mental health. Four of the peer educators have mental health conditions including bi-polar, self-harm, anxiety and Psychosis. Not only has it improved their mental wellbeing by talking about their conditions but it has also helped their peers to understand mental health better and to remove the stigma around it.

Priority

1. To participate in Thrive LDN – the London-wide movement to improve the mental health and wellbeing of all Londoners. Supported by the Mayor of London and led by London Health Board Partners

2. To look for opportunities to build on the peer support work that has already started
11. Promoting resilience, prevention and early intervention

Between 25-50% of adult mental illness may be preventable with appropriate interventions in childhood. Poor mental health and wellbeing in childhood and adolescence is associated with a range of poor childhood and adult outcomes.

Early intervention gives the scope to treat the causes of poor health (Allen, 2011). By early is meant any (or all) of the following:

- Early in a child’s life (pre-conception, ante-natal, post-natal support and early years services).
- Early in the life cycle of the child’s difficulties (as soon as these are detected).
- Early in the presentation of the child’s difficulties (very swiftly after the child is first seen for a difficulty at a health or social care service).

The Council has developed a Family Resilience Strategy, which aims to promote better joint working by bringing together the borough’s early help offer as an Early Help Family Hub. The hub will see the alignment of existing agencies, such as Children’s Centres, Change and Challenge (Troubled Families) and the Parent Support Service to give a better holistic overview of whole family needs when providing support. The hub will work closely with health and other agencies and will ensure that an effective multi-agency response is put in place where necessary.

We want families to:

- Be resilient, thrive and strengthen their community
- Preserve family life wherever possible
- Have the best physical and mental health and wellbeing
- Support children in their learning and education
- Be as economically self sufficient as possible
- Live free of crime and domestic abuse

The right service at the right time

Different children, young people and families have different needs. Some children will flourish in a family who is accessing universal services which are available to everyone, such as health visiting, children’s centres, schools and leisure services. Others will require more targeted interventions to tackle emerging needs, such as family support services, or additional help and support at school. Some families will have more complex issues which require either a multi-agency response from targeted services, or specialist services from children’s social care, youth offending teams or
specialist health services. We will assess the need for early help services by utilizing the Enfield Threshold Guidance, which is a tool to inform all those working with children about to assess and identify a child’s level of need and how to access the right level of support.

Our MASH (Multi Agency Safeguarding Hub) is designed to make it easier for professionals and agencies to access relevant early intervention and support for a child, young person or family who requires targeted or specialist services. The THRIVE model will be incorporated into the working of the MASH.

**Think family**

We will ensure that all agencies recognise their responsibility to think in terms of the whole family, in order to provide holistic support. Rather than individual agencies working with individual family members in isolation, agencies will work as part of a team around the family, recognising the needs and aspirations of all family members, and supporting them to make positive changes.

**Family resilience**

Effective universal services will enhance families’ unique qualities, strengths and skills to encourage them to cope with future challenges. We will work with families in a way that empowers and motivates them to develop routines, relationships and coping strategies so that they can respond as positively as possible to any future difficulties.

Enfield’s Parent Engagement Panel (PEP) is a network of parents and carers who share ideas and give each other support, take part in events and activities that represent the views of parents in consultations and meetings with the council. PEP offers community support and information for vulnerable families, and helps to raise aspiration and family resilience by equipping families with new skills and knowledge to support their own and other families.

The Early Help and Family Hub will offer holistic support for all Enfield families encompassing:

- Health and child development
- School readiness
- Employment support and access to child care
- Parenting advice and support
- Support for families with more complex needs
- Early identification of Special Educational Needs.
Specific services include:

**Children’s Centre Therapeutic Sessions:**

Bookable parent consultation slots with a psychologist to clarify concerns and to consider supportive strategies.

**Incredible Years Parenting Programme:**

Evidence based parenting programme focussed on preventing and treating young children’s behavioural problems and promoting their social, emotional and academic competence.

**Short-term Therapeutic Intervention:**

Therapeutic intervention with a CAMHS practitioner (Clinical Psychologist). This is usually offered as five sessions, followed up by a supported referral to CAMHS if necessary.

**Priority**

**To implement the Family Resilience Strategy and develop a Family Hub offer for 0-19 year olds**

**Our actions**

- Early Help and Family Hub reporting to be aligned to GP localities
- Develop a multi-agency panel to review referrals for children with identified needs
- Further development of the Play and Communication Programme
- Development of the Early Help Module for casework recording across Early Help services and linking to the Child Portal referral system
12 Schools, Academies and Colleges in Enfield

The Government has stated its commitment to supporting Mental Health in schools. In July 2018, the Next Steps was published.

There was a pledge to build on the ‘range of excellent work that already takes place in schools and colleges. Supporting good mental health goes hand-in-hand with equipping young people with the qualifications, knowledge and resilience they need to live a fulfilling adult life.’

In Enfield mental health in schools has been a long standing focus for the local area which has been influenced by the consistent commitment to partnership working across Education, Health, Social Care and the Voluntary Sector. We provide a whole system of support for CYP and stand together to work through challenges as well as the successes. Therefore across the partnership and in schools there is already excellent work in place. More recently there are four developments that are informing and furthering this work:

- The SEND Strategy (2018-2021) was developed and will be launched in November 2018 at the next SEND Strategy Board. An action plan accompanies this.
- Mental Health in schools Survey was completed in August 2017.
- The Healthy London Partnership Mapping Exercise Regarding Mental Health Support in school was completed July 2018. This covered all school provide across primary, secondary and special school provision.
- The Sandwell-Whole School Well-Being Charter Mark

SEND Strategy (2018-2021)

The SEND strategy identifies the outcomes for all children and young people with SEND, aged 0-25 within the London Borough of Enfield. Our offer will ensure that children and young people with SEND have their needs identified at the earliest opportunity, can access inclusive mainstream education and are supported with a smooth transition to adulthood.

In Enfield the children/young people with the highest needs in our schools includes those with:
- speech and language and communication needs, and
- social, emotional and mental health needs (SEMH).

The strategy identifies that primary schools in Enfield have a higher level of children with SEMH needs than the national average.
Children and young people with SEMH needs are therefore central to this strategy. There is strong and cohesive alignment between the action plans for the SEND Strategy and the Local Transformation Plan for CYP Mental Health.

**Mental Health in School Survey (2017)**

As part of the previous SEND Action plan (SEMH), a survey was undertaken in 2017 to provide more in depth understanding of how schools are supporting CYP with SEMH in Enfield. This survey was jointly commissioned by the CCG and Enfield Council and was fed into the CQC Thematic Review of Children’s Mental Health Services in September 2017. There was a 50% return rate and the main findings reported were:

- Most schools reported that SEMH needs are assessed through ongoing monitoring and staff reporting concerns.
- Schools reported a wide variety of support available for students’ SEMH needs. Mentoring was widely reported.
- Schools indicated a variety of therapeutic support currently offered to CYP with SEMH needs.
- The majority of respondents reported that they currently provide language and social skills groups (LASS) to meet the SEMH needs of their CYP. Traditional Nurture groups were available in over one fifth of schools, and provision similar to Nurture groups was available in over a third of schools.
- The majority of schools commission the Enfield Educational Psychology Service (EPS) to support them in meeting the SEMH needs of their students (74%).
- All schools reported that they refer to Specialist Community CAMHS (Tier 3) to meet the SEMH needs of their CYP. 98% referred to EPS and 84% referred to Behaviour Support Service (BSS).
- The majority of schools reported that the school's SEN/Inclusion team are responsible for coordinating and monitoring SEMH support. This suggests that schools have a clear understanding that SEMH is now a recognised category of SEND (DfE, 2015) and have taken steps to ensure that SEMH falls under the remit of SEN or Inclusion teams.

Examples of feedback from young people about SEMH support in schools:

“At school there is an on-site medical person there for when you physically don’t feel well but there doesn’t seem to be an equivalent person for when people feel stressed or upset.”

“...there should be a ‘Health and Wellbeing’ person at school for students to talk to. There could be a clinic run in the school.”

“Careers advisers come into school to talk to students but not someone who deals with mental wellbeing.”
Nearly 94% of respondents reported that the views of CYP are included in the process of assessment for SEMH needs; this practice is in line with the SEND Code of Practice (DfE, 2015).

**Healthy London Partnership (HLP) Mapping Exercise Regarding Mental Health Support in school (July 2018)**

The HLP mapping exercise built on the results of the survey and was completed under the remit of the CYP Mental Health Partnership Group. It brought in other key developments related to mental health in schools such as:

- Multi-Agency Fair Access Panels for children at risk of exclusion
- The Transforming care agenda
- Focussed support for vulnerable groups, e.g. Looked After Children
- Personal Social and Health Education programmes on offer to schools
- ‘Mental Health Week’ and ‘World Mental Health Day’ events - provided to schools.
- ‘Active in Mind’ projects
- Healthy Schools London Award
Sandwell Whole School Well-Being Chartermark

**Sandwell Whole School Well-Being Chartermark**

Enfield Public Health and Enfield Educational Psychology Service are implementing the Sandwell Whole School Well-Being Charter Mark with Enfield schools following on from the work of Sandwell Public Health and Educational Psychology Service. The pilot phase will commence in October 2018. The aim of this charter mark is: ‘To improve the Well-Being of the Whole School Community.’ This will be achieved through:

- Implementing an action research-based enquiry with schools which leads to the award of a Charter Mark on completion.
- Promoting a systemic approach where emotional health and well-being is embedded throughout the culture of the school and curriculum.
- Pupils, parents/carers and staff involvement and well-being being central to the process.

The project will launch with 10-15 schools with a second phase starting in January 2019 to include 15 more schools. Expected outcomes are:

- Increased awareness and support for children and young people in schools with SEMH needs
- Increased pupil attendance
- Reduced fixed term and permanent exclusions
- Increase in staff well-being and resilience/reduced sickness and absences
- Decreased referrals to CAMHS and other Tier 3 services
- Increased value and facilitation of authentic participation of young people, parents, carers and school communities
- Increased awareness of mental health and well-being in children and young people
- Closer collaborative working and support for our schools in relation to SEMH at a preventative level.

**Priority**

To implement an agreed quality standards across schools for therapeutic and therapeutically informed interventions

**Our Actions**

- Undertake a review of the existing quality standards in Enfield
- Develop arrangements that will offer therapeutic interventions in line with the BPS Standards for Schools as set out in the document: ‘BPS Child & Family Clinical Psychology Review - What good looks like in psychological services for schools and colleges. Primary prevention, early intervention and mental health
provision’ and the ‘BPS Child and Educational Psychology Review – Delivering psychological therapists in schools and colleges’.

- Working with Enfield schools, explore school liaison links to NHS CAMHS with a view to developing strong and coherent relationships, supported by effective communication
- CYP Mental Health Partnership Group to plan and deliver a Mental Health in Schools Conference for SENCOs in the Spring Term (2019).

**Priority**

*To co-produce and pilot a collaborative approach across sectors for ‘Getting Help’ services to schools whilst maintaining a clear interface with specialist mental health services.*

**Our Actions**

- To set up and pilot SEMH hubs bringing together all mental health providers who are offering intervention in two school partnerships. It aims to set up systems as a forerunner for the Mental Health Support Teams as outlined in the Next Steps (2018). Children’s Well-Being practitioners will be part of this development from January 2019.
- To introduce Children’s Well Being Practitioners through recruit to train (in partnership with NHS CAMHS).
- To continue to work collaboratively to implement the THRIVE model across Enfield Schools.
- Provide evidenced parenting programmes for children with SEMH (particularly conduct disorders) in the early years and school age population. This will ensure parents are provided with knowledge and skills so that they can effectively support their child’s behaviour, as evidenced by outcome measures and longer term evaluation of impact. This will be aligned with the early help offer.
- To ensure there is a high quality local area offer for children with SEMH aligned with key principles, including the commitment to raising awareness of mental health issues in CYP

**Priority**

*To review systems to ensure vulnerable children access school and support.*

**Our Actions**

- Reviewing the purpose and methodology of the primary Fair Access Panel and the multi-agency SEMH crisis response offer. The aim is to reduce the number of children at immediate risk of permanent exclusion. This ensures schools, parents
and CYP receive appropriate support to put an effective plan in place so that they remain in an educational provision.

✓ Develop a coherent whole system approach for children who are provided with home tuition or are not in school and who are presenting with complex mental health needs. This will build on the education services Attendance Support Unit/Home Tuition Meeting.

Priority

To offer a Whole School Well-Being Charter Mark to schools in Enfield, e.g. Sandwell

Our Actions

✓ Team to have signed up 10-15 Schools for October 2018 start (to include primary, secondary and special schools). The second phase to commence in January 2019.

✓ Agree Communication Strategy for reporting outcomes at the Health and Well-Being Board.

✓ Presentation of the first Sandwell Charter Marks by July 2019.

✓ Agree a plan for sustainability by July 2019.

Priority

To co-produce a training programme with all providers including schools and the voluntary sector, young people and their parents

Our actions

✓ To have a workforce development and sustained training programme on SEMH for schools which will ensure they have increased confidence and knowledge when working children with social, emotional and mental health needs and challenging behaviour. Specific topics will include the most prevalent mental health issues, including ADHD, deliberate self harm, eating disorders, anxiety and depression, and Cognitive Behaviour Therapy (CBT) for exam stress.

✓ Schools to each have a named professional for providing advice on SEMH. This will be a protocol-led arrangement, supported by training and communication provided for schools. This will be built on from using existing professional relationships and contacts (e.g. EPS, SEWs, BSS).

✓ Continue to roll out the Attachment Lead programme and support the Nurture Group, LASS interventions.
✓ The CYP Mental Health Partnership to plan and deliver a SENCO conference on schools mental health for March 2019.

✓ Await and support the roll out of the Designated Mental Health Lead Training for schools. A member of the CYP Mental Health Partnership is on the DfE Professional Reference group related to this development.

✓ Identify and develop specific training with continued support/supervision for Learning Support Assistants and Teaching Assistants, e.g. Health Mentors or ELSA.
13. Children & Young People IAPT Transformation

*Future in Mind* recommends implementation of Children & Young People Improving Access to Psychological Therapy (CYP IAPT), as the major transformation programme for existing CAMH services and partner agencies.

Enfield joined the CYP IAPT Learning Collaborative in 2016, creating a local partnership between CAMHS, the Educational Psychology Service, the Schools Behaviour Support Service and the Youth Offending Unit. A local CYP IAPT Steering Group is in place to drive implementation, reporting into the Children and Young People’s Mental Health Partnership Group. We are working to embed the key principles of CYP IAPT across the system in a number of ways:

- **Leadership**
  - Three senior staff have completed the CYP IAPT leadership training, and through this have undertaken quality improvement projects in their respective areas. These staff occupy key strategic roles: the CAMHS Clinical Lead, The Head of Educational Psychology and SEWS, and a senior CAMHS Clinical Psychologist leading on participation. In addition to these discrete projects we are working to ensure that key leadership meetings have agendas closely aligned with CYP IAPT transformation aims.

- **Supervision**
  - Across the partnership supervisors have completed CYP IAPT training in a number of modalities, including CBT, Systemic Practice and Parent training. Our services also draw on existing expertise in CBT, systemic therapy and child and adolescent psychotherapy to ensure rigorous supervision is in place across the service.

- **Evidence-Based Therapies**
  - Staff have completed therapy training in IPT-A, CBT, Systemic Practice and Parent Training.
  - In addition to CYP IAPT training, there is a depth of experience in the workforce, with expertise in a range of other evidence-based approaches, such as EMDR, Trauma-focussed CBT, Short-Term Psychoanalytic Psychotherapy, Mentalisation-Based Therapy and Dialectical Behaviour Therapy.
  - CAMHS and SEWS will provide placements for CWP trainees in 2019, which will enhance local provision of early short-term evidence-based interventions.
• Participation
  
  o There are thriving young people’s participation initiatives in several areas of the service. The CAMHS YP Participation group is consulted on various service developments, and successfully bid for Trust funding to put on a YP mental health awareness event in the local community. A number of our services are including young people in recruitment processes and training events.

• Outcomes
  
  o Through outcome and feedback tools, we are seeking to strengthen a service culture of full collaboration between child, young person, parent/carer and therapist. In CAMHS we are establishing digital collection of ROMs using ICAN, enabling seamless data entry and immediate feedback of ROMs to clients. Through our CWP trainees, we will also be trialling POD in CAMHS and SEWS to evaluate its potential to enhance our use of ROMs across the system. Our services are using a range of outcome measures to guide therapy, support service monitoring and decisions about service development including: Goal Based Outcomes, SDQ, RCADS, CGAS and ESQ which will become part of the CAMHS minimum data set.

All providers have accepted CYP IAPT principles and there are targets set for progressive improvement. The new CAMHS minimum data set which was launched in January 2016 incorporates the collection of CYP IAPT data and provider compliance has been promised supported by infrastructure investments included in the Transformation Plan.

All services participating in CYP IAPT are asked to ensure that 90% of closed cases, seen three or more times, have full data from at least two time points, one of which can be assessment. The outcome data will be used in direct supervision of the therapist, to determine the progress of therapy, overall effectiveness of the service and to benchmark services. Embedding outcome monitoring across the whole of CAMHS and other mental health providers will focus services on the benefits resulting from interventions and help transform how services are delivered.

Enfield has successfully bid for three Child Wellbeing Practitioners and will be looking to embed them into the work of the SEMH hubs for Schools and CAMHS Access Pilot and ensure sustainability.

Priority

To ensure ongoing transformation by continuing to embed CYP IAPT principles into the whole system of provision

Our actions

✓ Improved access through advice, signposting and early intervention.
✓ To link the CAMHS Access pilot to schools, the SEMH hubs and the work of the Child Wellbeing Practitioners

✓ To consolidate the implementation of digital collection of ROMS, increase overall collection of paired measures and improve the feedback process from ROM data to quality improvement

✓ To continue to strengthen service user participation in service design
14. Extending Access to Services

There is commitment across the partnership to ensure that we work collaboratively to deliver the most effective service possible from within available resources. The two generic CAMHS teams have been combined into one team working alongside the adolescent team, and the intention is that they will be accessed through a single point of access. There needs to be a balance between clinic-based work and outreach – some young people/families need to be seen where they feel comfortable – for example; in satellite clinics or by basing sessional workers in schools, academies, colleges and community settings. We continue to explore ways to extend access out of school hours and in different locations in order to ensure services are as accessible as possible.

Through CYP IAPT the range of therapeutic options has been extended and the range of therapies offered by CAMHS is:

- Individual psychodynamic psychotherapy
- Dynamic interpersonal psychotherapy
- Interpersonal psychotherapy
- Group psychotherapy
- Time limited child and adolescent psychotherapy
- Psychopharmacology
- Systemic family practice
- Cognitive Behavioural Therapy (CBT)
- Eye movement Desensitisation & Reprocessing (EMDR)
- Individual parenting sessions
- Webster Stratton Parenting Groups

In addition there is a member of staff trained in Video Interaction Guidance, which is comparable to the Video Interaction Parenting Programme (VIPP)
The NHS Constitution now includes the expectation that the number of new children receiving CAMHS will increase to 32% in 2018/19, 34% in 2019/20 and 35% in 2020/21, of children and young people with a diagnosable mental health condition will receive CAMHS treatment. Based on Mental Health Services Data Set (MH SDS), the outturn for 2017/18 was 22.5%

Enfield has participated in workshops and seminars to improve data and reporting:

<table>
<thead>
<tr>
<th>Flowing Data</th>
<th>Date attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Young People’s Mental Health: flowing data to the Mental Health Services Data Set (MH SDS) support workshop</td>
<td>04/05/2018</td>
</tr>
<tr>
<td>Web ex on Outcomes</td>
<td>31/05/2018</td>
</tr>
<tr>
<td>Web ex on Outcomes</td>
<td>20/07/2018</td>
</tr>
<tr>
<td>Web ex on Outcomes</td>
<td>08/10/2018</td>
</tr>
<tr>
<td>London Borough of Enfield – MH SDS submission</td>
<td>28/11/2018</td>
</tr>
</tbody>
</table>

We have calculated that in order to achieve the 32% target for 2018/19, 2,664 CYP will need to be seen by NHS funded CAMHS services with two or more contacts. We have also calculated its main provider’s contribution, based on historical activity, will be 82% of the target, with the remaining activity coming from other NHS-funded providers, including the London Borough of Enfield, NHS organisations providing mental health services and the voluntary and charitable sector.

<table>
<thead>
<tr>
<th>Access* (prevalence based) treatment target</th>
<th>2017/18</th>
<th>2018/19</th>
<th>PCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enfield prevalence target 2018/19</td>
<td>32%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enfield prevalence</td>
<td>8,123</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of CYP 2018/19</td>
<td>2,664</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Access is defined as ‘total number of individual children and young people aged 0-18 receiving two or more contacts in the reporting period’. Treatment is defined as 2 contacts with no-time out. Age is 0-17y-365 days at first contact (second contact can be after 18 birthday), an individual can be counted only once in a financial year; treatment may include

* Relates to the proportion of BEH treatments compared to CCG’s total to achieve 32% access rate

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There has been a significant focus on reducing waiting times between April and July 2018, and on reaching the trajectory to achieve 32% from August onwards. This has included the implementation of a new model to support this.

Please see below graph, the prediction uses both MHSDS publications and local submissions.

The chart will be refreshed each month following MHSDS submission.

In order to achieve 32% by March 2019, 1210 children will need to be contacted between August 2018 and March 2019, average 173 children per month, approximately 9 children per day (using 20 working days in a month as an example).

The table shows the MHSDS flow for December 2018 including provisional and local data, Enfield was achieving 26.2%, therefore we are on track to meet the target.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST</td>
<td>1441</td>
<td>17.3%</td>
<td>1845</td>
<td>22.1%</td>
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</tr>
<tr>
<td>GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST</td>
<td>15</td>
<td>0.2%</td>
<td>5</td>
<td>0.1%</td>
<td></td>
</tr>
<tr>
<td>ROYAL FREE LONDON NHS FOUNDATION TRUST</td>
<td>33</td>
<td>0.4%</td>
<td>15</td>
<td>0.3%</td>
<td></td>
</tr>
<tr>
<td>TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST</td>
<td>60</td>
<td>0.7%</td>
<td>30</td>
<td>0.4%</td>
<td></td>
</tr>
<tr>
<td>DAZU</td>
<td>35</td>
<td>0.4%</td>
<td>32</td>
<td>0.4%</td>
<td></td>
</tr>
<tr>
<td>CYP IAPT estimate</td>
<td>0</td>
<td>0.0%</td>
<td>58</td>
<td>0.7%</td>
<td></td>
</tr>
<tr>
<td>London Borough of Enfield</td>
<td>282</td>
<td>3.4%</td>
<td>196</td>
<td>0.8%</td>
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</tr>
<tr>
<td>Other NHS Providers</td>
<td>34</td>
<td>0.4%</td>
<td>0</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Other NHS Funded Voluntary Sector Providers</td>
<td>10</td>
<td>0.1%</td>
<td>127</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1910</strong></td>
<td><strong>22.9%</strong></td>
<td><strong>2179</strong></td>
<td><strong>26.2%</strong></td>
<td></td>
</tr>
</tbody>
</table>
Local data is currently being used for two providers, and the plan is to ensure that data is flowing accurately and consistently through the MHSDS by April 1st 2019 by web pool. To note that Information Governance issues have caused the delay in implementation and these have now been resolved. In order to meet the revised target:

- The two providers have been registered with an ODS code in order to be able to submit data
- A task and finish group has been set up to project manage implementation and will run beyond April 1st 2019 to ensure data integrity.

Enfield EPS and CAMHS is a well thought of service, and up until the summer of 2017 the vast majority of CYP were seen for an initial assessment within 13 weeks of referral. However there have been a number of recent changes in key members of staff, an increase in both the number of referrals and complexity of cases, and mandated changes in the way waiting time from referral to first assessment are recorded and reported. Therefore we have invested money in front line staff to increase the clinical resource available to reduce waiting times. The number of CYP waiting over 13 weeks to be seen by the Generic CAMHS Team has already started to reduce, and we expect that by October 2018, 92% of all CYP will be seen within 13 weeks of referral.

**Recovery Plan Waiting Times**

<table>
<thead>
<tr>
<th>Action</th>
<th>Time scale</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve productivity</td>
<td>On-going/reviewed monthly</td>
<td>This is kept under review – the increase in complexity of children presenting to the service has impacted on productivity</td>
</tr>
<tr>
<td>Effective waiting list management</td>
<td>On-going/reviewed monthly</td>
<td>Waiting times for generic CAMHS have improved and we expect to meet the 32% access target. Monthly calls in place to monitor progress.</td>
</tr>
<tr>
<td>Ongoing recruitment to vacant posts</td>
<td>Immediately</td>
<td>Trust currently on track to achieve recruitment plan</td>
</tr>
<tr>
<td>CAMHS Access/Triage Team to commence</td>
<td>October</td>
<td>A new team funded to see children and young people who might not meet the eligibility criteria for current services. The team will triage, signpost, and provide additional clinic capacity.</td>
</tr>
<tr>
<td>LTP/THRIVE implementation</td>
<td>Ongoing</td>
<td>The CQC CAMHs Thematic Review was positive about many elements of service provision and partnership working in Enfield. The CAMHS Access and further work on THRIVE implementation should ensure sustainability.</td>
</tr>
</tbody>
</table>

**Priority**

To ensure that the number of children with a diagnosable mental health condition receiving CAMHs treatment achieves the incremental targets over the next three years

**Our actions**

✓ Recovery plan implementation
15. Adolescent Outreach and Crisis Intervention

The SAFE (our adolescent outreach service) and Alliance teams together provide a highly responsive service for adolescents at risk and Enfield has the lowest Tier 4 admission rate in NCL. Tier 4 admission data is shown below, this is taken from data collated by Enfield clinicians, which is checked where possibly against data supplied from the NHSE Specialist Commissioning Team. Figures form 2011/12 and 2012/13 in particular reflect the impact of work of the Alliance Team in reducing the number of Tier 4 admissions, and length of stays, and we are keen to ensure that this is maintained, through ongoing collaboration with the NHS England Specialist Commissioning Team.

Tier 4 Bed Admissions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total OBDs</td>
<td>3642</td>
<td>2145</td>
<td>1328</td>
<td>1910</td>
<td>1621</td>
<td>1029</td>
<td>2582</td>
<td>1685</td>
</tr>
<tr>
<td>Admissions and re-admissions</td>
<td>44</td>
<td>30</td>
<td>25</td>
<td>20</td>
<td>23</td>
<td>11</td>
<td>20</td>
<td>31</td>
</tr>
</tbody>
</table>

Since April 2015, SAFE has successfully trialled an urgent assessment service for children and young people admitted to paediatric wards at the North Middlesex and Barnet Hospitals with presentations of deliberate self-harm (DSH). The more proactive approach has resulted in a three-fold increase in the number of ward assessments carried out by senior CAMHS clinicians but has impacted on service delivery in other areas. For 2015/16 it was proposed to use Transformation Funding for eating disorders to provide permanent backfill for the senior clinicians included on the DSH rota, and carry out a waiting list initiative across all services and because of the uncertainty around funding, this continued in 2016/17. Going forward it is our intention to implement a whole service response to children and young people’s needs, through implementation of a THRIVE type model, accessed via the Multi Agency Safeguarding Hub (MASH). However this will not be as comprehensive as originally envisaged and it is likely the DSH rota will need to continue. Revised investment proposals which were based on a skills audit and discussions with Heads of Service and the clinical team are detailed in the finance section.

The DSH rota will pick up children and young people from the Transforming Care cohort who attend the A&E Departments in crisis, but the intention of the work described in the section on Transforming Care on page 23 is to prevent this from happening. Initial evidence of impact from the work of the STAY Team and associated network of service, is that the level of risk of children on the At Risk Register is reducing.
Guidance from NHS England includes the expectation that CCGs will have a dedicated mental health and liaison response for children and young people presenting to emergency departments, in wards, and community settings which includes provision for a response across extended hours.

**Out of hours NCL-wide nurse-led component**
Following consultation with key stakeholders, options appraisals and financial analysis, it was agreed the core out of hours component be provided by a nurse-led component delivering twilight cover 7 days a week, plus weekend cover from 9am to midnight. The component will be delivered by Band 6 nurses with Band 7 leadership and will be integrated into Paediatric Liaison. Estimated costs are £100k per CCG in North Central London, which for Enfield CCG is expected to be funded through the annual uplift in *Future in Mind Transformation Funding*. 
In Enfield non recurrent funding has been agreed in 2018/2019 to extend the DSH rota and meet the increased demand until the NCL STP Team come on line.

Priority

To extend access, particularly for vulnerable young people who may be reluctant to engage with services, by making it easier to get an appointment at different locations including out of school hours

To work with STP partners on the implementation of the proposed NCL CAMHS Liaison service

Our actions

✓ Implement the NCL crisis pathway in Enfield
16. Eating Disorders

The Royal Free Hospital Eating Disorder Service (EDS) provides a specialist eating disorder service for Enfield children and young people. The EDS was first commissioned in 2008 is now commissioned by Barnet CCG as lead commissioner on behalf of Enfield, Haringey, Camden and Islington CCGs.

The EDS consists of an outpatient department where most Enfield young people are treated. However, where patients are not progressing in outpatients, the Eating Disorder Intensive Service (EDIS) offers day service support and also outreach in the community, including the young person’s home. The aim of the EDIS is to try and prevent patients being admitted onto a hospital ward.

Reported data has suggested an increase in hospital admissions, and that this increase also appears to include those young people who have been in the EDIS for a year or more. The Royal Free Hospital reports that they are presenting with significant comorbidities and thoughts of suicide.

In partnership with the four NCL CCGs, we will be seeking to understand what factors are driving this increase and the overall effectiveness of the EDIS through a comprehensive service review.

To do this, we will be looking at under what circumstances CYP are admitted to a paediatric wards, how long a young person they should remain there before receiving specialist inpatient management on a specialist ward, and whether or not it might be more appropriate to be referred directly to a specialist placement. We will also seek to establish the difference between the outpatient service and the intensive service, what existing key performance indicators are used and what gaps there are in assessing the EDS performance.

We will also be looking at the entire treatment journey, or the ‘patient pathway’, to see what efficiencies can be achieved to improve the young person’s experience of the service, and seeking direct feedback from young people and their parents or carers, to see what other improvements need to be made.

We will also be using NHSE’s commissioning guidance as well as National Institute of Health and Care (NICE) guidelines to steer our work, and ensuring that the service will
achieve the mandated national targets, including emergency, urgent and routine waiting times, as well as other quality measures.

The table below details the waiting time performance for the last six quarterly periods. This year’s target is for 95% of urgent young people to be assessed within a week of a referral being received by the provider. For routine cases, the target is for 95% of routine cases be assessed within four weeks of a referral being received. The target applies to all referrals, regardless of who has made it, whether it be from a school, a parent or carer, a GP or even a self referral.

<table>
<thead>
<tr>
<th>Financial year and quarterly period</th>
<th>Waiting time to be seen (numbers of young people)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent (2018/19 Target: 95% 0-1 weeks)</td>
<td>0 - 1 Weeks</td>
<td>1 - 4 Weeks</td>
<td>4 - 12 Weeks</td>
<td>12 Plus Weeks</td>
<td>Compliance</td>
<td>0 - 1 Weeks</td>
<td>1 - 4 Weeks</td>
<td>4 - 12 Weeks</td>
<td>12 Plus Weeks</td>
</tr>
<tr>
<td>2018-19 Q1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18 Q4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18 Q3</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18 Q2</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18 Q1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75.0%</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016-17 Q4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75.0%</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Further information about Eating Disorders can be found here:

https://www.nhs.uk/conditions/eating-disorders/

**Priority**

To ensure that the services commissioned for eating disorders continue to meet local need through a comprehensive review
17. Work with Vulnerable Children and Young People

It is a priority for the CCG and the Council to strengthen early identification and intervention, and ensure that there is a common understanding and ability to recognise mental health problems among volunteers and professionals working with young people. We want to ensure that this means children and young people’s mental health difficulties are recognised early enough and that appropriate early interventions are provided.

The Transformation Plan was developed using existing JSNA and needs assessment information and we are confident in the priorities that have been agreed but this is an iterative process that will continue to support developments going forward.

Looked After Children

The HEART CAMHS team is commissioned to receive referrals from Social Workers of looked after children aged 0-18, and to provide support to Foster Carers, via referrals from Supervising Social Workers.

Enfield currently has 341 looked after children aged 0-18. In the financial year 2017-2018 HEART CAMHS had 96 referrals and accepted 100%. This represents 28% of LAC in Enfield, whereas there is evidence suggesting 45% cent of looked after children aged 5 to 17 in London experience a mental health disorder11, we know that up to 78% of LAC score over 17 on the SDQ (CYP-IAPT LAC implementation group) and that over 60% will need specialist input (NICE 2010).

Looked After Children (LAC) represent a high need group, where early intervention has been shown to reduce later cost burden on health and social care services. Research suggests that a very high level of looked after children could benefit from CAMHS input. Since all looked after children have been through adverse childhood experiences, which are known to lead to negative health, social and educational outcomes, we would like to reach majority of LAC through either direct CAMHS input, training and support to foster carers, or consultation to social workers.

11 https://www.london.gov.uk/sites/default/files/gla_migr ate_files_destination/M ental%20health%20report.pdf
The CAMHS HEART team is currently a team of 2.1 full time equivalents. The small size of the team means we can only manage a proportion of LAC who might benefit from our direct input. Therefore we will need to look at the demand and capacity of the HEART CAMHS team, particularly in relation to young people in the age group 16 to 25 years, given the current service is only commissioned for young people up to the age of 18.

Unaccompanied Asylum Seeking Children

In the last few years and in common with many other London boroughs, Enfield has seen a steady increase in the number of Unaccompanied Asylum Seeking Children (UASC) looked after arriving in the Borough. Data for 2017 from Public Health England\textsuperscript{12} indicated Enfield had 70 UASCs, the third highest in London. Only Croydon, Hillingdon and Brent had higher numbers with 390, 85 and 75 respectively.

UASC become looked after children by virtue of their status and are afforded the same rights as any other LAC.

This means that all the statutory duties and good practice guidelines for promoting the health and wellbeing of LAC apply. As with any Looked after Child, an unaccompanied child or young person is eligible for free treatment on the NHS, and this will continue to place a pressure on local health and social care provision. UASC will require access to local health and care services, translation services and safeguarding interventions where required. These children may have additional needs through trafficking and human slavery, child sexual exploitation and exposure to blood borne viruses.

Care Leavers

There are over 100 young people over the age of 18 supported by the leaving care teams, or with care leavers’ rights. These young people currently do not receive specialist mental health services which are designed around their particular needs having grown up in the care system.

Care history is an adverse childhood experience which increases vulnerability for a range of negative social, health, educational and financial outcomes, including poor

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\textsuperscript{12} https://fingertips.phe.org.uk /profile/group/mental-health/profile/cypmh
mental health, increased hospital admissions, difficulty parenting one’s own children and involvement with the criminal justice system.

Care leavers are particularly vulnerable, as most are in semi- or fully-independent accommodation rather than foster care, meaning they can easily become socially isolated, a known stressor for psychological difficulties. They get limited input from leaving care social workers.

In a recent report, Ofsted highlighted a lack of transition support in Enfield to adult mental health services, and a lack of mental health provision for care leavers in its last inspection report of HEART. Therefore, there is a need to improve transition services for 18 years and over and the Future in Mind vision for mental health suggests services should be restructured to break down barriers between adult and adolescent services.

This is a high need group who often do not receive an adequate service from adult mental health for a variety of reasons. For example, they have a level of complexity which sometimes means they are excluded or drop out from services. Their difficulties may not fall into traditional mental health categories (being more attachment based) therefore they do not meet service criteria; their wellbeing needs can be too mild or too severe, perhaps needing lengthy therapy to address chronic attachment difficulties for traditional services.

When care leavers do need input, they are likely to be costly elsewhere in the health and social care system e.g. more crisis input, inpatient psychiatric admissions, involvement with the criminal justice system, child protection systems, etc.

We need to consider a commissioned service which takes an early intervention approach, with a smooth transition / seamless experience of care from childhood to adulthood,

**Youth Justice**

The rate of first time entrants to the youth justice system per 100,000 population is 457.9, compared to the London rate of 380.3, and 292.5 for England\(^\text{13}\). We believe the increase in youth custody rate to be due to population increases primarily as result of changes to the benefit system

The Enfield Youth Offending Unit (YOU) is considered to be well performing. The CCG is an active member of Enfield Targeted Youth Engagement Board (ETYEB), and there are regular items on CAMHs and Future in Mind. We aim to ensure that young people in the youth offending system have ready access to mainstream services with additional funding provided for CAMHS psychologist and school nurse sessions to facilitate access and provide training. The Brandon Centre is commissioned to work

\(^{13}\) PHE Fingertips data (2017), numerator taken from Police National Computer data
with nominated young people, some of whom are offenders or are at risk of offending and good outcomes can be demonstrated.

Enfield YOU is part of the Resettlement Network and this provides some additionality to the current team. Since 2016, Enfield CCG has been working with the Health and Justice Team to improve how the YOU works with local health services. There are improved care pathways for young people with learning disabilities, communication problems and head injury. In 2017 there has been training for the Youth Offending Team in a range of mental health topics led by Young Minds.

A speech and language therapist is embedded within the YOT and is carrying out review of cases and supporting staff to recognize potential problems and communicate more effectively with young offenders. In the earlier part of this financial year, the Liaison and Diversion post that will cover Enfield has been appointed to. This key role will act as a link between health and social care services and the criminal justice system, ensuring that wherever possible, children and young people who have been involved in criminal activity are actively diverted away from the police and justice services.

**Peri-natal mental health**

There is a strong link between parental (particularly maternal) mental health and children’s mental health. Perinatal depression impacts on at least 792 babies each year. The perinatal period (pregnancy to one year after birth) is critical to a child’s development and attachment. Perinatal mental health services, and Parent and Infant Mental have been identified as areas where there is a strong evidence base and care pathways and provision needs to be strengthened.

The Five Year Forward View for Mental Health\(^1\) 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.

The commissioners and providers who form part of the North Central London STP 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. The service is up and running and provides equity of access and consistency of provision across the five boroughs.

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\(^1\) Mental Health Taskforce report to NHS England (2016) *The Five Year Forward View for Mental Health*
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.

**Learning Disabilities and Autism**

See Transforming Care for children with learning disabilities and autism in Enfield on p23 and for the STP on p67 insert

The number of children and young people with autism is increasing and whilst a multi-agency pathway is in place for children under six years of age, provision for older children in particular needs to improve. Work on a revised diagnostic pathway for both groups is in progress. Schools are reporting an increase in the number of girls with high functioning autism who are experiencing mental health issues and we are working with the Autism Advisory Service to look at a system response. NCL STP has obtained some additional funding from NHS England to support training for CAMH staff together with 10k funding for each borough for personal budgets.

**Child Sexual Exploitation**

It has been agreed that there will be one London pilot site for the Child House model for victims of child sexual abuse and child sexual exploitation and that this will be provided in North Central London. Enfield has worked with colleagues across NCL STP to ensure successful implementation and agree pathways into local services.

**Transition CQUIN**

A transition CQUIN is currently in place, and is being implemented, covering transition from CAMHS to adult mental health services and primary care (primary care transfer is at discharge not at age 18, therefore not being included in this work) with the expectation that there will be a year on year improvement in patient experience. We are aware that further work is needed on transition processes for young people with complex needs, and there is a monthly discussion about this group of young people at the complex care panel.

The Trust has provided assurance that the transition policy has been reviewed and amended, and that transition planning is included within each Borough’s work stream. Commissioners have quarterly review meetings with the provider to review progress and agree plans where slippage has occurred.

**Priority**

To review transition processes, particularly for children and young people with complex needs, across the following groups:
✓ ADHD
✓ Autism
✓ Children Missing from Education (CME) or EHE
✓ Health and justice
✓ LAC (in Enfield and out of borough, including Care Leavers and UASC)
✓ Post Adopted children
18. Information Technology

Commissioners, both the CCG and the London Borough of Enfield, are committed to moving to outcomes based commissioning. Improvements in Information Technology were a key enabler in our original plan and progress since October 2015 has included:

- Adoption of information technology to support collection of outcome measures during therapy sessions utilising ICAN information software (developed by North East London Foundation NHS Trust).
- Development of a CAMHS microsite as part of the BEH Mental Health Trust website.
- The Council's CAMHS staff now have remote access to RIO. This will support the recording and performance when working in outreach capacity in schools, children’s centres, etc.
- Roll out of the Cypher Phone App - Cypher is a free, safe and anonymous social network for young people aged 11-19 years to share their secrets, thoughts and lifestyle, in the form of short anonymous posts, in a space free from judgment or cyberbullying. Promotion of an e-counselling app with Dazu, the Young Carers’ project. Currently there are over 60 regular users, mainly female, with an average age of 16 years.
- Improved data collection as part of national reporting for CYP IAPT (see chapter 19. Data – access and outcomes).
- Implementation of friends and family test kiosks
- Plans to promote NHS Go a health app which has been designed for young people aged 16-24 years across London, developed by the Healthy London Partnership Children and Young People’s Programme.

Referrers, young people, parents/carers and commissioners all share a common need to receive timely and clear information from Tier 3 CAMH services.

Priority

To continue to promote the self-help phone apps

To complete the data warehouse and support to the voluntary sector around the use of ICAN

- Adoption of information technology to support collection of outcome measures during therapy sessions utilising ICAN information software (developed by North East London Foundation NHS Trust).
✓ Ensure all information governance elements are addressed (including compliance with the latest version of the IG Toolkit)

✓ Improved data collection as part of national recording for CYP IAPT including data flows as part of the MHSDS reporting requirements
19. Data – access and outcomes

The Mental Health Services Data Set (MHSDS) contains data about the care of children, young people and adults who are in contact with mental health, learning disabilities or autism spectrum disorder services. It is a national requirement that all NHS-commissioned and jointly commissioned services, including non-NHS providers.

The MHSDS is a patient level, output based, data set which delivers robust, comprehensive, nationally consistent and comparable person-based information for children, young people and adults who are in contact with Mental Health Services. The MHSDS is referred to as a ‘secondary uses’ data set which intends to re-use clinical and operational data for purposes other than the provision of direct clinical care for patients. For example, it supports a number of functions, including:

- Commissioning of services from mental health providers
- Local and national performance management and benchmarking
- National reporting and analysis
- Clinical audit
- Research
- Service planning

The vast majority of our providers are already able to submit MHSDS data and we are working with a small number of voluntary and charitable organisations to ensure that we have full data capture in line with the national requirement from NHS England. We will be ensure that the arrangements in place by December 2018 and which will support regular data flows and robust data quality, whilst being cost effective.

We use data to regularly monitor service performance including a range of Key Performance Indicators (KPIs), and we use this to inform discussions with our service providers as part of our contractual dialogue with them. Key measures we report on include:

- Performance against the access standard (32% for 2018/19 and measured monthly), rising to 34% next year and 35% in 2020/21.

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Waiting time performance (measured weekly and monthly), including the percentage of CYP seen within 13 weeks of referral to initial assessment, where we have set a target of 92% with our main provider

Demand, measured by referrals received and accepted

Appointments attended and those where the CYP did not attend without prior warning

Productivity and the number of CYP currently being treated

Workforce composition

The quality of the data from our main provider is assured through a performance management framework underpinned by a regular schedule of formal meetings. Other providers’ data will be assured through arrangements with their lead commissioner.

The table below shows performance data over time from our main CAMHS provider. There has been a dramatic increase in referrals into the service, resulting in an increase in referrals that were rejected, but it is anticipated that the new CAMHS Access team, funded recurrently from 19/20 will address this.

<table>
<thead>
<tr>
<th>Year/KPI</th>
<th>11/12</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>17/18*</th>
<th>17/18 final</th>
<th>18/19 Apr-Dec 18</th>
<th>18/19 FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals accepted</td>
<td>1547</td>
<td>1571</td>
<td>1703</td>
<td>16:10</td>
<td>1338</td>
<td>1337</td>
<td>581 (1,743)#</td>
<td>1467</td>
<td>1084</td>
<td>1987</td>
</tr>
<tr>
<td>Referrals Rejected</td>
<td>234</td>
<td>342</td>
<td>497</td>
<td>569</td>
<td>818</td>
<td>555</td>
<td>226 (25%)</td>
<td>760 (34%)</td>
<td>553 33.8%</td>
<td>757 33.8%</td>
</tr>
<tr>
<td>First to FU Ratio</td>
<td>1:9.42</td>
<td>1:7.49</td>
<td>1:3.18</td>
<td>1:8.2</td>
<td>1:10</td>
<td>1:7.5</td>
<td>1:6.9</td>
<td>1:8.3</td>
<td>1:6.35</td>
<td>1:6.35</td>
</tr>
<tr>
<td>DNA rates 1st</td>
<td>15.6%</td>
<td>12.8%</td>
<td>21%</td>
<td>21%</td>
<td>14%</td>
<td>11%</td>
<td>15%</td>
<td>19.8%</td>
<td>9.4%</td>
<td>9.4%</td>
</tr>
<tr>
<td>DNA rates FU</td>
<td>13.8%</td>
<td>12.9%</td>
<td>16%</td>
<td>16%</td>
<td>8.5%</td>
<td>11%</td>
<td>11%</td>
<td>12.2%</td>
<td>13%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Enfield CAMHS are using the ICAN platform for the digital collection of outcome data. ICAN is integrated with RiO, the case management system, and enables clinicians and service users to complete measures via tablet, smartphone or PC; where they can be immediately scored and viewed. The service is in the process of rolling out the implementation of ICAN across CAMHS teams. This includes training workshops for teams and individual coaching. The service is evaluating all activity through ICAN on a monthly basis so that it can track the level of use of ROMs generally, as well as the percentage of paired measures completed. This regular evaluation will inform and refine future implementation efforts, with the aim of increasing the number of paired measures completed.

See Section 14 Extending Access to Services for more detailed information about report back on the CAMHS access target.

Appendix 1 shows progress against outcomes included in the first LTP
20. Workforce

Background

As a borough-wide health and social care system, we will be working with our partners to address the requirements of the 'Stepping forward to 2020/21: The mental health workforce plan for England' published in July 2017 by Health Education England to support the delivery of the Five Year Forward View for Mental Health in England.

We are conscious that Enfield CAMHs are well thought of and that we have a well-motivated and committed workforce, which is key to delivering our Local Transformation Plan. Whilst external pressures on the service have affected key performance indicators like waiting times, there has good engagement of clinical staff and others both in the development and implementation of the Transformation Plan, including the refreshed plans, and a determination to deliver improvements.

The CCG and the Council worked together to agree the revised transformation programme in 2016/17, including an investment plan, focussed on ensuring the sustainability and growth of the CAMHs community multidisciplinary service, supported by the Family Resilience Strategy, the development of the Early Help Family Hub and work in schools. The LTP is supported by a Memorandum of Understanding between the providers, and the Section 75 agreement which details the funding that each partner has agreed to.

In agreeing the revised investment plan in 2016/17, it was noted that:

- As Future in Mind is a national programme, competition for CAMHS staff is high, and it has been difficult to recruit staff
- Retirements of experienced senior CAMHS staff mean that there is a need to look at how the balance between senior clinical leaders and new staff is restored
- The skill mix audit for the original plan, emphasized the need for nurse prescribers and psychologists/staff trained in psychological interventions
- The Head of Service for what was previously a joint CAMH service, is Council employed. Given the size of the transformation programme and need to focus on improving productivity, meeting waiting targets, and reducing DNAs and patient cancellations, the establishment of a BEH MHT service manager post for the Tier 3 service has been identified as a priority in the revised investment plan
- Better Care Funding has been agreed by the Council and NHS to fund Council commissioned posts in the SAFE/Adolescent team

Given the above it was agreed that the priority for Future in Mind was to retain the remaining Council commissioned/funded staff, and fund an additional 5 clinical staff to
an appropriate skill mix from recurrent and non-recurrent funding, and ensure there is appropriate management and administrative support for the service.

**Enfield CAMHs Workforce**

The table below details the current Enfield CAMHS workforce as at the end of October 2018.

<table>
<thead>
<tr>
<th>CAMHS Staff</th>
<th>GENERIC</th>
<th>HEART</th>
<th>CCCT</th>
<th>SCAN</th>
<th>CDT</th>
<th>SAFE &amp; Alliance</th>
<th>EPIP</th>
<th>SEWS</th>
<th>Parent Groups</th>
<th>Other</th>
<th>VTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>1.60</td>
<td></td>
<td></td>
<td>1.00</td>
<td>2.80</td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td>6.40</td>
<td></td>
</tr>
<tr>
<td>Consultants</td>
<td>2.60</td>
<td>0.50</td>
<td>1.10</td>
<td>1.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5.70</td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td>9.00</td>
<td>0.50</td>
<td>0.50</td>
<td>3.00</td>
<td>1.00</td>
<td>3.70</td>
<td>0.60</td>
<td>0.30</td>
<td>1.50</td>
<td>20.10</td>
<td></td>
</tr>
<tr>
<td>Psychotherapists</td>
<td>3.30</td>
<td>0.60</td>
<td></td>
<td>0.40</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.30</td>
<td></td>
</tr>
<tr>
<td>Family Therapists</td>
<td>4.40</td>
<td>0.50</td>
<td></td>
<td>1.00</td>
<td></td>
<td>0.90</td>
<td></td>
<td></td>
<td></td>
<td>6.80</td>
<td></td>
</tr>
<tr>
<td>CAMHS Practitioners</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.70</td>
<td>0.60</td>
<td></td>
<td></td>
<td>1.30</td>
<td></td>
</tr>
<tr>
<td>Parent Infant Psychotherapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.20</td>
<td></td>
</tr>
<tr>
<td>Staff in Training</td>
<td>1.80</td>
<td>1.00</td>
<td></td>
<td>0.40</td>
<td>0.00</td>
<td>0.40</td>
<td></td>
<td></td>
<td></td>
<td>3.60</td>
<td></td>
</tr>
<tr>
<td>Total clinical staff without trainees</td>
<td>22.70</td>
<td>3.10</td>
<td>0.50</td>
<td>5.10</td>
<td>1.00</td>
<td>9.80</td>
<td>1.20</td>
<td>2.60</td>
<td>0.90</td>
<td>2.50</td>
<td>49.40</td>
</tr>
<tr>
<td>Management</td>
<td>1.00</td>
<td></td>
<td></td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Operational support</td>
<td>5.00</td>
<td>0.70</td>
<td>0.30</td>
<td>2.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td>9.00</td>
<td></td>
</tr>
<tr>
<td><strong>Total staff</strong></td>
<td><strong>28.70</strong></td>
<td><strong>3.10</strong></td>
<td><strong>0.50</strong></td>
<td><strong>5.80</strong></td>
<td><strong>1.30</strong></td>
<td><strong>12.80</strong></td>
<td><strong>1.20</strong></td>
<td><strong>3.60</strong></td>
<td><strong>0.90</strong></td>
<td><strong>4.50</strong></td>
<td><strong>62.40</strong></td>
</tr>
</tbody>
</table>

Enfield CAMHs Workforce (and excludes the Educational Psychology Service)

The clinical workforce in 2017 was 43.2, and since there has been additional non-recurrent investment in the SCAN and CAMHS Access Team. Recurrent funding for both initiatives will become available in 2019/20.

In our original plan we noted that the Royal College of Psychiatrists guidance on workforce, capacity and functions of CAMHS in the UK provided a helpful range of examples of skill mix in Tier 2/3 Specialist CAMHS from what would be described as a ‘one star’ service through to a ‘five star’ service. Using this range for benchmarking purposes, for Enfield to achieve a ‘three star’ service would require a clinical workforce of 31.7 whole time equivalent staff, and 49.1 wte to achieve a 5 star service. The Enfield clinical workforce in 2015 was 39.3, excluding trainees, but including 2wte interims funded through the waiting list initiative. The banding structure was broadly in line with, but potentially not as diverse as in some CAMH services, with relatively few high banded posts (8c and above) and relatively few lower banded posts (Band 6 and below). There is now more career progression opportunities within the service.

In order to meet the ambition of the *Future in Mind* programme and deliver the NHS Operating Plan target by 2019/20, in 2016 we calculated that an additional 15.0 wte clinical staff would be required, although we anticipated that this would be offset by
productivity improvements, extended use of the voluntary sector and further
development of Tier 2 provision. This is work in progress but the number of clinical
staff has increased and the introduction of the CAMHS Access service will lower the
eligibility threshold and increase throughput.

Overall our original plan recognised the need to retain experienced staff and to ensure
the clinical team offer a broad range of therapeutic interventions. The workforce is
ageing and as noted above it is essential going forward to maintain a balance between
experienced clinical leaders and new staff. This is the subject of ongoing review but
staff retention of staff is good and new staff are being recruited despite the competition.

The invitation to participate in the national CYP IAPT programme came at an
opportune time, in terms of reviewing the range of evidence based therapies available,
and agreeing the staff that would benefit from the training programme. The outcomes
of the review have continued to influence funding proposals included in the Local
Transformation Plan. We are keen to ensure learning is cascaded and that the
principles of CYP IAPT are embedded across the system. An implementation group
has been established to lead this process. This is supported by the Mental Health
Forum which has a key role in supporting professional development and ensuring
there is a common understanding of available support. To date the CYP IAPT
programme has demonstrably increased clinicians’ skills in systemic family therapy, in
evidence based parent training, and in Cognitive Behaviour Therapy (CBT), which
were identified as areas which needed to be strengthened in the original plan. Other
commissioned services have been reviewed and this includes discussions about
workforce and local need. For example, the Royal Free Eating Disorder Service
reviewed its staff team and skill set and as a result there was an increase in CBT
trained staff and family therapists. The Brandon Centre has expanded its multi-
systemic therapy team to include treatment for young people with worrying sexual
behaviour.

Workforce Planning

NCL CCGs have been successful in bidding for funds to support community and
mental health workforce development. The approved scheme will use targeted
training programmes to upskill registered professionals and others to take on extended
and advanced roles in priority service areas: mental health, learning disabilities, long
term conditions, urgent and emergency care, and leadership.

The scheme supports the Five Year Forward View priority area of Mental Health, in
particular, talent management and recruitment and retention of staff which is an STP
priority. It will also feed into the programme of CAMHS clinician rotation being
developed. See STP Section on page 90
Workforce Training

Training is at the core of transformation, and is essential to increase the capacity and capability of the wider system. A number of initiatives have been delivered or are currently being deployed across a number of organisations.

- The CAMHS clinician training programme has been developed by training and development officers for the Council and BEH MHT, and agreed by both organisations.
- There has also been a broad based education forum, the Social, Emotional and Mental Health (SEMH) Group, to develop training within schools.
- The Mental Health Forum has been a focus for developing training for the voluntary sector and schools.
- Training for Council staff, e.g. youth workers, social care staff and children’s centres and nursery staff has mirrored the training offered by the SEMH and the mental Health Forum. Training has also been offered to the two main Enfield colleges.
- CAMHS want to develop neurodevelopment skills within the generic and adolescent teams and increase trauma focused training and positive behavior support.
- There has been an extensive positive behavior support training across all settings to develop early services supporting the transforming care programme.
- Funding has been obtained through HENCEL for a mental health programme in schools to look at supporting young people around exam time.

There is a joint commitment to sustain the training programme beyond 2018, through the mental health champion programme, use of underspends, delivery of training by existing teams, and application for funds from other sources.

Priority

To co-produce a training programme with all providers including schools and the voluntary sector, and young people and their parents and/or carers.

Our actions:

- MH steering group continues to meet with all key partners, including health and social care, with dates scheduled for a minimum of six months ahead in the future.
- Scope all current training courses to gain an overview in terms of duplication and gaps and establish a comprehensive training programme.
✓ Establish a secure central point for all Enfield employees to access training available

✓ Introduce a mandatory CAMHS training programme for all new voluntary sector and school staff in Enfield

✓ Increase community based clinical capacity and the range of evidence based therapeutic interventions offered through joint workforce planning and CYP IAPT
21. Financial delivery

Currently 6% of the National Mental Health Programme budget is spent on children and young people, although children and young people account for 23% of the population and one in ten 5-15 year olds has a mental disorder. The costs incurred to the public purse of not treating children and young people early in their lives are considerable.

- Mental health problems in children and young people are associated with excess costs estimated as being between £11,030 and £59,130 annually per child. These costs fall to a variety of agencies (e.g. education, social services and youth justice) and also include the direct costs to the family of the child’s illness.

- There are clinically proven and cost-effective interventions. Taking conduct disorder as an example, potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems.

- The costs associated with treating children and young people in the community with crisis support or outreach are considerably less than in patient care.

- 30% of all crime (costing £20 billion a year) is committed by people who had a clinically diagnosable conduct disorder in childhood or adolescence. A child with conduct disorder at ten years of age subsequently costs the state around £100,000 more than other children.

CCG and Council expenditure on CAMHS is shown below.
<table>
<thead>
<tr>
<th>CCG Expenditure</th>
<th>Expenditure Type</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEH MHT</td>
<td>Block</td>
<td>1,807,812</td>
<td>1,849,392</td>
<td>1,891,928</td>
<td>1,939,226</td>
<td>2,012,917</td>
</tr>
<tr>
<td>T&amp;P</td>
<td>C&amp;V</td>
<td>51,931</td>
<td>42,418</td>
<td>47,000</td>
<td>90,000</td>
<td>96,847</td>
</tr>
<tr>
<td>SLAM</td>
<td>C&amp;V</td>
<td>31,054</td>
<td>20,110</td>
<td>52,049</td>
<td>52,902</td>
<td>38,808</td>
</tr>
<tr>
<td>NCAs</td>
<td>Spot Placements</td>
<td>22,000</td>
<td>22,000</td>
<td>75,000</td>
<td>77,175</td>
<td>77,175</td>
</tr>
<tr>
<td>Brandon</td>
<td>Block</td>
<td>47,500</td>
<td>47,500</td>
<td>47,500</td>
<td>48,875</td>
<td>50,732</td>
</tr>
<tr>
<td>DAZU</td>
<td>S75</td>
<td>14,806</td>
<td>14,806</td>
<td>14,806</td>
<td>20,381</td>
<td>20,381</td>
</tr>
<tr>
<td>Hencel Funding (HEE)</td>
<td>Training</td>
<td>0</td>
<td>20,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>YOS</td>
<td>S75</td>
<td>37,239</td>
<td>37,239</td>
<td>37,239</td>
<td>65,763</td>
<td>65,763</td>
</tr>
<tr>
<td>LBE Complex Care</td>
<td>C&amp;V</td>
<td>1,170,267</td>
<td>1,099,317</td>
<td>1,832,323</td>
<td>1,428,153</td>
<td>1,476,710</td>
</tr>
<tr>
<td>Royal Free</td>
<td>Eating Disorders</td>
<td>268,161</td>
<td>265,441</td>
<td>272,000</td>
<td>281,000</td>
<td>291,678</td>
</tr>
<tr>
<td><strong>Total CCG</strong></td>
<td></td>
<td>3,450,770</td>
<td>3,418,223</td>
<td>4,269,845</td>
<td>4,003,475</td>
<td>4,131,011</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Council Investment in Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Staff</td>
</tr>
<tr>
<td>Brandon</td>
</tr>
<tr>
<td>DAZU</td>
</tr>
<tr>
<td><strong>Total Council</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Future In Mind Transformation Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future In Mind Transformation Funding</td>
</tr>
<tr>
<td>FIM Waiting List Funding</td>
</tr>
<tr>
<td>Health &amp; Justice Funding</td>
</tr>
<tr>
<td>CYP IAPT</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Schools Investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Staff (SEWS/BSS)</td>
</tr>
<tr>
<td>Psychology in ASA Schools DSG</td>
</tr>
<tr>
<td><strong>Total Schools</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,601,091</td>
</tr>
</tbody>
</table>

79
The CCG meets the Mental Health Investment Standard. In our original plan we noted that ‘Investment in the CAMH service has been relatively static over recent years, but this is in contrast to many areas where disinvestment of the previously ring fenced LA area based grant and NHS CAMH services has been significant. This strategy is being written at a time of financial challenge for both the Council and the CCG, but as evidenced by work on the strategy, there is a joint commitment to maintaining effective CAMHs provision in the context of increasing need, and to further developing joint commissioning through the Section 75 agreement.’

This continues to be the case, and changes to the original submission of the Transformation Plan were required as a consequence. In our March 2017 submission we reported that ‘in the light of the significant savings plan in place across all Council departments Enfield Council will continue to invest in early intervention services which meet their statutory responsibilities, but will withdraw funding from the CAMHS Tier 3 multidisciplinary services which are more usually NHS-funded services.’ The decision was taken to use LTP funding to prioritise the sustainability of the Tier 3 service.

To note that:

- In our original plan we stated our intent to use the funding allocated for eating disorders on the crisis pathway as we were meeting need from pre-existing funding.

- In 2016/17 the CCG and the Council also agreed that Better Care Funding would be used to fund part of the SAFE/adolescent outreach service.
The LTP spending plan for 2017/2021 is shown below.

<table>
<thead>
<tr>
<th>Recurrent funding available</th>
<th>£699k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of 3 Clinical posts</td>
<td>£214k</td>
</tr>
<tr>
<td>Tier 3 sustainability</td>
<td>£481k (by 19/20)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£695k</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 Year non recurrent funding available</th>
<th>£176k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Educational Psychologist + EPIP</td>
<td>£108k</td>
</tr>
<tr>
<td>Cost of Band 7 Nurse Prescriber</td>
<td>£68k</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£176k</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Remaining non recurrent funds</th>
<th>£677k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Data Manager</td>
<td>£49k (PA / £98k for Two Years)</td>
</tr>
<tr>
<td>Cost Band 8B Service Manager</td>
<td>£94k (PA / £188k For Two Years)</td>
</tr>
<tr>
<td>Staff Grade Dr</td>
<td>£134k (PA / £268k For Two Years)</td>
</tr>
<tr>
<td>Admin Band 4</td>
<td>£40k (PA / £80k For Two Years)</td>
</tr>
<tr>
<td>EPIP</td>
<td>£20k (PA / 40k for Two Years)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£669k</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicative split of additional CYPMH allocations</th>
<th>2017-18</th>
<th>2018-19</th>
<th>2019-20</th>
<th>2020-21</th>
<th>2016-21</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Enfield CCG</td>
<td>116</td>
<td>166</td>
<td>112</td>
<td>113</td>
<td>164</td>
</tr>
<tr>
<td><strong>Total LTP Funding</strong></td>
<td><strong>1095</strong></td>
<td><strong>1261</strong></td>
<td><strong>1373</strong></td>
<td><strong>1486</strong></td>
<td></td>
</tr>
<tr>
<td>Agreed F&amp;P Spending Plan 17/18 to 19/20</td>
<td>875</td>
<td>875</td>
<td>875</td>
<td>695</td>
<td></td>
</tr>
<tr>
<td>Remaining (with ED added)</td>
<td>220</td>
<td>386</td>
<td>498</td>
<td>791</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>2017-18</td>
<td>2018-19</td>
<td>2019-20</td>
<td>2020-21</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CAMHS Access Waiting List Initiative</td>
<td>150</td>
<td>150</td>
<td></td>
<td></td>
<td>Set up CAMHS Access Team. Recurrent investment from 19/20.</td>
</tr>
<tr>
<td>SCAN Waiting List Initiative</td>
<td>30</td>
<td>90</td>
<td></td>
<td></td>
<td>Recurrent investment from 19/20</td>
</tr>
<tr>
<td>Clinical Psychologist Waiting list</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour Support Training</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STP Workstream on crisis and urgent care</td>
<td>50</td>
<td>100</td>
<td>100</td>
<td></td>
<td>Slippage in implementation - assuming PYE for 18/19</td>
</tr>
<tr>
<td>STP Workstream on Tier 4 – co commissioning with NHSE</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td></td>
<td>Slippage in implementation - assuming PYE for 18/19</td>
</tr>
<tr>
<td>Crisis and Urgent Care</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
<td>Additional support for Self Harm Rota until NCL STP Team comes online</td>
</tr>
<tr>
<td>CAMHS SCAN Team (Nurse and Psychologist)</td>
<td>60</td>
<td>120</td>
<td></td>
<td></td>
<td>Agreed priority. 60k in 2019/20 because agreed waiting list money to fund to Sept 2019</td>
</tr>
<tr>
<td>CAMHS Access Team</td>
<td>125</td>
<td>300</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of making staff employed on fixed term contracts permanent</td>
<td>273</td>
<td>361</td>
<td></td>
<td></td>
<td>*From 19/20 - Service Manager - 95k, CAMHS Consultant – 158k, Voluntary Sector PIP 20k *From 20/21 - Pip/Ed Psych - £108k</td>
</tr>
</tbody>
</table>

220  395  578  901

The table on the previous page shows how slippage and additional LTP funding has and will be spent. Essentially in 2017/2019 non recurrent funding was allocated to priority areas that were under pressure. Where possible it is planned to make these and other non recurrent commitments recurrent between 2019/2021 to meet the commitments we made in the October 2017 refresh to invest in the Social Communication and Neurodevelopmental Team and increase whole system capacity to support implementation of a THRIVE type service model. As stated earlier in the document we were disappointed not to be invited to bid to be a trail blazer but we will be looking at how we can operationalise key elements of the plan with schools and key stakeholders.

Whilst we have to reduce our original ambition for system changes including: extended access and flexible appointing, wider responsiveness to crisis including into emergency departments, and peer support and training, the CCG and the Council remain committed to the transformation programme described in this document.

The CCG passes through NHSE funding for CYP IAPT, unfortunately there are no further funds available for backfill.
22. Governance

The Enfield Children and Young People’s Mental Health Plan is a working document and will continue to be reviewed and updated, on an annual basis, throughout its lifetime. Implementation will be the overall responsibility of the Enfield Children and Young People’s Mental Health Partnership Group, which meets monthly, supported by the CYP IAPT Steering Group, which provide operational and clinical support, and Task and Finish Groups that will be set up to drive individual work streams, for example the IM&T, and STAY working groups. The Children and Young People’s Mental Health Partnership Group will report to the Joint Commissioning Group, which is a Sub-Committee of the Health and Wellbeing Board. Terms of reference will be kept under review, including levels of senior oversight.

A Road Map summarising our Local Transformation Plan proposals is included on p13 this will be supported by an Action Plan which has been developed by the Children and Young People’s Mental Health Partnership Group. Any delays with implementation and issues with delivery will be reported to the Joint Commissioning Board. The Health and Wellbeing Board will receive regular progress reports on implementation of the plan.

The Children and Young People’s Mental Health Partnership Group will work closely with key strategic groups leading on maternity services, children’s centres and early years, children with disabilities, targeted youth engagement (youth justice), and so on. We also work in collaboration with other North Central London Boroughs/CCGs where appropriate (see pages 48-80) with work co-ordinated through the NCL STP CAMHS Board.

Consultation and co-production with children, young people and families is regarded essential, and will be an integral part of the review and implementation process going forward. Progress against the Transformation Tracker will be used to monitor implementation, with priority given to demonstrating improvement in outcomes.
23. Risk Management

The October 2017 refresh combines our original *Future in Mind* submission with the extended Executive Summary we added to meet assurance requirements, into one simpler and shorter document which retains the priorities that have been agreed with partners including children and young people and their parents and /or carers, and highlights the progress which has been made. A more accessible document should support joint accountability for the Health and Wellbeing Boards aim of ensuring that mental health is everyone’s business. As noted about the Children and Young People’s Mental Health Partnership Group is responsible for implementing the plan, including risk management.

Enfield CAMHS are well thought of services and there is a genuine commitment to delivering what is an ambitious programme, and good progress has already been made with implementation. 2015/16 was viewed broadly as a period of consolidation, and we have worked together as a system to refresh our *Future in Mind Local Transformation Plan*

The informal feedback from the recent CQC Thematic Review of Children and Young People’s Mental Health Services commented on the strength of our joint working relationships and fact that all the right elements of a comprehensive service are in place but perhaps not to the extent needed to meet increased demand. We are aware of the need to work together to monitor demand for services and agree mitigations. We are conscious that some of proposals, such as back fill to support CYP IAPT and service developments, are dependent to some extent on being able to find suitable staff at a time when other CCGs will be looking to do the same. We are hoping to use our local networks to recruit people, and will monitor progress and agree mitigating actions through the partnership meetings. Improvements to SCAN/Neuro-disability services are dependent on more specialist staff and we will work with neighbouring CCGs to mitigate risk between us. A full risk log is included in the Executive Summary on page 10.

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 five main identified initiatives for 2018/19: acute care pathway, primary care mental health including IAPT, CAMHS, mental health workforce and liaison psychiatry. Other areas of focus include community resilience, perinatal, student mental health and dementia.

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.

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 five NCL Boroughs will be working together on six areas as part of the NCL STP CAMHS.

These are:

a. **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
b. **Specialist Community Eating Disorder Services** - dedicated eating disorder teams in line with the waiting time standard, service model and guidance
c. **Crisis and Urgent Care Pathways** - 24/7 urgent and emergency mental health service for children and young people. Out of hour’s crisis service to be launched in Q4 2018/19.
d. **Transforming Care** - supporting children and young people with challenging behaviour in the community, preventing the need for residential admission
e. **Liaison** – To improve the provision of liaison service to children and young people who present in A & E depts.
f. **New Care Model for CAMHS Tier 4** – Ensure care is delivered as close to home as possible for children and young people by commissioning local Tier 4 CAMHS to eliminate out of area placements for non-specialist acute care by 2020/21.

Across the five 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 five boroughs; such as:

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

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 35% of children with a diagnosable condition being able to access evidence-based services by April 2020/21 as set out in the Mental Health Taskforce.

The transformation of children and young people’s mental health and wellbeing services, will not necessarily bring savings during the time 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\textsuperscript{16}.

### NCL Prevalence Data

<table>
<thead>
<tr>
<th>Borough</th>
<th>Population aged 5-16</th>
<th>Est. prevalence of any MH disorder, aged 5-16 (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>Barnet</td>
<td>56,063</td>
<td>4,691 8.40%</td>
</tr>
<tr>
<td>Camden</td>
<td>27,904</td>
<td>2,546 9.10%</td>
</tr>
<tr>
<td>Enfield</td>
<td>52,460</td>
<td>5,195 9.90%</td>
</tr>
<tr>
<td>Haringey</td>
<td>37,905</td>
<td>3,745 9.90%</td>
</tr>
<tr>
<td>Islington</td>
<td>23,981</td>
<td>2,417 10.10%</td>
</tr>
</tbody>
</table>

Source: Fingertips, 2014

\textsuperscript{16} Cavendish Square Group
Priority 1: Workforce Development & Training Risk Management

Rationale for a joint priority across NCL

Across NCL, there are two mental health NHS trusts and an Integrated Care Organisation that provide CAMHS services for the five boroughs. In addition, the specialist Eating Disorder Service for the five 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

It is to continuously review the current workforce provision across NCL which will enable the effective planning for the workforce requirements in order to address the mental health and psychological well-being needs of children and young people in NCL. We will use the ‘Stepping forward to 2020/21: The mental health workforce plan for England July 2017’ report to steer our work. This document sets out the high level road map for regions, STPs and local areas from which to build their regional workforce plans to 2021 that reflect local needs and strengths.

As part of a wider strategic assessment, we also need to address a number of questions as we look to maximise and optimise our workforce over the next few years. For example, we will be asking what additional staff are required, and how will we recruit these in line with the national ambition as set out in the ‘Stepping forward to 2020/21’ document. We need to understand what new roles may be required to address future demands on mental health services and what alternative ways of delivering support are required. Training will also be key to ensuring the workforce is adequately skilled to deliver the support required by children and young people with mental health needs. We also need to consider the impact on physical health that mental health issues can have and how we seek to ensure our workforce can address those aspects of mental health too.

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Addressing these questions may see care and support being delivered in alternative ways, such as further collaborative working with the voluntary sector, schools and colleges. We do not envisage moving to a single workforce model but will share ideas, expertise and learning to develop a more efficient CAMHS system and network of service provision.

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

This section details the current position in NCL and what it is we want to achieve in the next two years and which aligns with the Five Year Forward View.

**Workforce mapping outcomes**

In 2017, an independent mapping exercise was undertaken across the five NCL CCGs. Whilst specific issues were identified in each CCG, the report concluded that some areas commission a broader range of services than others which may lead to a more diverse range of roles and skills and a broader scope for workforce development in line with the NCL CAMHS and Perinatal initiative and current national policy drivers. The work also identified individual CCGs’ skill mix and staffing models, how they compare across NCL, but also in relation to wider benchmarks.

Following this work, we have been able to identify changes to the NCL CAMHS workforce required in order to achieve the ambitions of the Five Year Forward View plan, the Mental Health Taskforce and Future in Mind. These include the following specific priorities and tasks aligned to the recommendations in the mapping report.

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring equity of access</td>
<td>- Each borough to review their own access performance, staffing and access to inform a benchmarking exercise</td>
</tr>
<tr>
<td></td>
<td>- Ensure a maximum wait for referral to first assessment (for 92% of CYP MH seen within 13 weeks)</td>
</tr>
<tr>
<td></td>
<td>- Understanding ethnicity and local population needs, and gaps that may exist</td>
</tr>
<tr>
<td>Ensuring the stability and sustainability of services</td>
<td>- ‘Recruit to train’ - implement across all boroughs, and sharing learning, e.g. CWP posts. Aim to establish a five borough-wide resource through economies of scale</td>
</tr>
<tr>
<td></td>
<td>- Seek to avoid fixed term contracts to facilitate delivery of a stable and sustainable workforce</td>
</tr>
<tr>
<td>Priorities</td>
<td>Tasks</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Upskill the NCL mental health workforce via digital avenues                | · Explore the potential to establish Kooth\(^{18}\) across NCL and how such solutions could dovetail with other interventions including face to face contacts  
  · Consider social media training for staff and how digital solutions (e.g. apps) could support CYP, and how social media impacts on CYP MH |
| Engage providers in developing services to deliver NCL shared priorities   | · Formally engage non-NHS/borough providers in local forums including the voluntary sector  
  · Undertake zero waste opportunities to build capacity and shift to digital solutions |
| Utilising capacity across NCL                                             | · Undertake a full service review through a demand and capacity model that reflects the needs of the local population, and considering the use of Voluntary Care Sector (VCS) providers wherever possible |
| Collaborate across the system to ensure that workforce mapping, skills and training needs are more robust and accessible; and that processes are in place to commission and deliver training | · Undertake borough level Training Needs Analysis and bring this together through an NCL requirement, securing economies of scale in delivering the identified training  
  · Undertake annual workforce mapping to continually assess service needs, underpinned by consistent metrics and benchmark data |
| Involve practitioners from adult mental health services in training in working with adolescents with mental health problems | · CAMHS commissioners to liaise with their adult mental health commissioners to identify training opportunities for adult staff in supporting CYP in acute environments |

**CAMHS training programme**

We recognise the training is a key component of the delivery of safe and effective care and support and we will continue to pursue a proactive programme of training across NCL. One area where we have been successful in securing Health Education England (HEE) funding is to establish an STP-wide clinically-led CAMHS training forum, linked to an agreed rolling programme of in-sourced training. The intention is to develop targeted training programmes to upskill registered professionals and others to take on extended and advanced roles in priority service areas: mental health, learning disabilities, long term conditions, urgent and emergency care, and leadership.

\(^{18}\) [https://kooth.com/](https://kooth.com/)
This supports the five year forward view priority area of Mental Health. In particular, talent management and recruitment and retention of staff is an STP priority. It will also feed into the programme of CAMHS clinician rotation being developed.

Once we have agreed the scope of training and high impact staff groups, we will be developing training materials prior to implementing the programme through the rest of the year and into 2019/20.

**Children’s Wellbeing Practitioners (CWPs)**

The Children’s Wellbeing Practitioners a new role that offers evidence-based interventions in the form of low intensity support and guided self-help to CYP with mild to moderate mental health problems.

CYP IAPT Collaboratives throughout the country have set up CWP programmes in response to the target of offering evidence based intervention to 70,000 more children and young people annually by 2020, by training up 1,700 new staff in evidence based treatments, as outlined in ‘Implementing the Five Year Forward View for Mental Health’.

In the first year, CWP services have been set up under the guidance of senior CWP Leads in 15 localities or ‘partnerships’, including Barnet and Islington CCGs, in services tailored to provide mental health support to children depending on local needs as part of local provision. A variety of service models were established in that time, including the CWP program being offered within schools, CAMHS services, Local Authority and Third Sector organisations. As CWPs are rolled out across other CCGs, we will be learning from those 15 partnerships which will help to inform the development of this program over the next few years and how we will therefore configure the workforce in support of it.

**Supporting Crisis and Out of Hours services**

Whilst we have been proactive in establishing early warning and preventative initiatives and services, we continue to see increasing demand for crisis interventions in CYP, as well as demands of services out of hours, the latter which requires liaison between the acute hospitals, CAMHS and social care. Therefore, we are increasing staffing capacity in the NCL-wide crisis service to better meet demand. We will also be reviewing the effectiveness of the current on-call rota and use of specialist registrar doctors grades to ensure greater consistency and more efficient and effective working arrangements across the five CCGs.
As part of the work to develop NCL-wide all-age liaison provision, we will need to review the staffing capacity of existing CAMH services and consider potential restructuring of existing resources to improve parity of access across the sector. We will also need to establish effective cross-training between adult and children’s mental health services to ensure both staffing cohorts have the skills / competencies to deliver within an all-age service. To support this, we expect to bid to HEE for a short term pilot for having an embedded CAMHS liaison post within a combined all-age service, as opposed to the current model of stand-alone CAMHS liaison. This would give us an opportunity to test the effectiveness of the model to inform future planning, ensuring a strong all-age liaison service.

**Vacancy management**

Whilst we will always be looking to recruit and retain the best staff in NCL, inevitably they do leave for a variety of reasons, taking on new roles, and moving to new organisations in new areas. So there will always be an element of staff turnover which we will need to manage in order to minimise the time that a post remains vacant.

Linked to the outcomes of the workforce mapping audit mentioned earlier in this section, we will use our NCL wide networks to constantly monitor vacancies within our commissioning functions as well as our providers, both NHS and non-NHS.

We will look at any emergent trends as vacancies arise and we will take whatever actions may be necessary to mitigate the risks associated with long term vacancies, seeking support from NHSE and Health Education England as necessary.

**Pan-London or national developments**

Given the pace of change in the provision of mental health services for CYP, we will continue to horizon scan, identifying any emerging trends or patterns in demand, and working collaboratively across NCL and with our other partners to ensure that we understand the staffing resource that may be required and how we will deliver this through a structured workforce planning programme.

As ever, we will be looking to optimise the workforce with available resource, and maximising the benefit to CYP with mental health needs.
## Links to key policies and initiatives

<table>
<thead>
<tr>
<th>Policy / initiative</th>
<th>Aims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Five Year Forward View</strong></td>
<td>- Continued reduction in waiting times</td>
</tr>
<tr>
<td></td>
<td>- Increase access to meet 32% of need on 2018/19, 34% in 2019/20 and 35% in 2020/21</td>
</tr>
<tr>
<td><strong>Future in Mind</strong></td>
<td>- Promoting resilience, prevention and early intervention – across sectors with schools, GPs etc.</td>
</tr>
<tr>
<td></td>
<td>- Developing the workforce</td>
</tr>
<tr>
<td></td>
<td>- Roll out CYP IAPT – including training via CYP IAPT for staff under 5, autism, and LD</td>
</tr>
<tr>
<td></td>
<td>- Make mental health support more visible and more easily accessible</td>
</tr>
<tr>
<td></td>
<td>- Professionals who work with children and young people trained in child development and mental health</td>
</tr>
</tbody>
</table>
Priority 2: Specialist Community Eating Disorder Services

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.

In our last report, we planned for the service to join the QNCC –ED network. An application has now been submitted to QNCC – ED to commence the peer review process. This process is likely to take a year to complete.

North Central London Commissioners will also be engaging in a review of the intensive eating disorder service. This review will is due to report in early 2019.

A key focus of our service development plans will also include exploring the options available to implement self-referrals.

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

**Table 1**

<table>
<thead>
<tr>
<th>Priority</th>
<th>Summary of Actions to Progress</th>
<th>RAG Rating</th>
</tr>
</thead>
</table>
| 1. Increase capacity and reduce waiting times to meet key requirements of NICE Guidance | - Additional staffing across MDT achieved-see table below  
- Waiting Times Targets – see table below | 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  
The Service Manager of the Eating Disorder service reports:  
- A seminar was held for the Jewish schools in spring 2018. | Achieved |
| 3. Offer telephone support for General Practitioners | Is available but requires further evidence of wider knowledge by GP’s.  
- The provider reports that clinicians are always available to speak to GP’s.  
- Plan to record GP contacts going forward in 18.19.  
- This area will also form part of the service review and service developments going forward. | Partially achieved |
| 4. Improved performance monitoring and management | Quarterly performance reports and contract meetings taking place.  
- Disaggregation of Urgent and Non-Urgent cases. A Service review is now taking place of the Intensive Eating Disorder Service and is due to report early 2019.  
- 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*

<table>
<thead>
<tr>
<th>CCG</th>
<th>Year of Performance</th>
<th>NCL Targets for Eating Disorders Service-Waiting Times RTT Non-Urgent/Urgent</th>
<th>Performance &lt; 4 weeks RTT non-urgent</th>
<th>Performance RTT &lt; 1 week urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>All NCL CCGs</em></td>
<td>2014.15</td>
<td>Baseline Year</td>
<td>54.0%</td>
<td>Not Known</td>
</tr>
<tr>
<td></td>
<td>2015.16</td>
<td>60%</td>
<td>69.2%</td>
<td>No Target</td>
</tr>
<tr>
<td></td>
<td>2016.17</td>
<td>80%/95%</td>
<td>85%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>2017.18 Q1</td>
<td>90%/95%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>2017.18 Q2</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>2017.18 Q3</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>2017.18 Q4</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>2018.19 Q1</td>
<td>95%</td>
<td>94.1%</td>
<td>100%</td>
</tr>
</tbody>
</table>

## Summary of Service Activity

*Table 3*

<table>
<thead>
<tr>
<th>Referrals for all five boroughs 2015.16, 2016.17 and 2017.18 Q1</th>
<th>Number of referrals received</th>
<th>Number of referrals accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>All NCL</em></td>
<td>181</td>
<td>171</td>
</tr>
<tr>
<td><em>All NCL</em></td>
<td>141</td>
<td>127</td>
</tr>
<tr>
<td><em>All NCL</em></td>
<td>166</td>
<td>153</td>
</tr>
</tbody>
</table>
Phase 3 of Eating Disorders Transformation

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. Subsequently a Self – Assessment was undertaken in 2018. This along with discussion with, Commissioners, providers, clinical partners and families have informed our new priorities as set out in Table 4:

Table 4

<table>
<thead>
<tr>
<th>RFL Eating Disorder Service Progress in 17.18</th>
<th>RAG</th>
<th>NCL Local Transformation Plan-Priorities 2018.19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-morbidities management.</td>
<td></td>
<td>The review of the Intensive Eating Disorder service will also be looking at this area of practice more closely.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In particular, there will be a focus on care pathways with generic CYPMH as it is recognised that this is an area that needs to be developed across NCL.</td>
</tr>
</tbody>
</table>

- The Service provider reports very strong links with community paediatrics. RFL ED team currently sits within Paediatrics at RFL accordingly.
- Care pathways have been developed and are closely monitored. Care pathways developed for patients with eating disorders requiring feeding and medical stabilisation.
- Care pathway for patients with eating disorders who self-harm.
<table>
<thead>
<tr>
<th>RFL Eating Disorder Service Progress in 17.18</th>
<th>RAG</th>
<th>NCL Local Transformation Plan-Priorities 2018.19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs and provision</td>
<td>❌ This is reported as maintained and full compliance.</td>
<td>✅ To be monitored in Performance Management meetings.</td>
</tr>
<tr>
<td>Evidence based care</td>
<td></td>
<td>✅ The implementation of self-referrals will form part of future service developments during this period.</td>
</tr>
<tr>
<td>Community model</td>
<td>❌ Reported as moved to full compliance.</td>
<td>✅ Additional training for schools and primary care.</td>
</tr>
<tr>
<td>NICE Concordant treatment standard</td>
<td></td>
<td>✅ Engage with peer review through QNCC. Application has been submitted. Initially a one year process to complete application.  ❌ To be reviewed in quarterly performance management meetings.  ❌ Referral to treatment will continue to be performance managed.  ✅ The intensive service will also review this component of the service.</td>
</tr>
<tr>
<td>RFL Eating Disorder Service Progress in 17.18</td>
<td>RAG</td>
<td>NCL Local Transformation Plan-Priorities 2018.19</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Engagement with CYP, families and carers.</strong></td>
<td></td>
<td>⚠ Exploring the options available for Self-referral for families to form part of future service development plan. ⚠ Signposting and navigation for families and professionals to access support will be monitored.</td>
</tr>
<tr>
<td>Currently any new family that is referred to the service is given the option to participate in Carer and Family courses which focus on eating disorders and how they are managed and treated. Families and Carers are then invited to a follow up sessions consisting of 6 ½ day workshops. The programme consists of a series of four workshops programs delivered during the course of the year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Demonstration of evidence based care.</strong></td>
<td></td>
<td>⚠ The service has now made an application to the QNCC- ED. The process is likely to take a year to complete.</td>
</tr>
<tr>
<td>Engage with peer review through QNCC</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transition and partnership working</strong></td>
<td></td>
<td>⚠ Will be monitored in performance management meetings. ⚠ Will also form part of service review.</td>
</tr>
</tbody>
</table>
### Appx 1: Workforce

<table>
<thead>
<tr>
<th>Workforce NCL/RFL Eating Disorders Roles</th>
<th>Capacity Grade</th>
<th>+Transformation Funding</th>
<th>additional WTE</th>
<th>Eating Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>7</td>
<td>0.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>8a</td>
<td>0.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family therapist</td>
<td>8a</td>
<td>0.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>7</td>
<td>0.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reception/Med sec</td>
<td>3-5</td>
<td>.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td>7</td>
<td>.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Grade Doctor</td>
<td></td>
<td>.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing outpatient</td>
<td>6</td>
<td>.27</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Priority 3: Crisis and Urgent Care Pathways

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

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.

The development of out of hours crisis has been included in the CAMHS workstream 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.
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 SR 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 to ensure 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.
- To reduce inpatient stays
- To implement action log
- To create a RMN bank so as to avoid RFH ECR costs
- To share good practice
- To provide accessible 136 suite within NCL

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 investment in expanding the crisis workforce and 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 the proposed New Care Model (NCM) programme for CAMHS Tier 4 across NCL and North East London (NEL). This is an iterative programme of work
taking a long term view of service development and delivery of the ambition to better meet the needs of those children and young people experiencing mental health crisis.

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

NCL-wide 24-hour crisis service

During 2017/18, commissioners and providers collaborated closely to develop and agree a model for 24-hour CAMHS crisis care that would meet as much of the vision as possible, 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
To ensure full coverage across 24 hours, seven days a week, commissioners and providers have agreed a service model that comprises three services elements, local in-hours crisis services; an NCL-wide out of hours nurse led crisis service; and out of hours NCL-wide on call psychiatry, as follows:

**Out of hours NCL-wide nurse-led component**

Following consultation with key stakeholders, options appraisals and financial analysis, it was agreed the core out of hours component be provided by a nurse-led component delivering twilight cover 7 days a week, plus weekend cover from 9am to midnight. The component will be delivered by Band 6 nurses with Band 7 leadership and will be integrated into Paediatric Liaison. The staffing model for the component is as follows:
A Single Tender Action (non-OJEU) was run during 2018 and the Royal Free Hospital was awarded the contract to deliver the component for an initial pilot period on the basis that they:

- Are able to mobilise in short timeframes;
- Have established working relationships with other CAMHS providers operating across NCL to ensure coordinated daytime and out of hours services; and
- Have an identified local base from which to operate which includes provision of paediatric A&E to ensure safe management of any co-morbid physical health needs.

A contract variation for the component has been signed and RFH has begun recruitment for the component, with a view to commencing service delivery in January 2019. The model for the nurse-led component comprises:

- Twilight and weekend 9am to midnight component integrated into the Paediatric Liaison team and the NCL on-call rota, to be provided by Band 6s with Band 7 leadership
- Nightshift covered by on-call junior doctor to enable children and young people to stay safe through the night
- Provision of mental health and paediatric assessments as and when required
- Advice, information and consultation to be provided to clinicians from other agencies when needed.
The nurse-led component will deliver the following outcomes:
- Reduction in time spent in A&E
- Improved CYP and family experience
- Timely response to CYP in out of hours crisis
- Reduction in numbers of CYP requiring specialist RMN Support on paediatric wards
- Reduction in length of admission to paediatric beds
- Improved outcomes for CYP
- Faster access to MH assessment

NCL-wide psychiatry on-call rota

The success and safety of the nurse-led OOH component is contingent on robust supervision from an on-call psychiatrist of senior-training grade or higher (consultant). Historically there have been a number of on-call psychiatry rotas operating across NCL with varying workloads and consultant remuneration for out of hours work is also variable. As part of the development of the 24-hours crisis offer it has therefore been proposed that a single rota for consultants across NCL be developed. A particular focus for this work is to ensure parity of access across the sector, greater equity in workloads and responsibilities and more consistency in contracting arrangements for on-call psychiatry.

Healthy London Partnership (HLP) children and young people’s mental health crisis peer reviews

Building on the HLP guidance on Improving care for children and young people in mental health crisis in London (October 2016), and the HLP CYP mental health crisis services self-assessment (2017), in autumn 2017, HLP invited local areas to participate in a series of peer reviews of CYP MH crisis services. In NCL, HLP undertook two peer reviews of CYP MH crisis services, of Barnet, Enfield & Haringey Mental Health Trust (February 2018), and a combined peer review of services provided by the Tavistock & Portman NHS Foundation Trust and Whittington Health (May 2018).

The HLP found many positives in the services provided by BEH, T&P and the Whittington. The review praised the knowledge and understanding that representatives from the pathway organisations have in relation to what the challenges are and what it working well. The report highlighted the progress that has been made in transforming the crisis pathway but noted that there is still variation in the service provided across the three boroughs.
The HLP review highlighted that the NCL STP programme and the associated CYP mental health work stream has aligned the transformation and created a strong vision for future transformation, with a focus on improving community and outreach provision to reduce inpatient stays, reducing variation in medical rotas and delivering a consistent extended hours service. The investment each CCG has agreed to fund this transformation jointly across the STP was highlighted as a strength. In addition the potential opportunity to develop a North Central and North East London New Care Model and deliver to further transformation across a wider geography in the future, was seen as a positive. The joint HBPoS bid for NCL was also seen to be a positive although it was noted that there is no plan B, if this bid is unsuccessful.

The review praised the amount of feedback sought from CYP across all boroughs and the way that this is being used to try to improve the experience for CYP, their:

<table>
<thead>
<tr>
<th>BEH</th>
<th>Barnet</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Have a crisis service even if this this is not commissioned, and make best use of what is in place</td>
</tr>
<tr>
<td></td>
<td>Fantastic and cooperative relationship with paediatric staff ward</td>
</tr>
<tr>
<td></td>
<td>Barnet Adolescent Service</td>
</tr>
<tr>
<td></td>
<td>Commissioning and implementation of Kooth</td>
</tr>
<tr>
<td></td>
<td>BRSP and mental health specialists allocated to schools</td>
</tr>
<tr>
<td>Enfield</td>
<td>Alliance and SAFE teams Considerable reduction in OBD and inpatient bed usage</td>
</tr>
<tr>
<td></td>
<td>Commissioner and Local Authority Multagency forum</td>
</tr>
<tr>
<td></td>
<td>CAMHS social care liaison role</td>
</tr>
<tr>
<td></td>
<td>Use of text support (in hours)</td>
</tr>
<tr>
<td>Haringey</td>
<td>AOT</td>
</tr>
<tr>
<td></td>
<td>QI forum</td>
</tr>
<tr>
<td></td>
<td>Schools link pilot and findings</td>
</tr>
<tr>
<td>Tier 4</td>
<td>Improvements at Beacon Centre</td>
</tr>
<tr>
<td></td>
<td>Bed Management Team</td>
</tr>
<tr>
<td>T&amp;P/Whittington</td>
<td>Assertive outreach on offer, particularly CAISS, the support provided and availability of staff etc.</td>
</tr>
<tr>
<td></td>
<td>The single phone number (in hours) which GPs, parents, schools and youth clubs are able to utilise. The duty system phone number is often used by GPs seeking advice. The Brandon Centre offer a text and email service (with out of office response) and will call back or respond the next day when contacted OOH.</td>
</tr>
<tr>
<td></td>
<td>Paediatric liaison on offer at each acute site and considerable joint working between PLT and CAMHS; the emphasis on consistency of care was praised with the same link person (one paediatrician and one Psychiatrist) throughout care. There are genuine shared protocols, which have been developed jointly, in place.</td>
</tr>
<tr>
<td></td>
<td>The Royal Free refurbishment, witnessed as part of the site tour, was impressive, and now offers a good atmosphere and calm environment. There are now up to</td>
</tr>
</tbody>
</table>
four rooms which can be used for mental health assessments as required, and break out rooms in inpatient areas.
- We Can Talk training has been rolled out at the Royal Free to improve the confidence of paediatric staff in caring for CYP with mental health conditions.
- In Camden there is a Liaison Diversion CAMHS nurse in Police stations which has improved the ability to seek advice, engagement with Police and their understanding to the pathway.
- All CYP have crisis plans which are co-produced and owned by CYP and their families. There is a process to develop a safety and coping plan for roll out and evaluate. There is also a digital in Islington (Good Things Foundation), and a crisis App for CYP is in development and will be piloted by the Brandon Centre.

Representatives from the local pathways in all boroughs welcome the feedback from the reviews and found them a positive experience which have generated ideas for improvement which are informing strategic planning going forward; a detailed action plan is being developed based on the recommendations from the peer reviews and delivery of this plan will be overseen by the NCL CAMHS Board.

**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

**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 2019
- Proposed launch date – April 2019

**Funding**
The five NCL CCG’s have identified a total budget of £500k per year to invest in the NCL-wide nurse-led out of hours component. In addition to this funding it is anticipate that the proposed NCM programme for NCL and possibly expanded to NEL will realise savings from CAMHS Tier 4 which will be reinvested into the acute care pathway.
Priority 4: Transforming Care

Rationale for Joint priority across NCL

Transforming Care is a national 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 programme aims to drive system-wide change to prevent unnecessary admission to hospital beds and the use of residential provision, to enable more people to live in the community, with the right support and care close to home.

The Transforming Care programme focuses on the five key areas of:
- Empowering individuals
- Right care, right place
- Workforce
- Regulation
- Data

We have been working together across North Central London, in collaboration with Local Authority Children and Young People’s Services, to realise 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*

We have established a CYP Sub Group of our NCL Programme Board, led by an identified lead Children’s Commissioner for NCL who is driving forward our agreed programme of work.

Achievements to date across NCL

A) *North Central London Admission Avoidance Register and NCL Care, Education and Treatment Reviews (CETRs) Protocol*

When someone is identified as being at risk of admission they are placed on an ‘admission avoidance register’. This register enables professionals to maintain an active focus on that YP with close monitoring, in conversation with professionals working with the young people and family. Where concerns are actively increasing and there is concern that the situation may result in a hospital admission, a CETR in convened. This review utilises Independent Expert by Experience and Independent Clinical Experts to facilitate discussion to ensure all measures and interventions have been considered to maintain the YP in the community.

In NCL we have developed a single process for this that we are working to embed across CCG and LA areas. The protocol for professionals, aims to support the
identification of those at risk and sets out 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. The shared protocol will enable us to ensure consistency of approach and equity of access to services for service users and their parents and carers across NCL. It will also enable us to review our local registers to monitor and assess need and use the information to inform commissioning plans and intentions to meet identified need.

B) Information placed on Local Offers to ensure consistency of information to service users and parents and carers

Information has been developed by NCL partners to utilise locally and publish on their Local SEND Offer to ensure consistency of information provided to service users and used to facilitate a discussion with local parents and carer forums. This is work that needs to continue to be embedded as a subgroup priority.

C) Positive Behaviour Support Service's

There are a range of different models for delivering behaviour support to children and young people with LD/Autism and behaviour that challenges and for their parents and carers. In NCL we are working towards a consistent model of positive behaviour support (PBS) services that are able to support families intensively in the home at times of crisis to implement PBS interventions and strategies. What is crucial is that these interventions are applied across the whole network involved in working with the YP so there is consistency of approach and reinforcement across all settings.

Enfield and Islington have been developing an intensive family support model based on the Ealing model, using positive behaviour support. The Ealing Model demonstrated a significant impact on reducing residential placements and inappropriate use of hospital beds in a crisis. PBS services allow us to develop a viable local alternative for a cohort of young people with challenging behaviours deterioration to the point where external placement becomes the only solution. These services are in their infancy and consideration will be given as to how we can embed these and roll out across the whole of NCL once they have demonstrated impact.

D) Shared Learning to Inform Commissioning

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. During 17/18 we have appointed Senior Care Co-ordinators across NCL to maintain an overview of the CETR process and the At Risk of Admission Registers. This work needs to be embedded during 18/19 but provides us with an opportunity to support YP and collate needs and experiences across NCL from CETR process.
E) Market Development

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 involve stimulating the market and working jointly to attract providers who can provide innovative solutions. NCL CYP commissioners have started to do some of this work with the involvement/facilitation of Oxford Brooks. Commissioners’ have started a dialogue with local providers to understand what is currently available, and what is possible, so we can develop services that are led by what our service users tell us and what local data tells us. A particular priority for us in 18/19 is to think about how we can support CYP and their parents and carers at times of crisis and how we can offer intensive support, possibly as a shared care arrangement that prevents family breakdown.

F) Capital and Housing

NCL continues to have a representative on the pan-London Capital and Housing sub-group to support the development of capacity on a regional basis. This sub group will support facilitation of the development of crisis support as set out above.

G) Accelerator Pilot

NCL has recently been successful in becoming an Accelerator Site for the CYP Transforming Care Programme; securing additional funding to develop a pilot of early intervention and intensive key worker support to families and CYP as an early intervention programme. The pilot aims to measure impact of intensive key worker support provided on a 3 month (in some cases 6 month) basis to families identified as amber on the at risk of admission register to prevent escalation to a RAG rating of red and therefore moving into CETR process. Alongside intensive key worker support the programme will also develop parent to parent support opportunities as well as making family therapy available to parents/carers and siblings. The pilot programme will be formally evaluated with the intention of being able to demonstrate an invest to save opportunity for CCGs and LAs.

NCL Transforming Care Programme – Key Priorities for 18/19

- Continue to embed local protocol and consistent process for admission avoidance register
- Improve data through work with providers to record LD/ASD and through better use of and profile of admission avoidance register
- Develop a clear engagement plan to ensure patient/family rep are engaged as partners at all stages and levels of decision making
- Continue market development work to consider development of NCL crisis Crash pad and shared care short break provision
Deliver NCL acceleration pilot and share learning from pilot
Consider how we can roll out PBS service across NCL as a whole and develop an investment proposal for Transforming Care Programme Board

Links to key policies and initiatives

Priority 5: Liaison

Rationale for joint priority across NCL

Extending mental health liaison is a key deliverable for the NCL STP and reflects the priority within the Five Year Forward View to ensure that ‘good quality mental health liaison services will be available more widely across the country’. Through the development of the NCL crisis care pathway it has become apparent that there is significant variation in availability of and access to CAMHS liaison across the sector. The current model is based on historical arrangements that have been in place for many years; is unsustainable due to reliance on high numbers of trainees; and does not provide a consistent all-age offer, which has resulted in a lack of parity across the system.

Our ambition

- To improve the service to children and 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 all-age liaison 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, adult liaison, pediatrics, 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

What we are aiming to achieve across NCL

NCL will develop a local integrated all-age liaison service which will seamlessly interface with the comprehensive acute care pathway for children and young people. The development of the acute care pathway will take into consideration wider developments in relation to crisis care for children and young people, including, for example, the possible roll out of the youth charity Redthread’s innovative Youth Violence Intervention Programme at UCLH\(^\text{19}\). Developments will be underpinned by

\(^\text{19}\) Redthread’s Youth Violence Intervention Programme runs in hospital emergency departments providing embedded youth workers delivering targeted interventions alongside clinical staff to engage young victims of assault and exploitation.
robust analysis of current and future workforce requirements, including staffing capacity and training implications of providing all-age liaison. The approach will need to ensure that:

- Current investment across NCL is at least maintained at the same level as 2018/19;
- Commissioning processes are streamlined and, if possible, there is a single process across NCL;
- Contracting is on same footing as main NHS standard contracts, is aligned to same national and NCL timescales and is on a more sustainable footing for providers; and
- The model of commissioning ensures integrated governance approach across mental health and acute providers and CCG commissioners.

**Current picture**

There are five acute hospital sites in NCL which have a range of arrangements for the provision and commissioning of CAMHS liaison. There has been a lack of new investment in these services and an indication that some, if not all, are currently under-resourced. This has had a significant impact on staffing levels (recruitment and retention) within services. Data on current services is currently patchy and there needs to be a full analysis of current clinical models, activity, performance and impact across the STP footprint. In addition, there is a lack of consistency in contracting and monitoring, and a lack of consistent financial oversight, which hampers shared evaluation and limits opportunities for stakeholders to collectively drive service transformation. Through the programme, commissioners and providers will therefore define and agree a commissioning and delivery model which is sustainable.

**Proposal**

A Mental Health Liaison Stocktake was held on 4th October attended by representatives of acute and mental health providers, commissioners and members of the Mental Health Workstream Experts by Experience Board. The meeting agreed a number of principles for developing a joined up strategy for mental health liaison across NCL. These embraced:

- Ambition
- Immediate priorities for 2018/9
- Contracting model

It was agreed that the ambition of the STP should be to reach Core 24 standard by for mental health liaison by 2021 for all hospitals in NCL. This would entail:

- A 24/7 service commissioned to operate as an on-site distinct service staffed at or close to the recommended level of staff numbers and skill mix to work on a 24/7 rota.
The service is commissioned to provide a one hour response to emergency referrals and a 24 hour response to urgent referrals from inpatient wards including acute admissions units.

There is the system capacity to respond to the needs of cohorts of patients (including those with personality disorders) who are regular attenders at A&E with a particular focus on admission avoidance.

In terms of a contracting model the Group agreed:

- The service could be commissioned either through acute contracts or directly from mental health providers but a consistent and transparent approach should be taken across NCL.
- A long term commitment (5 years) should be made to the services.

**Key milestones**

- Convene task and finish group – October 2018
- Analysis of current provision, including clinical models, activity, performance, cost and commissioning arrangements – October 2018 to January 2019
- Proposals for future delivery and commissioning models defined and options appraisal undertaken – January to March 2019

**Key Stakeholders**

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

**Funding**

It is anticipated that the financial contribution for the CAMHS element of an all-age service would be found within the existing financial envelope. This may entail some restructuring of current financial arrangements, options for which will be fully considered through appropriate options appraisal / business case processes.

Consideration is being given to the possibility of submitting a bid to HEE for non-recurrent funding to pilot an all-age liaison model which includes an embedded CAMHS liaison post (as opposed to the current model of stand-alone CAMHS liaison). This would provide an opportunity to test of the effectiveness of the model to inform future planning.
### Links to key policies and initiatives

<table>
<thead>
<tr>
<th>Linked to key policies and initiatives:</th>
<th>Aims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five Year Forward View</td>
<td>By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the ‘core 24’ service standard as a minimum.</td>
</tr>
</tbody>
</table>
Priority 6: New Care Model for CAMHS Tier 4

Rationale for a joint propriety across NCL

The development of New Care Models for CAMHS Tier 4 services is a priority within the Five Year Forward View for Mental Health and is a priority within the North Central London (NCL) Sustainability & Transformation Plan. It is recognised that the outcomes for children and young people experiencing severe mental illness can be both poor and inconsistent. Through joint work across NCL, the STP aims to improve population based health outcomes for children and young people experiencing mental health crisis and/or those with complex and enduring mental health needs. The wider collaboration across the STP provides an exciting opportunity to share learning and resources to better meet the mental health needs of children and young people across the system and tiers of need.

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

Current picture

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.

Looking beyond NCL, North East London (NEL) is the only other London STP area that has not developed local commissioning for Tier 4. NHSE Specialised Commissioning therefore made a specific request to NCL to develop a sub-regional shadow-NCM collaboration between NCL and NEL STPs, with the view to improving outcomes for children and young people across a wide geographical area. NHSE have indicated that the following adolescent specialist services would be involved in the shadow-NCM programme:
<table>
<thead>
<tr>
<th>Provider name</th>
<th>Unit name</th>
<th>OBDS commissioned</th>
<th>Commissioned beds</th>
<th>Total bed capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet, Enfield &amp; Haringey (BEH) MH Trust</td>
<td>Beacon Centre</td>
<td>4,976</td>
<td>13.63</td>
<td>14</td>
</tr>
<tr>
<td>East London Foundation Trust (ELFT)</td>
<td>Acute T4 CAMHS</td>
<td>4145</td>
<td>11.36</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>PICU</td>
<td>5103</td>
<td>13.98</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Day care service</td>
<td>2264</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>North East London Foundation Trust (NELFT)</td>
<td>Brookside</td>
<td>9483</td>
<td>25.98</td>
<td>30</td>
</tr>
<tr>
<td>Ellem Mede</td>
<td>Ridgeway Unit</td>
<td>7975</td>
<td>21</td>
<td>26</td>
</tr>
<tr>
<td>Whittington</td>
<td>Simmons House</td>
<td>TBC</td>
<td>12</td>
<td>TBC</td>
</tr>
<tr>
<td>Great Ormond Street Hospital (GOSH)</td>
<td>Mildred Creek</td>
<td>TBC</td>
<td>10</td>
<td>TBC</td>
</tr>
<tr>
<td>Royal Free Hospital (Eating Disorders)</td>
<td>TBC</td>
<td>TBC</td>
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</table>

In response to this request, Chief Executive Officers of the four NHS providers of general acute CAMHS Tier 4 services and the corresponding community CAMHS (BEH MHT, Whittington Health, NELFT and ELFT), plus the Tavistock & Portman NHS FT as the SRO for the NCL programme, have commenced a joint programme of work to identify the number of beds required within and across NCL/NEL and the potential savings from preventing out of area placements as well as reduced lengths of stay. A Non-Discloser Agreement (NDA) has been drafted in order to release the contract with NHSE to commence the programme; the NDA is currently awaiting signature.

Updated CAMHS specialised inpatient service review analysis data for NCL STP

The following usage analysis for 2017/18 has been compiled by NCL commissioners in collaboration with case managers from NHSE Specialised Commissioning:
## NCL Tier 4 CAMHS Admissions

<p>| Data Source | NHS E | HLP |<br />
|-------------|-------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Barnet est popn 2016 aged 0-18 | 90,336 (ONS 2017) |<br />
| <strong>Admission</strong> | 33 | 39 | 34 | 7 | 41 | 35 | 6 | 41 |
| <strong>LOS London</strong> | 1,923 | 2,220 | 2,740 | 749 | 3,489 | 2,852 | 735 | 3,587 |
| <strong>Cost</strong> | £958,686 | £1,007,955 | £1,595,878 | £467,354 | £2,063,232 | £1,597,062 | £459,307 | £2,056,369 |
| <strong>Av Cost</strong> | £499 | £454 | £582 | £624 | £591 | £560 | £625 | £573 |
| Camden est popn 2016 aged 0-18 | 47,642 (ONS 2017) |<br />
| <strong>Admission</strong> | 5 | 9 | 14 | 23 | 11 | 10 | 21 |
| <strong>LOS London</strong> | 650 | 1,218 | 701 | 1,064 | 1,765 | 1,049 | 1,021 | 2,070 |
| <strong>Cost</strong> | £143,739 | £601,102 | £630,340 | £663,904 | £1,294,244 | £631,263 | £645,020 | £1,276,283 |
| <strong>Av Cost</strong> | £221 | £494 | £899 | £624 | £733 | £602 | £632 | £617 |
| Enfield est popn 2016 aged 0-18 | 83,773 (ONS 2017) |<br />
| <strong>Admission</strong> | 20 | 23 | 5 | 6 | 11 | 4 | 5 | 9 |
| <strong>LOS London</strong> | 1,187 | 1,165 | 185 | 213 | 398 | 473 | 207 | 680 |
| <strong>Cost</strong> | £563,675 | £625,566 | £291,389 | £132,906 | £424,295 | £291,389 | £174,103 | £465,492 |
| <strong>Av Cost</strong> | £559 | £537 | £1,575 | £624 | £1,066 | £616 | £841 | £685 |
| Haringey est popn 2016 aged 0-18 | 61,480 (ONS, 2017) |<br />
| <strong>Admission</strong> | 22 | 16 | 10 | 4 | 14 | 9 | 2 | 11 |
| <strong>LOS London</strong> | 1,331 | 1,532 | 435 | 151 | 586 | 833 | 148 | 981 |
| <strong>Cost</strong> | £679,371 | £821,833 | £500,394 | £94,219 | £594,613 | £500,394 | £90,018 | £590,411 |
| <strong>Av Cost</strong> | £510 | £536 | £1,150 | £624 | £1,015 | £601 | £608 | £602 |
| Islington est popn 2016 aged 0-18 | 40,819 (ONS 2017) |<br />
| <strong>Admission</strong> | 13 | 17 | 7 | 2 | 9 | 7 | 3 | 10 |
| <strong>LOS London</strong> | 697 | 1,591 | 857 | 81 | 938 | 1,234 | 81 | 1,315 |
| <strong>Cost</strong> | £142,332 | £810,165 | £786,502 | £50,542 | £837,043 | £786,502 | £53,600 | £840,102 |
| <strong>Av Cost</strong> | £204 | £509 | £918 | £624 | £892 | £637 | £662 | £639 |
| NCL est popn 2016 aged 0-18 | 324,050 (ONS 2017) |<br />
| <strong>Admission</strong> | 93 | 114 | 65 | 33 | 98 | 66 | 26 | 92 |
| <strong>LOS London</strong> | 5,788 | 7,726 | 4,918 | 2,258 | 7,176 | 6,441 | 2,192 | 8,633 |
| <strong>Cost</strong> | £2,587,803 | £3,866,621 | £3,804,503 | £1,408,924 | £5,213,427 | £3,806,609 | £1,422,048 | £5,228,657 |
| <strong>Av Cost</strong> | £447 | £500 | £774 | £624 | £727 | £591 | £649 | £606 |</p>
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<thead>
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<th>16-17 Out of London</th>
<th>16-17 Total</th>
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<th>17-18 Out of London</th>
<th>17-18 Total</th>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Admission</td>
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<td>Av Cost</td>
<td>£570</td>
<td>£713</td>
<td><strong>£627</strong></td>
<td><strong>£593</strong></td>
<td><strong>£776</strong></td>
<td><strong>£619</strong></td>
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<td><strong>Camden</strong> est popn 2016 aged 0-18 <strong>47,642</strong> (ONS 2017)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Admission</td>
<td>11</td>
<td>19</td>
<td>30</td>
<td>31</td>
<td>9</td>
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<td><strong>£698</strong></td>
<td><strong>£594</strong></td>
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<tr>
<td><strong>Enfield</strong> est popn 2016 aged 0-18 <strong>83,773</strong> (ONS 2017)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission</td>
<td>8</td>
<td>12</td>
<td>20</td>
<td>26</td>
<td>5</td>
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<tr>
<td>LOS London</td>
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<td><strong>£807</strong></td>
<td><strong>£705</strong></td>
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<td><strong>Haringey</strong> est popn 2016 aged 0-18 <strong>61,480</strong> (ONS, 2017)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission</td>
<td>11</td>
<td>23</td>
<td>34</td>
<td>23</td>
<td>15</td>
<td>38</td>
</tr>
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<td>£1,410,084</td>
<td>£741,021</td>
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<td>£655</td>
<td><strong>£652</strong></td>
<td><strong>£602</strong></td>
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<td><strong>Islington</strong> est popn 2016 aged 0-18</td>
<td>40,819 (ONS 2017)</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Admision</td>
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<td>18</td>
<td>30</td>
<td>34</td>
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<td>44</td>
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<tr>
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<td>£2,695,133</td>
<td>£2,648,048</td>
<td>£744,087</td>
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<td>£631</td>
<td>£626</td>
<td>£782</td>
<td>£655</td>
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<tr>
<td><strong>NCL</strong> est popn 2016 aged 0-18</td>
<td>324,050 (ONS 2017)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Admision</td>
<td>66</td>
<td>110</td>
<td>176</td>
<td>156</td>
<td>50</td>
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<tr>
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<td>8,895</td>
<td>18,712</td>
<td>15,127</td>
<td>4,188</td>
<td>19,315</td>
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<tr>
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<td>£3,128,433</td>
<td>£12,258,314</td>
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<tr>
<td>Av Cost</td>
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<td>£668</td>
<td>£641</td>
<td>£604</td>
<td>£747.00</td>
<td>£635</td>
</tr>
</tbody>
</table>

**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

Through the shadow-NCM programme, the STPs will develop a sub-regional CAMHS pathway across NCL and NEL which will increase integration between locally provided community CAMHS, social care and education, acute hospitals and paediatric liaison services. In addition, through the delegation of specialised commissioning functions in relation to contracting and payment of children and young people’s psychiatric inpatient care, the programme will achieve greater integration with adolescent inpatient services for general acute, eating disorders, learning disability and psychiatric intensive care.

The programme will result in a more preventative approach and ensure that care is provided in the most appropriate place at the right time, preventing Tier 4 admissions, reducing lengths of stay and supporting appropriate and safe discharge through improved integration across the children’s health, education and care system. By working across a larger geographical footprint, the programme will increase efficiency and equity of access to high quality community, acute and inpatient services, improving population based mental health outcomes for children and young people and realising savings that will be reinvested into community services.

We will develop a local integrated pathway for CYP requiring beds that includes rapid community based response to crisis. This will result in admission prevention, reduced length of stay and support appropriate and safe discharge and a reduction of admission to acute paediatric beds across the footprint. NCL and NEL 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.

The NCL CAMHS Project Board is currently overseeing this work and a wider NCL/NEL programme board is being established to lead the work. The programme board will be responsible for ensuring that commissioners and providers work collaboratively with service users and that there is service user challenge and oversight as proposals are developed.

Funding

Non-recurrent funding of £20k per NCL CCG (£100k in total) was allocated to provide fixed-term project support during 2018/19. BEH MT have indicated that they are able to provide ongoing support to the programme at no additional cost to commissioners.

Key Milestones

- All NCL / NEL partners sign non-disclosure agreement – September 2018
- Signing of contract with NHSE Specialised Commissioning – September / October 2018
- Baselining of in area and out of area 2017/18 month 12 full year outturn to set NCM budget for 2019/20 – November / December 2018
- Establish forecast activity for 18/19 – November / December 2018
- Undertake modelling to inform phasing of implementation and potential financial implications of implementation, e.g. including any options for pump-priming of community crisis services – January to March 2019
- Commence delivery of shadow place-based commissioning of CAMHS Tier 4 – April 2019

Links to key policies and initiatives

<table>
<thead>
<tr>
<th>Linked to key policies and initiatives</th>
<th>Aims</th>
</tr>
</thead>
</table>
| 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 |

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Conclusion

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 also submitted a bid for wave 2 funding which was successful which will help to sustain the service for 2018/19.

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, evaluation and management, which is planned for 2018/19, will help us to make an informed decision on next steps. Our intention is to ensure that the delivery of services have an impact on our waiting time targets and that we have more robust data that informs more targeted commissioning decisions for future services.

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 and adult mental health services. 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 completed has help us to 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.

We have also made progress in relation to our commitment to improve services for young people in crisis. We have already developed a proposal for an operating model for an out of hours’ service, which will cover the whole of NCL footprint. The model that we will be implementing in Q4 2018/19 will be set within the parameters of the agreed financial envelope and will interface with current and future arrangements for the collaborative commissioning of local CAMHS 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.

In order to provide improved services for children and young people who present in A & E departments, we will also need to review liaison services as part of the liaison psychiatry workstream. Further analysis is planned for A&E activity and performance of current liaison services in NCL. This will help us to understand current provision and scope further work needed to deliver transformational and sustainable changes to our services.
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.

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 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 remains that we aim to address variation in provision and improve care for our population in a sustainable way whilst ensuring that patient experience and better outcomes remain priority.
## Appendix 1

### Progress against initial LTP priorities

<table>
<thead>
<tr>
<th>Funding scheme number</th>
<th>Description of local priority</th>
<th>The expected outcome of the scheme</th>
<th>KPIs Main KPI in bold</th>
<th>KPI baseline</th>
<th>KPI target Main KPI target in bold</th>
<th>Progress</th>
</tr>
</thead>
</table>
| **Local priority stream 1 – retain** | £10k Training local primary care, schools and other tier one services on eating disorders | Improved understanding of ED and ED care pathways. | Improvement in voluntary sector, primary care, parent and teacher understanding of ED via a survey | Not measured as new scheme | Qtr. 3 and 4 75% participants have an improved understanding of ED via a survey. | Training Programme completed and KPIs met
New focus on Positive Behaviour Support |
<p>| <strong>Local priority stream 2</strong> | Self-harm and crisis Intervention | Reduction in self harm A&amp;E presentation and subsequent admissions. Reduction in Tier 4 admissions. Audit for OOH. | % young people assessed within one working day of referral. % young people meeting their PROMs - personal GBOs at discharge or within six months of treatment ending. % of clinicians completing CGAS at discharge. | New Scheme and baseline to be established by 31/12/15. Pilot work is baseline for A and E visits and inpatient admissions following deliberate self-harm. 2013/14 CORC show less than 2% client outcome measures recorded and 94% CGAS completed for clients. | Qtr. 3 recruitment and baseline set. Qtr. 4 2016/17 70% young people assessed within one working day of referral. 50% young people meeting personal GBOs at discharge or within 6 months of treatment ending. 99% clinicians complete CGAS at discharge. QTR 4 2016/17 target: 95%. New target 2017/18: 60 % young people assessed within two working day of referral. | Due to changes in service funding this priority now combined with 3. NCL CCGs CAMHS Delivery Group - Crisis work has now taken the lead for coordinating this work with an expectation to agree NCL wide KPIs. |
| <strong>Local priority stream 3 – the KPIs for 3 and 4 are the same.</strong> | Waiting list initiative | Reduced waiting times | Generic CAMHS % young people commence treatment within 0-4 weeks of referral. % of DNA reduced for first and follow up appointments. | July KPI data – 32% of young people commence treatment within 4 weeks of referral. DNA rate 12.1% first and 13.1% FU. | Qtr. 3 Recruitment. Qtr. 4 CAMHS 60 % young people commence treatment within 6 weeks of referral. 1% reduction in DNA rate for first and follow up. 2016/17 Qtr. 4 CAMHS target: 100% 2017/18 target: 65% young people offered an initial appointment and commencement treatment within 13 weeks. | Completed. Due to changes in service funding this priority has changed to 65% young people offered an initial appointment and treatment commenced within 13 weeks. Some issues in 18/19 due to increase in referrals. CAMHS Access Team should improve performance. |</p>
<table>
<thead>
<tr>
<th>Funding scheme number</th>
<th>Description of local priority</th>
<th>The expected outcome of the scheme</th>
<th>KPIs Main KPI in bold</th>
<th>KPI baseline</th>
<th>KPI target Main KPI target in bold</th>
<th>Progress</th>
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<td>Waiting list imitative</td>
<td>Reduced waiting times</td>
<td>Generic CAMHS % young people commence treatment within 0-4 weeks of referral. % of DNA reduced for first and follow up appointments.</td>
<td>July KPI data – 32% of young people commence treatment within 4 weeks of referral. DNA rate 12.1% first and 13.1% FU.</td>
<td>Qtr. 3 Recruitment. Qtr. 4 CAMHS 70% young people commence treatment within 4 weeks of referral. 1% reduction in DNA rate for first and follow up. 2016/17 Qtr. 4 CAMHS target: 100%. 2017/18 target: 65% young people offered an initial appointment and commence treatment within 13 weeks.</td>
<td>Completed. Due to changes in service funding this priority has changed to 65% young people offered an initial appointment and commences treatment within 13 weeks.</td>
</tr>
<tr>
<td><strong>Local priority stream 5 – the KPIs for 5, 6 and 7 are the same.</strong></td>
<td>CYP IAPT - backfill</td>
<td>Staff trained in CYP IAT. Increased return of outcome based goals. Reduced DNAs.</td>
<td>CYP IAPT trainees. % PROMS and Clinician outcome measures collected. % of DNA reduced for first and follow up. Numbers actually trained in CYP IAPT.</td>
<td>2013/14 CORC show less than 2% client outcome measures recorded. 2014/15 Rio shows 94% CGAS completed for clients. DNA rate 12.1% first and 13.1% FU</td>
<td>Qtr. 3 Numbers trained. Qtr. 4 2016/17 for CYP IAPT trainees - national target is 50% of client PROMs collected. The national target is 90% of client and clinician data collected. 1% reduction in DNA rate. QTR 4 2016/17 for CYP IAPT trainees - 90% of clients PROMs collected. 99% Clinicians report CGAS. All CAMHS staff - 30% of clients PROMs. 99% Clinicians report CGAS.</td>
<td>Completed. ICAN platform being used for digital collection of outcome data.</td>
</tr>
<tr>
<td><strong>Local priority stream 6 the KPIs for 5, 6 and 7 are the same.</strong></td>
<td>CYP IAPT - additional backfill</td>
<td>Staff trained in CYP IAT. Increased return of outcome based goals. Reduced DNAs.</td>
<td>CYP IAPT trainees. % PROMS and Clinician outcome measures collected. % of DNA reduced for first and follow up. Numbers actually trained in CYP IAPT.</td>
<td>2013/14 CORC show less than 2% client outcome measures recorded. 2014/15 Rio shows 94% CGAS completed for clients. DNA rate 12.1% first and 13.1% FU</td>
<td>Qtr. 3 Numbers trained. Qtr. 4 2016/17 for CYP IAPT trainees - national target is 50% of client PROMs collected. The national target is 90% of client and clinician data collected. 1% reduction in DNA rate. QTR 4 2016/17 for CYP IAPT trainees - old target:90% new target: 50% of clients PROMs collected. 2017/18 target: 100% new target: 60% Clinicians report CGAS. All CAMHS staff - 30% of clients PROMs. Old target: 99% new target: 50% Clinicians report CGAS.</td>
<td>Completed. The Data Warehouse is under development. ICAN platform is being used for digital collection of outcome data.</td>
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<tr>
<td>Funding scheme number</td>
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<td>The expected outcome of the scheme</td>
<td>KPIs</td>
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<td>KPI baseline</td>
<td>KPI target Main KPI target in bold</td>
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<tr>
<td>Local priority stream 7 - the KPIs for 5, 6 and 7 are the same.</td>
<td>CYP IAPT - Data Officer</td>
<td>Increased return of outcome based goals. Reduced DNAs.</td>
<td>CYP IAPT trainees. % PROMS and Clinician outcome measures collected. % of DNA reduced for first and follow up. Numbers actually trained in CYP IAPT.</td>
<td>2013/14 CORC show less than 2% client outcome measures recorded. 2014/15 Rio shows 94% CGAS completed for clients. DNA rate 12.1% first and 13.1% FU</td>
<td>Qtr. 3 Numbers trained. Qtr. 4 2016/17 for CYP IAPT trainees - national target is 50% of client PROMs collected. The national target is 90% of client and clinician data collected. 1% reduction in DNA rate. QTR 4 2016/17 for CYP IAPT trainees - old target: 90% new target: 50% of clients PROMs collected. Old target: 100% new target: 60% clinicians report CGAS. All CAMHS staff - 30% of clients PROMs. 99% Clinicians report CGAS.</td>
<td>Completed.</td>
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<td>Local priority stream 8</td>
<td>CYP IAPT Principles to Voluntary Sector</td>
<td>Consistency in the collection of patient reported outcomes PROMS and clinician reported.</td>
<td>Consistent collection of outcome measures.</td>
<td>Not measured as new scheme. Baseline set in Qtr. 3. Targets will vary by voluntary organisation. Identify each organisation’s collected outcome measures.</td>
<td>Qtr. 3 2016/17 Baseline. QTR 4 TBC e.g. Reduce the various experience of service to two questionnaires.</td>
<td>Plan in place to ensure data is flowing by 1 April 2019.</td>
</tr>
<tr>
<td>Local priority stream 9</td>
<td>Implementation of Transformation Plan - backfill</td>
<td>Improved access and increased numbers of FFT collected by CAMHS Service.</td>
<td>% staff in post.</td>
<td>To be agreed in Qtr. 3 2017/18</td>
<td>Qtr. 3 - 20% of staff in post and 20017 Qtr. 4 – 100% staff in post.</td>
<td>Ongoing. A number of interim posts have been made recurrent and therefore this should improve.</td>
</tr>
<tr>
<td>Local priority stream 10</td>
<td>Neuro- development/ SCAN</td>
<td>Reduced waiting times</td>
<td>Urgent % young people assessed and treated within 72 hours of referral. Non urgent % young people assessed and treated within 13 weeks of referral. % of children and young will be assessed within 6 weeks of referral.</td>
<td>April to July KPI data - 21% young people seen within 4 weeks.</td>
<td>22% Urgent target within 4 weeks of referral. Non-urgent old target; 100% new target: 30% young people assessed within 13 weeks of referral.</td>
<td>Completed. Due to changes in service funding this priority has changed to 65% young people offered an initial appointment and commences treatment within 13 weeks. Some issues in 18/19 because of increase of referrals, Recurrent funding for additional staff approved and this should improve performance</td>
</tr>
<tr>
<td>Local priority stream 11</td>
<td>Enfield Parent and Infant Project (EPIP)</td>
<td>Reduced waiting times</td>
<td>% parents and their children commence treatment within 6 weeks of referral.</td>
<td>April-July KPI data - 90% parents and children seen within 6 weeks</td>
<td>Qtr4 95% parents and their children offered an initial appointment and commence treatment within 6 weeks of referral.</td>
<td>Completed. Due to changes in service funding this priority has changed to 100% offered an initial appointment and commences treatment within 13 weeks.</td>
</tr>
<tr>
<td>Funding scheme number</td>
<td>Description of local priority</td>
<td>The expected outcome of the scheme</td>
<td>KPIs Main KPI in bold</td>
<td>KPI baseline</td>
<td>KPI target Main KPI target in bold</td>
<td>Progress</td>
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<tr>
<td>Local priority stream 12</td>
<td>IT Infrastructure Improve to support clinicians, CYP IAPT roll out</td>
<td>Increased return of outcome based goals</td>
<td>Project plan for the IT Implementation.</td>
<td>No baseline as this is a new project. Baseline will be agreed in Qtr. 3.</td>
<td>Qtr. 3 Agree IT project plan. 100% Implementation of IT work plan. QTR 4 old target: 100% new target: 75% Implementation of IT work plan.</td>
<td>Completed.</td>
</tr>
<tr>
<td>Local priority stream 13</td>
<td>IT Infrastructure - Apps &amp; Web Design to improve access</td>
<td>Increased use of the website</td>
<td>Project plan for apps and website.</td>
<td>No baseline as this is a new project. Baseline will be agreed in Qtr. 3. Website usage to be determined.</td>
<td>Qtr. 3 Agree IT project plan. 100% Implementation of IT work plan. QTR 4 old target: 100% new target: 75% Implementation of IT work plan.</td>
<td>Completed</td>
</tr>
<tr>
<td>Local priority stream 14</td>
<td>Destigmatisatio n Campaign</td>
<td>Improved understanding of social, emotional and mental health issues.</td>
<td>% improved understanding of mental health issues</td>
<td>Not measured as new scheme. Baseline will be agreed in Qtr. 3. Website usage to be determined.</td>
<td>Qtr. 3 Planning. Qtr. 4. Conduct a survey. 70% of those surveyed to have an increased understanding of mental health issues</td>
<td>Completed. Celebrated World mental Health Day 17/18 and 18/19</td>
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<tr>
<td>Local priority stream 15</td>
<td>Peer Support and Engagement</td>
<td>Improved understanding of social, emotional and mental health issues.</td>
<td>Number of peer supporters, % collection of survey, % increased involvement of CYP and Parents/Carers</td>
<td>Not measured as new scheme. Baseline will be agreed in Qtr. 3. Number of parents/carers and CYP involved in CAMHS consultation groups.</td>
<td>QTR 3 Planning. Qtr. 4 20% increased participation by parents and young people. 15 peer supporters and Survey outcome measures from young people they engage.</td>
<td>Completed.</td>
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<tr>
<td>Local priority stream 16</td>
<td>Voluntary Sector Capacity Development</td>
<td>Improved working between voluntary sector organisations, improved working between CAMHS and voluntary sector</td>
<td>Funding strategy and funding bids completed</td>
<td>Not measured as new scheme /use time to change baseline</td>
<td>Funding Strategy produced. Number of bids completed.</td>
<td>Completed.</td>
</tr>
<tr>
<td>Local priority stream 17</td>
<td>Provider Forum</td>
<td>Improved knowledge of local services, increased consistency and improved working between groups</td>
<td>Mapping of local provision and hold one forum</td>
<td>Not measured as new scheme</td>
<td>Qtr. 3 Survey outcome measures and work plan/training topics. Qtr. 4 Hold Provider Forum.</td>
<td>Ongoing Mental Health Provider Forum is taking forward the anti-stigmatism work.</td>
</tr>
<tr>
<td>Local priority stream 18</td>
<td>Child Sexual Assault, Sexual Abuse and Exploitation Scoping work</td>
<td>Improved care pathways and better understanding of these care pathways</td>
<td>Mapping of NCL provision.</td>
<td>Not measured as new scheme</td>
<td>Care pathways identified and scoping options for future provision</td>
<td>Being progressed by the NCL CCGs CAMHS Project Group.</td>
</tr>
<tr>
<td>Funding scheme number</td>
<td>Description of local priority</td>
<td>The expected outcome of the scheme</td>
<td>KPIs Main KPI in bold</td>
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<td>Local priority stream 19</td>
<td>Audits - DNA, vulnerable children, primary care needs assessment</td>
<td>Improved information on potentially vulnerable group and how to access</td>
<td>Audit recommendations</td>
<td>Not measured as new scheme</td>
<td></td>
<td>To be achieved as part of the JSNA refresh</td>
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<tr>
<td>Local priority stream 20</td>
<td>Training on Mental Health issues</td>
<td>Improved understanding of social, emotional and mental health issues.</td>
<td>% increased understanding of mental health issues</td>
<td>Not measured as new scheme</td>
<td></td>
<td>Qtr3 planning. Qtr 4. 70% of those surveyed have an increased understanding of mental health issues</td>
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<tr>
<td>Local priority stream 21</td>
<td>Youth Offending Unit</td>
<td>To further integrate physical health and mental health services within the Youth Offending Unit.</td>
<td>% reduction in re-offending rates for individuals participating in the YOU programme.</td>
<td>Not measured as new scheme</td>
<td></td>
<td>2016/17 Qtr. 4 Planning, 2017/18 –Qtr.1-Q1 Qtr4 – hold training for YOU staff. 2017/18 Qtr.3 – appointment of staff for Enfield L&amp;D team, Wood Green Custody Suite.</td>
</tr>
<tr>
<td>Local priority stream 22</td>
<td>Data Sharing</td>
<td>To improve data sharing across NCL CCGs.</td>
<td>Under development and To Be Confirmed.</td>
<td>To Be Confirmed</td>
<td></td>
<td>To Be Confirmed</td>
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