NHS

Walsall Clinical Commissioning Group

Walsall Local Transformation Plan for Children and Young People's Mental Health and Wellbeing – One year later

2015 – 2020

October 2016 Progress and Update

Draft version 7th October 2016 Final version to be submitted 31st October 2016

Improving Health and Wellbeing for Walsall

Foreword

In 2015 Walsall Clinical Commissioning Group (CCG), Walsall Metropolitan Borough Council (MBC), Partners and Providers developed the Walsall Mental Health and Emotional Wellbeing needs Assessment, Strategy and local Transformation Plan for Children and Young People with feedback and input from children and young people, families and carers.

The final version gained approval from the Health and Wellbeing Board, The Children and Young People's Partnership Board and the Mental Health programme Board by December 2015.

The transformation action plan (which included the needs assessment and strategy as appendices) received assurance from NHS England in November 2015. Additional transformation funding was available from December 2015.

This document describes our achievements to date having commenced implementing the plan and strategy in January 2016 with funding available to support transformation from December 2015. This document confirms how we have utilised the additional resources to accelerate the transformation of our local mental health and emotional wellbeing service offer over the next five years.

The contents of this document will be reflected in the refresh of the strategy. The transformation action plan is continuously updated and additional actions identified will be incorporated and included as specified appendices with the final refresh submission on the 31st October 2016.

An updated project plan with the strategy refresh will be attached to the final submission following endorsement from the WHWBB.

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1. Introduction

Supporting children and young people to have good mental health and wellbeing is important in Walsall. We recognise the difference this can make in daily life and how it supports them to achieve a successful future.

The strategy and transformation plan were produced to confirm our priorities and actions needed to achieve them and started following approval from January 2016 through to 2020.

Walsall's Vision

We want children and young people in Walsall to enjoy a happy, confident, childhood.

We will work to improve the mental health and wellbeing of children and young people in Walsall by supporting individuals and communities.

We will support children and young people in Walsall to build resilience to be able to manage their mental health and wellbeing.

2. Progress against the priorities in the strategy and transformation action plan

Priority One:

Make sure delivery of mental health and emotional wellbeing is everybody's responsibility

Key aims: We want everyone to understand the factors that influence wellbeing and good mental health and understand who they can help to promote and support wellbeing and good mental health.

We want to remove the stigma associated with poor mental health.

We want to increase the knowledge and awareness about mental health and wellbeing needs with the people who work with children and young people and to improve understanding of the help and support available and when it is necessary to seek specialist support.

Successes:

1. Schools link pilot in 10 schools in Walsall. This pilot aimed to develop a named CAMHS link for 10 schools in Walsall and for each school to have a named mental health lead.

   Two days were facilitated by the Anna Freud Centre to introduce the principles of the 'CASCADE' framework. The framework supports partners involved in supporting Children and Young People's mental health. The model is clarifies the role and are responsibilities of all partners and confirms agreed point of contact in school and CYP mental health services.

   Walsall extended the pilot to run until March 2017. The pilot has been fully evaluated. The CAMHS link has produced a local pathway for schools to help them imitate the pilot and implement a process of having a designated mental health lead in the school, a clear understanding of the role of schools and confirms the local pathway to access further support and help.

   We also added the additional role for the pilot and that was to support the early help locality panels by attending and supporting partners in case discussions.

   Work to promote the pathway to the rest of the schools in Walsall will take place during November to March 2017.

An appendix – a report about the pilot to date will be attached to final submission.

2. The Healthy Schools Programme is being revisited and implemented in Walsall. Healthy Schools includes ensuring children and young people receive support to manage emotions, cope with change, have positive self esteem, manage relationships and develop interpersonal problem solving skills. The Ofsted framework judgement on personal development, behaviour and welfare of children and learners also includes a requirement to provide this support.

Gaps:

The offer of mental health awareness training is offered through the Children's Services Learning and Development Programme; however this needs to be reviewed.

Future intentions:

Review of training needs to be completed with partners from Public Health and Children's Services within 2017/18.

Priority Two:

Improve information and advice available for children and young people, families and professionals with regard to emotional mental health and wellbeing

Feedback has confirmed that information available about mental health and wellbeing for children and young people is limited, not all in one place and not easy to access. Many people, including people who work with children and young people are not aware of all the support and services available, or how to access it.

We want to have a clear pathway in place, confirming mental health and wellbeing support and services for children and young people to access.

Successes:

1. Increased access to advice from the face to face counseling service. Additional outreach of 15 days has been taking place across schools and other organisations to raise awareness with young males aged 15 to 17 and those from BAME.

The final submission of the refresh will include a report from the provider of the qtr 2 data and confirmation of the outcomes from the liaison days.

Future intention:

This priority is an ongoing long term area of improvement. The intention is to have consistent information for all partners' websites for CYP mental health and for this to be in place by the end of March 2017.

Priority Three:

Prevention and early help, earlier recognition and intervention

We want to ensure all children, young people and families have access to timely, evidence based, high quality specialist mental health support when it is needed. Feedback confirms that:

- There isn't enough support to help with significant behavioural issues and there is the perception that many children are not able to access the secondary specialist mental health services.

- Awareness of the online counselling service and the face to face counselling service is inconsistent.

- Walsall GP's fed back they want a single point of access to refer children and young people to when they have mental health and wellbeing needs.

- GP's, Schools and other professionals fed back they feel there is a gap in support between the help they offer, school nurses and health visitors offer and CAMHS.

Maternal mental health is also important, if expectant mothers and those with new born babies (up to a year old) are supported with their mental health this has a direct impact to their child/children. Although support to the parent is from adult services this requires a joined up approach with children's services. In Walsall the current community based adult maternal mental health services do not include access to a specialist perinatal mental health consultant offered through the birth unit.

Successes:

1. Behaviour support has been mapped as part of the Healthy Child Programme. This compliments the mapping of mental health and emotional wellbeing resources. This mapping also included confirming the current workforce.

These mapping documents will merge and be attached as part of the final submission of the plan refresh. The workforce mapping will be separate.

2. Walsall Behaviour Support Team is embedded as a traded service within Walsall primary schools and includes an advisory consultative CAMHS nurse role. Teachers receive training and guidance in behaviour management in the classroom and also a guide for initial help and screening, with a clear process for accessing the input for the CAMHS nurse. This is now being promoted to all secondary schools (maintained and academy) for buy in of a tailored version of the team to meet needs in secondary schools.

3. There is a CAMHS professional working within Walsall YOS who also works within the secondary (tier 3) mental health service. The professional support CYP within YOS and enable consistency if they access further secondary mental health support.

4. Short term additional capacity has been given to the face to face counselling service to increase capacity two days a week enabling more CYP to access counselling.

The final submission of the refresh will include qtr 2 data for this service as an appendix.

5. Short term additional capacity has been given to the online counselling provision to ensure they have the capacity to provide additional hours counselling for CYP (monitoring confirm increased demand for the service in 2015).

The final submission of the refresh will include qtr 2 data for this service as an appendix.

6. GP liaison nurse role: This role started in February and considers all referrals received by Walsall CAMHS (secondary mental health services) where the referral doesn't require a secondary mental health response. A children's paediatric panel has formed and meets every week to consider these cases. This panel made up of health professionals who support CYP then agree where the CYP needs would be best met and refer them appropriately i.e. school health advisors, parenting course, face to face counselling, early help, children's centres etc.

   This process has considered 271 cases since 1st April 2016 and has stopped most referrals being bounced back to GP's with a CYP having unmet needs. (It has though led to an increase in referrals to the school health advisors, with recent confirmation that 40 % of referrals were for mental health and wellbeing).

There is an appendix attached with evidence from DWMHPT about this role.

7. Maternal mental health. Walsall Health Visitors Service reviewed and developed a revised local maternal mental health pathway in partnership with maternity services and included mental health services. The Black Country STP has applied for funds on behalf of the Black Country to implement the specialist mental health support required to enable access to a dedicated peri-natal mental health consultant and dedicated specialist mental health nurses.

A copy of the bid will be attached to the final submission of the refresh as an appendix.

Future intentions:

A model of tier 2/targeted mental health services and primary mental health is being developed with the aim to mobilise the model during January 2017 onwards.

This will include a single point of access for all referrals and include self referral.

Workforce planning and development will be finalised and identify workforce gaps in tier 3, tier 2 and universal services. Where there have been recruitment issues these will be flagged to show there is national shortage and how this will impact future recruitment.

Walsall will have a workforce identified from across the partnership in place and will join the West Midlands IAPT collaborative to commence the roll out of CYP Improving Access to Psychological Therapies (IAPT) a national programme within the timescales required by performance assurance areas, which requires all areas to be part of CYP IAPT by 2018.

The workforce will consist of professionals from universal, targeted and specialist services to ensure IAPT is embedded across the whole pathway.

16/17 increase in funds to the CYP MH transformation allocation (allocated to Walsall CCG) are being used to implement a model of primary mental health/targeted tier 2 to complement the existing services and resources commissioned by other partners to form a complete pathway. The model should be fully functioning during 2017/18.

Priority Four:

Access to evidenced based, high quality services

Targeted and specialist mental health services should have appropriate professionals in the team and should provide evidence based support.

Specialist mental health services (CAMHS) are supporting children and young people with more complex mental health needs.

Many GP's felt they cannot access the specialist secondary mental health services CAMHS for their patients.

Children and young people who meet the criteria to access the secondary specialist mental health service and who are not in crisis, experience long waiting times for the follow on appointment, after their first initial assessment appointment.

Children and young people in emergency crisis are admitted to the paediatric ward of the local acute hospital.

Successes:

1. Workforce reviewed in 2015 to understand 'bottlenecks' and pressures. Funding to increase capacity within secondary mental health service (CAMHS) funded long term. Waiting times are reducing and there is evidence to show increase in the number of CYP being accepted into the service and supported. For data on referrals, acceptance and waiting times see appendix: Walsall CAMHS Transformation Evidence.

There is an appendix attached with the current Walsall CAMH staffing structure

2. Increasing evidence based interventions on offer including DBT (Dialectical behaviour therapy), DPP (dyadic developmental psychotherapy) and Learning disabilities (LD) /CAMHS training in LD and sexually harmful behaviours).

For data on training completed there is an attached appendix: Walsall CAMHS Transformation Evidence

3. Pathways within the secondary mental health service mapped and NICE recommended interventions confirmed.

4. Approach to manage 'did not attends' reviewed and a text messaging service introduced. Where consent is given on referrals contact with other partners who can support attendance are also notified of appointments.

5. IPADS using one off additional funds available from NHSE have been purchased and in use to help with assessments and to gain patient feedback.

6. The Early Intervention into Psychosis Service contract specification has been reviewed and includes all age and the requirement for referral to treatment targets and treatment with NICE based intervention.

The final submission of the refresh will include extracts from the specification as an appendix.

7. Development of a dedicated CYP Community Eating Disorder Service. This is a pan trust model with Dudley CCG. In partnership a service model was agreed, a specification has been produced (which includes the requirements within current national guidance for referral to treatment time and use of evidence based interventions). Recruitment to the team has been underway with 2 posts still to be filled. Recruitment to the OT role has been unsuccessful, therefore it has been agreed to utlilise further nursing hours with the understanding that eating disorders cases will be prioritised to access the OT within the general service. Mobilisation of the service will take place between October and November 2016 with service start in January 2017. For confirmation of the recruitment

For data on recruitment to the CED there is an attached appendix: Walsall CAMHS Transformation Evidence

The draft service specification will be attached to the final submission of the plan refresh

8. ICAMHS (crisis and treatment at home service) now has permanent staff in place following conformation for recurrent funding from 2016 onwards. It is fully staffed and mobilised. Additional transformation funds have been allocated to increase the medic input to also support this service. This service has reduced the number of admissions into both acute and inpatient CAMHS and in most admissions reduced the length of stay.

For recruitment details and caseload of ICAMHS, there is an appendix: Walsall CAMHS Transformation Evidence.

ICAMHS provides daily support to the local acute trust paediatric ward (resulting in a reduction of length of stay with the majority of YP being discharged same or next day).

ICAMHS provide home treatment to try to de-escalate situations where a hospital admission may be required. ICAMHS also support the CPA process for inpatient CYP and ensure that discharge from hospital is supported by supporting Children's Services to identify how future needs will be met such as if the YP requires a residential setting

Where a YP is able to return home to family ICAMHS support discharge by ensuring there is a treatment and care plan in place to meet the needs of the CYP in the community setting.

9. Walsall has reviewed the register of section 117 aftercare duties for CYP in Walsall.

10. Walsall CCG maintains a working relationship with NHS England Specialised Commissioners who commission inpatient CAMHS. The Walsall commissioner has an established working relationship with specialised

commissioners and a process is followed. Walsall CAMHS have a clear referral process into tier 4 and escalate to the CCG if there are safeguarding concerns about bed availability. Walsall CCG through its designated safeguarding nurse lead and the Director of Quality has an adopted escalation process to NHSE.

Walsall receives regular data about admissions to tier 4 specialist inpatient CAMHS and reviews the impact of current community based response (ICAMHS).

Gaps:

Although inpatient admissions reduced significantly following the mobilisation of ICAMHS this has now levelled out. ICAMHS has limitations – it is not funded to be 24/7 it is a service 8 to 8 every day of the week. Due to capacity the intervention is meant to be short term and obviously the team cannot be with a YP all day and night.

Recently Walsall has experienced an increase in admission for CYP with a MH need and has LD and/or autism.

Walsall CCG commissioners are reviewing the cases as part of reflective practise to identify gaps or potential key stages where additional support may have supported a de-escalation of the situation. This is complex and not purely an NHS MH response. The review will include all the resources and services in place to support CYP with MH LD and or ASD to establish if the early prevention, social care needs and the MH needs were met prior to admission to inpatient provision. Walsall Commissioners with ICAMHS and Children's services are actively supporting the Care Pathway Approach /Care Treatment Review process and being responsive to support appropriate discharge from inpatient settings.

Secondary mental health CAMHS criteria provide support to up to 17 years old.

Future intentions:

The current proposal to gain additional funds from NHSE will be based on meeting the continued gaps in psychology and clinicians to support the start of treatment. There is also a demand for family therapy. This may not reduce the waiting times for an initial appointment 'choice' but would reduce the current waiting times for 'partnership' the start of treatment which at present has the shortest waiting time of 7 days, the longest waiting time of 257 days and an average of 125 days. This will also support the assurance area for at least 32% CYP with a diagnosable mental health condition to be able to access NHS mental health services

Developing local tier 4 responses and developing a place of safety/crisis provision is being picked up by the BC STP with Wolverhampton CCG leading on MH, as part of a future BC proposal.

Transitional arrangements have been reviewed and in place, there are differences to the scope of support and thresholds to access adult's mental health. The additional transformation funds from 2018/19 will be used to raise the age of secondary mental health specialist services (camhs) acceptance to up to 18 years old and the national CQUIN indicator for ensure robust transitional arrangement will be considered.

Priority Five:

Make sure we meet the needs of vulnerable children and young people

There are some children and young people who may be considered at more risk of developing mental health and wellbeing needs and could include those who:

- live away from home (including those known as looked after children or in care)
- have been adopted
- are Care Leavers (moving into adulthood after they have lived away from home and been considered a looked after child).
- have a special educational need
- have a physical or learning disability
- are within autistic spectrum (AS)
- are in contact with the youth justice system including those in prison
- are in alternative educational settings
- are young carers
- are part of communities considered vulnerable; such as gypsies, Roma and travelling communities, recent migrants, and those with higher deprivation factors etc
- have parents with a mental health need and its affects them
- live in a household where there is domestic abuse
- live in a household where there is substance misuse
- are at risk of significant harm from emotional abuse and neglect
- who have been sexually exploited and/or abused

(This list does not include all possible vulnerable groups; it is the overall aim of all partners to support children and young people from all possible vulnerable groups).

The impact of parental mental health, domestic abuse and substance misuse is a factor which affects a child or young person's mental health and wellbeing, commonly known as the toxic trio and should be considered although support to the parent is from adult services and requires a joined up approach with children's services.

Successes:

1. FLASH a service dedicated to supporting the needs of Walsall looked after children has mobilised. This service is funded by Children's Services specifically to meet the needs of looked after children who may be at risk of placement breakdown. The service operates across the Black Country area to be able to support Walsall CYP placed outside of Walsall who are within a reasonable travelling distance.

The final submission of the plan refresh will include an appendix: the service model and data of case loads.

2. The birth to 5 year old pathway for neuro development has been reviewed and implemented across partners.

The final submission of the plan refresh will include an appendix: the birth to 5 pathways.

3. An ASD and ADHD clinic approach has been implemented in CAMHS reducing waiting times significantly.

4. The initial assessment screening for secondary mental health services (choice appointments) has been revised and will include questions to pick up on

matters linked to the 'Toxic Trio' that of parental mental health, parental substance misuse and family domestic abuse.

5. Within the secondary mental health service (CAMHS) a protocol and process has been developed in relation to Child Sexual Exploitation (CSE) to support the approach for CSE in Walsall.

6. Localities with clusters of schools have been developed in 2015/2016 to embed the early help response in Walsall and include multi agency input.

7. Meetings have been held with regional Health and Justice Commissioner and key partners in Walsall to develop joint approaches in supporting CYP within the justice system and also to develop relationship with the liaison and diversion service.

8. Process embedded to ensure partners support the development of Education Health and Care Plans and there is a clear local offer.

9. A dedicated CAMHS professional placed within Youth Offending Service

10. Secondary mental health LD/CAMHS is fully mobilised with staff permanently recruited confirmed access is not based on attendance at a specialist education provision but on presenting needs. Criteria and access will be confirmed clearly.

11. Local processes have been developed and embedded to conduct community based/pre admission care treatment reviews for CYP with a LD and or ASD to ensure decisions are based on what is in their best interests. An at risk register of CYP who are considered to be at risk of needing a hospital admission has been implemented with monthly review schedule as a minimum).

Gaps:

MASH – arrangements for mental health worker not yet determined.

Future intentions:

Developing in partnership with Walsall Council Children's Services, education and DWMHPT a resource to provide capacity above and beyond normal service provision for the therapeutic intervention and support for CYP LAC in the internal residential homes – supporting repatriation back into Walsall and reducing placement requiring out of area specialist residential provision.

A proposed service model for this resource will be submitted as an appendix in the final submission of the plan refresh.

Priority Six:

Being accountable and transparent

We want to show that how we meet the needs of children and young people's mental health and wellbeing will be accountable and transparent.

We will support the national developments to improve mental health and wellbeing.

Successes:

1. Development of local performance data scorecard for secondary mental health CAMHS to be included in 17/18 contract.

2. Online service and face to face service provide regular data and performance information as part of contract.

3. Local service secondary mental Health (CAMHS) is reporting to the MHSTD (site for national data collation).

4. Governance of strategy and transformation plan implementation embedded.

There is an appendix attached confirming the current governance for CYP MH & WB strategy and transformation in Walsall.

There is an appendix attached confirming the record of activity in relation to CYP MH & WB transformation in Walsall.

5. Development of the Sustainability & Transformation Plan (STP)

   Walsall's CYP MH transformation plan is aligned to the Black Country STP, the ambition of the STP is to operate as 'one NHS commissioner' across the Black Country, leading to: substantial reductions in care and service variations; standardised services; maximisation of resources and workforce through better use of skill mix; alignment with WM Combined Authority regeneration and MH Commission strategy.

This opportunity focuses on developing an integrated commissioning and service delivery model. By sharing best practice and aligning to the work of other agencies/partners the aim is to reduce variation; improve access, choice, quality and efficiency; and develop new highly specialised services in the Black Country such as Children's Tier 4, secure services and services to manage those with personality disorders.

By agreeing common service specifications/models across CAMHS, we will be able to develop standardised and potentially more cost effective solutions, minimising 'differentiated' services and 'service flavours'. By comparing service delivery approaches across the Black Country and performance, opportunities to reduce variation will be identified. With the aim of reducing role duplication, streamline service management and allow investment in front line staff development and up-skilling. There will also be further opportunities to develop this across the wider local health economy (West Midlands) through the work in the MERIT vanguard.
Standardisation will:

- Simplify access to services improving health and wellbeing for users, families, staff and communities
- Have common responsive and standardised all age Early Intervention services
- Combat variation in care and service delivery across the Black Country
- Ensure clear, simplified pathways for users, ensuring most effective use of resources

- Achieve economies of scale for providers and reduction of duplication Improve utilisation in front line services through better skill mix usage and reduction in temporary and locum costs

CAMHS is embedded in the BC STP as part of the Mental Health workstream. With the 'amalgamation' of the providers, there will be horizontal integration of services in order to introduce efficiencies and savings.

The STP includes the high level plans by senior managers (from the 4 CCGs) that there will be the consideration commission services that cross the footprint.

Walsall and Dudley CCG already share a pan trust specification for CEDs CYP and tier 3.5 ICAMHS. Regular contact and communication enables information sharing with the aim of aligning services provided by the same provider trust.

The final submission will include more information about the BC STP and also how this links to Walsall Together.

Gaps:

Engagement with CYP, families and carers takes place with each service provided to gain feedback and input into the individual services.

Engagement to develop the needs assessment, strategy and transformation action plan was extensive. There is a gap in the need to ensure CYP are represented and in a position to influence and inform future transformation. CYP, Families and carers engagement and involvement in the strategic development needs to be developed further.

Future Intentions:
Confirm representation from Walsall Youth Council. Develop engagement and involvement plan to ensure CYP inform and lead further service transformation.

Walsall CCG's 2017/18 commissioning intentions (in draft) confirm the intention to continue to use transformation funds to improve CYP MH and WB.

Ensure the transformation of CYP MH and WB in Walsall meets the future assurance areas in relation to CYP MH required by NHS England and contain in the Five Year Forward View. Walsall CCG has reviewed the technical guidance and assurance areas for CYP MH and WB and is planning how to meet these areas. This includes reviewing current data and capacity of services, to determine if they will be able to deliver the required target to increase the percentage of CYP with a diagnosable MH accessing an NHS MH service.

There is an appendix attached with the current funding in Walsall for CYP MH and WB

Education & Children's Services Overview & Scrutiny Committee

16th February 2017

Child & Adolescent Mental Health Services CQC report update

Introduction

In February 2016 the CQC completed a thorough review on the CAMHS service. The feedback received was very positive however there were four areas in which improvements were required. Actions have been taken in response to each area as detailed below.

Variations in service and waiting time from referral to treatment (19 wks in Walsall compared to 8wks in Dudley)

Walsall CAMHS initially held a considerable waiting list for children/young people referred for intervention. In early 2016 we had 223 patients waiting for intervention from a CAMHS clinician however we have since this time carried out a number of different approaches in order to reduce our waits appropriately.

- Full review of the partnership list to ensure that all cases were still appropriate for CAMHS input
- Due to Transformation funding we have recruited additional staff into the CAMHS team whom would dedicate their time to assessing children initially in choice but would also then offer interventions in partnership
- A full review of pathways was undertaken to ensure that the service provision was fully streamlined
- Caseload review for every clinician

In October 2016 we were notified by NHS England that an additional allocation of funds would be released specifically for the reduction of waiting lists. This funding was to be non-recurrent and therefore we employed locum practitioners to address the partnership waiting list. The table below clearly demonstrates the reductions in the waiting times for access to the service as well as referral to treatment times.

	31/01/16	30/09/16	31/01/17	31/03/17 (forecasted)
Priority Choice	No wait	No wait	No wait	No wait
Choice	8 weeks	5 weeks	6 weeks	6 weeks
Partnership	223 waiting – average wait = 19 weeks	167 waiting – average wait = 17weeks	110 waiting – average wait = 12 weeks	65 waiting – average wait = 8 weeks

Evidence was provided to NHS England in February 2017 to demonstrate the changes in the figures for quarter three and that the CAMHS team had in fact made a further reduction than originally planned. Quarter four evidence is due to be sent to NHS England in April which will evidence the forecasted waiting times as shown above.

As a team we continue to strive to provide the best level of care we can and consistently review all areas of the service to ensure that we are assessing and discharging cases in a robust and efficient way. The aims of the service is to ensure that the CAPA full booking system is implemented to enable the complete removal of a waiting list, this should be in place by Autumn 2017, however it should be noted that the waiting list initiative money is short term and by May 2017 we will no longer be able to employ the locum practitioners who are enabling us to maintain the waiting lists at present.

Safety of the service (especially the provision of safety alarms)

Safety procedures within clinic have been strengthened since the CQC inspection. All CAMHS staff (including admin) have been issued with a personal alarm which they wear attached to their name badge at all times in clinic. The alarms have a high pitch bell noise which all staff have been trained to identify if sounded in clinic.

The safety procedure has been put in place for CAMHS staff (enclosed) and where a clinician is known to be treating a very difficult patient additional team members will be on alert if intervention is required. Admin staff who are faced with difficult service users or parents have also been issued with a safety procedure should their safety feel compromised.

In many cases CAMHS clinicians are expected to undertake home visits as well as deliver therapeutic interventions in an external setting; for this scenario there is a further safety procedure followed. Clinicians are expected to sign in and out of the building stating where they are and the time they are due back; if they do not return at the time stated a phone call is made to ensure their safety. A code word is used by the clinician over the telephone to alert the team that they need support which is immediately escalated to the police. In the majority of cases where the service user is known to be a potential risk to the clinician visits will be made in pairs or even restricted to being held in clinic.

The safety of the CAMHS staff is of paramount importance and we do not take any unnecessary risks that may place staff in a compromising situation.

Out of hours access to psychiatrists

CAMHS is commissioned to deliver an intensive service 8am – 8pm, seven days per week. The team respond to the Paediatric Assessment Unit (PAU) at Manor Hospital every day until 4pm and on a weekend until 12 noon. As part of the first allocation of Transformation funding a contribution was made by the CCG towards a psychiatry post to support ICAMHS and Eating Disorders cases. The doctor appointed against this funding currently responds to these cases during working hours however a child or young person that has been admitted to PAU outside of ICAMHS response times would typically be seen by a psychiatrist next working day in order to be assessed due to there being no 'on call' psychiatrist.

Discussions have been held between CAMHS and the Children's Commissioner in respect to an allocation of funding being made available through the next 'top up' of Transformation funding to allow for a 24/7 psychiatry 'on call' rota, this is still yet to be agreed. We also need to determine if there is a need for 24/7 psychiatry as since the ICAMHS has been operational we have seen a dramatic decrease in the need for psychiatry input.

Completion of record keeping and risk assessments for people receiving care

Following the CQC inspection in February a considerable amount of work has been undertaken to remedy the inconsistent approach that CAMHS were using to assess risk with the service users. The young person's FACE risk assessment tool (enclosed) has been adapted to include questions around child sexual exploitation (CSE) and has now been fully embedded into the CAMHS documentation process. A full training package has been rolled out to all existing CAMHS staff and is included in the induction process for new staff coming into the team.

ICAMHS staff complete the FACE risk assessment with all children/young people they assess on PAU at Manor Hospital, this aids them to make an informed decision regarding the support they need. Within the main CAMHS service children/young people that are seen in Choice are asked six very specific risk questions which allow the clinician to decipher the level of risk and whether the full FACE risk assessment needs to be completed.

All children/young people that are treated in CAMHS will be fully risk assessed at regular intervals throughout their treatment. For some, this may be every six months but for others it may be revisited every time their presentation changes.

The FACE risk assessment tool has now been included into our electronic patient record and clinicians complete the tool directly on the system, providing a consistent approach to how we document risk levels. At present our psychiatry team are not using the Oasis system other than to view patient information however they are due to be trained in how to input data within the next six weeks.

The CAMHS care plan has also been revised and has been combined with the Goal Based Outcomes tool. All children/young people that are entering into the service for intervention will complete the document with their clinician in order to capture their goals and aims that they want to achieve from their treatment. The document is signed by the service user (or parent/guardian) and then becomes a live pro-forma that is revisited regularly throughout the treatment plan. The service user is always offered a copy of the care plan, this allows them to familiarise themselves with the treatment plan they will receive and the goals they have set.

The Goal Based Outcome Care Plan (enclosed) has also been embedded into the Oasis system which again allows for a consistent approach to the capturing of data for all children/young people within the service.

As well as a revision of documentation and processes a complete training package has been cascaded to all clinical staff in CAMHS on the inputting of risk assessments and care plans. We also offer 'update' training should any member of staff require a refresher in how to input data on to the system.

Conclusion

CAMHS is a fast paced team that constantly needs to review processes and procedures in order to capture and assess any new directives that are cascaded down from NHS England, i.e. CSE etc. In order to ensure that the team are working consistently and efficiently we regularly undertake caseload reviews, revision of documentation and audits that allow us to ensure the team is delivering the service that is required by our service users and partner agencies.

CAMHS works as a multi-disciplinary team and offers a wide range of therapies to an ever increasing population requiring a service, because of this we work in strong collaboration with the Children's Commissioner and alongside our service users and families to provide a service that is fit for purpose but the keeps the vice of the child at heart of everything we deliver.

Name:	NHS number:	Completed by:

FACE Risk Profile Young Person V3.1 Confidential

This form to be completed following the assessment and/or review of risk, in accordance with local Clinical Risk Management Standards. Written details of current and past risks/behaviour should be provided on p2/3.

Family name:	Given name:	Title:
Preferred name:	Date of birth:	
NHS number:	Social care ID:	
Care co-ordinator name:	Contact details: *(tele / email / fax)*:	

Other agencies involved at time of assessment *(select as appropriate and detail below)* None ☐

CAMHS ☐	Health *(acute)* ☐	Social care ☐	YOS ☐
Police ☐	Education ☐	Other (specify) ☐	
Details:			

Assessment details

Location of assessment:		Date of assessment:		
Assessment type:		Initial ☐	Review ☐	Discharge ☐
CPA status at time of assessment:		CPA ☐	Non-CPA ☐	N/A ☐
Legal status:	None ☐	Informal inpatient ☐	Detained inpatient ☐	Section ☐
	S 17 leave ☐	CTO ☐	Guardianship ☐	S 117 ☐
	Section Details:			
Was the young person assessed in a crisis situation?			Yes ☐	No ☐

Assessment summary

Is there any evidence of a history of significant risk behaviour?	Yes ☐	No ☐

Involved in serious incident in past 3 months?	No ☐	Yes ☐	Near miss ☐	Not known ☐

Current risk status

Risk of violence/harm to others	
Risk of suicide	
Risk of deliberate self-harm	
Risk of severe self-neglect	
Risk of accidental self-harm	
Risk of abuse/exploitation by others	
Risk related to physical condition	
High risk of relapse?	Yes ☐ No ☐

Rate all items using the scale shown *(n/k=not known):*

0 = No apparent risk. *No history/warning signs indicative of risk.*

1 = Low apparent risk. *No current indication of risk, but service user's history and/or warning signs indicate possible risk. Required precautions covered by standard care plan i.e. no special risk prevention measures or plan required.*

2 = Significant risk. *Service user's history and condition indicate the presence of risk and this is considered to be a significant issue at present. Requires a contingency risk management plan.*

3 = Serious risk. *Substantial current risk. Circumstances are such that a risk management plan should be/has been drawn up and implemented.*

4 = Serious and imminent risk. *Service user's history and/or warning signs indicate the presence of risk and this is considered imminent. Highest priority to be given to risk prevention.*

Persons potentially at risk *(select as appropriate and detail on p3)* None ☐

Self ☐	Other child ☐	Parent ☐	Staff member ☐	Teacher ☐	General public ☐
Other *(specify)* ☐	**Details:**				

Is there a dependent child? Yes ☐	No ☐	Regular contact with children? Yes ☐	No ☐

Further actions recommended / required *(select as appropriate and detail below)* None ☐

Further risk assessment ☐	Discussion with RC / MDT ☐	Date of next review:

Completed by:	Profession:
Signature:	Date:

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Risk factors and warning signs

Enter ✓ or 'yes' in all boxes which apply. Enter 'n/k' if not known, 'no' if not present. If none apply within any section tick the 'No' box at the top of the relevant column. Current risk factors are those within the current episode of care. Under 'Notes' give brief description of risk factor/warning sign.

Clinical symptoms indicative of risk	**History No ☐**	**Current No ☐**
Ideas of harming others		
Ideas of self-harm/suicide ideation		
Delusions		
Voice experiences or hallucinations		
Depression		
Eating problems		
Impulsivity/lack of impulse control		
Social withdrawal		
Focus and concentration difficulty		
Unrecognised learning disability		

Notes:

Behaviour indicative of risk	**History No ☐**	**Current No ☐**
Physical harm to others		
Threats/intimidation *(includes bullying)*		
Use/carrying of weapons		
Sexually inappropriate or abusive behaviour		
At risk of Child Sexual Exploitation (CSE)		
Suicide attempts		
Deliberate self-harm *(with no evident suicidal intent)*		
Self-injurious behaviour *(no intent to self-harm)*		
Drug/alcohol abuse		
Fire-setting		
Damage to property		
Reckless or unsafe behaviour		
Severe self-neglect		
Absconding		

Notes:

Forensic history	History No ☐	Current No ☐
Conviction for violent offences		
Conviction for sexual offences		
Conviction for arson offences		
Other conviction *(i.e. joyriding)*		
Police involvement		
Admission to secure unit		
Admission to open unit		
Other risk factors/non-convicted offences		

Notes:

Personal circumstances indicative of risk	History No ☐	Current No ☐
Family break-up difficulties		
Recent severe stress *(e.g. end of relationship)*		
Concerns expressed by others *(relatives/carers)*		
Recurrence of circumstances associated with risk		
Abuse/victimisation by others *(inc. bullying)*		
Homelessness		
Problems at school *(e.g. drop in performance)*		
In 'looked after children system'		
Physical health factors		

Notes:

Care-related indicators	History No ☐	Current No ☐
Discontinuation of medication		
Failure to attend appointments		
Unplanned disengagement from services		
Medication concordance		
Neglect by parents *(evident or suspected)*		
Compulsory admission		
Other risk factor(s) *(specify):*		

Notes:

Descriptive summary of main risks identified *(give brief details of recency, severity, frequency, pattern, ideation and intent; include details of serious untoward incidents, near misses, etc.; and static or dynamic factors)*

Have actions been taken in the past to reduce risk? *(detail and effectiveness)*	Yes ☐	No ☐	Unclear ☐

Details:

Young Person's view of risk *(give details, including young person's view of what is needed to reduce risk)*

Is the young person aware of possible risks?	Yes ☐	No ☐	Unclear ☐

Details:

Carer's view of risk *(give details, including carer's view of what is needed to reduce risk)*

Are the young person's carer(s)/family aware of possible risks?	Yes ☐	No ☐	N/A ☐	Unclear ☐

Details:

Strengths and protective factors *(e.g. insight, self-monitoring, social support)*

Details:

Risk formulation *consider how identified risks become triggered (problem, predisposing, precipitating and perpetuating factors) and the interaction of most relevant risk and protective factors*

Details:

Risk Management / Crisis Contingency Plan *(include treatment, supervision and monitoring strategies for areas of concern and where appropriate consideration of positive risk management)*

Details:

Date completed:		Review date:	

Actions to be taken *(e.g. in the event of risk behaviour/relapse/failure to attend (in order of priority, detail below)* None ☐

Contact carer / family member ☐	Contact NHS Direct / GP ☐	Contact Care Co-ordinator ☐
Review by Care Co-ordinator ☐	Review by RC ☐	Review in MDT ☐
Consider referral to Crisis Service ☐	Consider use of MHA / recall ☐	Contact school ☐
Contact YOS Officer ☐	Visit home ☐	Other *(specify)* ☐
'Out of Hours' Emergency Contact No. given ☐	'In Hours' Contact No. given ☐	

Details:

Crisis / Contingency Plan completed	Yes ☐	No ☐	Date completed:
Relapse Plan completed	Yes ☐	No ☐	Date completed:

Information sources available / accessed in completing risk profile *(select all sources used)*
The information recorded within this assessment and scores assigned are on the basis of all available information, which has been gathered from the following sources:-

Young Person assessed ☐	Case notes ☐	Carer/relative ☐
Social Care ☐	Education/school ☐	Other *(specify)* ☐

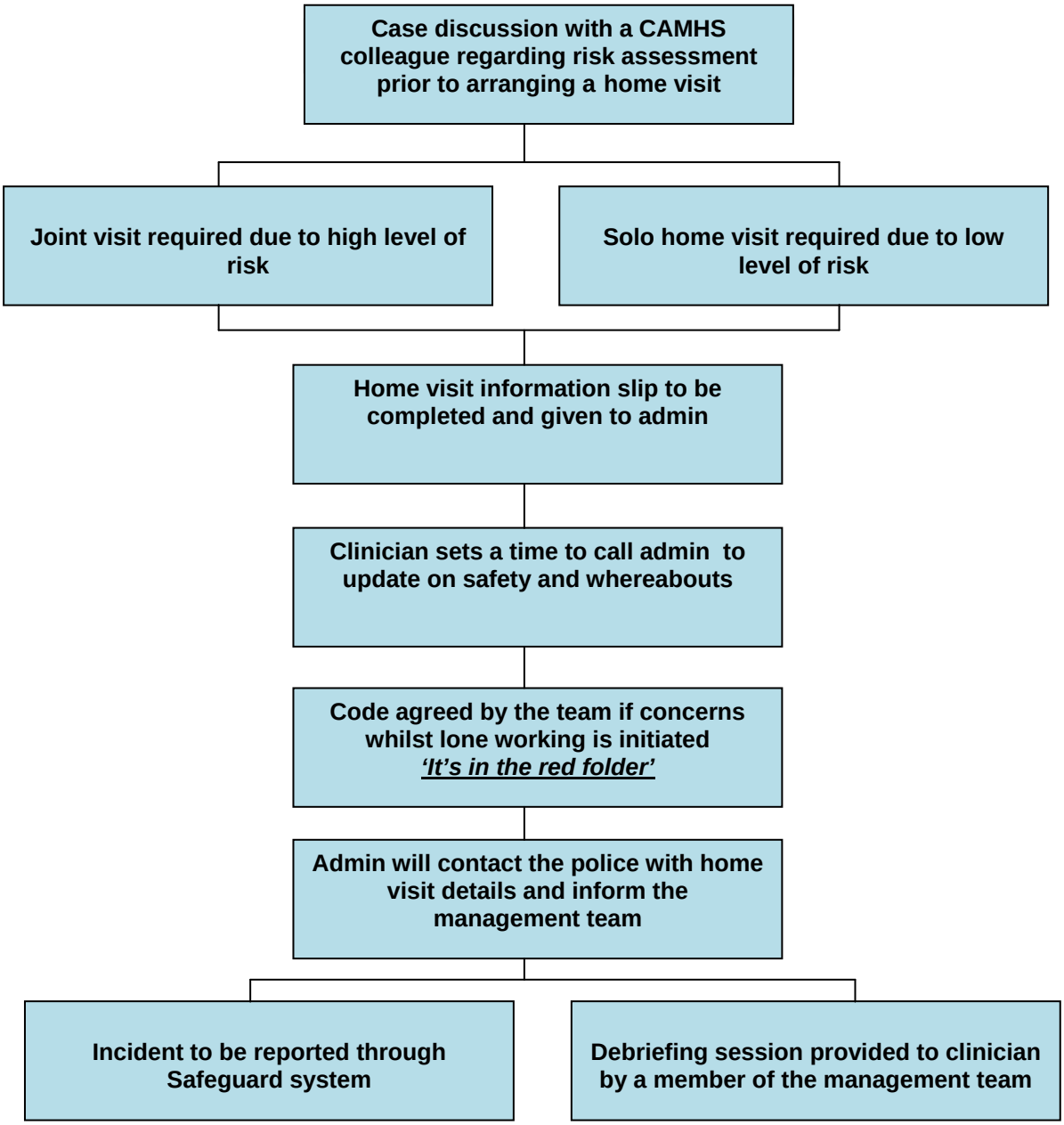
Details:

Record of completion

Completed by *(print name):*	Profession:
Signature:	Date:

Copies to	Select, if yes	Date, if yes	Copies to	Select, if yes	Date, if yes
File	☐		Social Care	☐	
Young Person assessed	☐		YOS Services	☐	
Carer	☐		Other Health Care	☐	
G.P.	☐		Other	☐	

Protocol/Procedure for a Home Visit in CAMHS



Induction and monitoring

- Lone working policy is sited in the induction file
- Procedures shared at induction
- Lone working procedures will be discussed and reviewed at supervision
- Lone working procedures/ incidents discussed in clinical governance meetings in CAMHS