Note this report should be reviewed in conjunction with the CAMHS benchmarking toolkit which has been distributed to all participants.
Section 1: Executive summary

Raising standards through sharing excellence
Executive summary

The CAMHS benchmarking project was initiated by NHS Benchmarking Network members as a priority work area in 2010. Since this date there has been ongoing interest in benchmarking CAMHS with further iterations of the work taking place in line with member needs. The project was developed with an acknowledgement that CAMHS is a key theme in mental health services and an area that is not currently subject to mainstream comparisons and performance analysis across the NHS. Child and Adolescent Mental Health Services (CAMHS) emerged as a particular interest within Mental Health for a number of factors including; the variability of CAMHS service models, the range in relative funding arrangements, service access restrictions in some areas, and growing demand pressures on CAMHS services across the NHS.

The CAMHS project content has been shaped by the Mental Health reference group who oversee all of the Network’s mental health projects. Changes were made to the project’s data specification for this year to provide greater detail around tier 1-3 services, and also to apply a new methodology for benchmarking tier 4 services. This latest iteration of the benchmarking report reflects the latest submissions from participants and cover the period 2012/13.

This benchmarking project report aims to document current approaches to delivering CAMHS, produce structured performance comparisons, and identify ongoing good practice in the management of mental health conditions for young people.

The report is presented from a service provider perspective. A total of 65 provider organisations are included within the report and parallel benchmarking toolkit. Data has been sourced from across the full spectrum of CAMHS providers (Mental Health Trusts, Secondary Care Trusts, Children’s Trusts, and the Independent sector). Data from the independent sector is relatively sparse and it is hoped that more tier 4 independent sector providers will participate in 2014. Comparisons include data on service models, access, activity, workforce, finance, key performance indicators, quality and outcomes. Each of these areas can be explored for both tier 1-3 services, and also for tier 4.

There are a wide variety of service models in operation for CAMHS. Tier 1-3 services that have high levels of provision and are delivered by most providers include; mental health promotion, training to tier 1 staff, CAMHS outpatient clinics and community services, family therapy and group work, out of hours on-call services, provision to specialist schools, support to YOTs, Looked After Children, and Eating Disorders. Services that are delivered on an infrequent basis include; ante and post-natal support, BME services, forensic CAMHS, sensory impairment teams, and crisis intervention services.

Tier 4 services typically cover sub-regional footprints and are commissioned by specialist commissioners. Services that have high levels of provision include; inpatient beds, eating disorders services, transition services, and intensive outreach. More niche services that are delivered on an infrequent basis include; day units, community based crisis support, family preservation schemes, and home treatment services. System level gaps in tier 4 services tend to be around access to secure and forensic provision. Tier 4 also historically experiences some difficulties in access to inpatient beds due to high levels of demand and shortage of bed numbers. The private sector have for many years been a presence in tier 4 CAMHS and provide a range of specialist services.
Executive summary – Tiers 1-3

- CAMHS delivery arrangements have changed significantly in the last 8 years with increases in service funding and capacity evident through targeted commissioning and the CAMHS grant. However, 2012/13 and beyond marks difficult times for many CAMHS services with the ending of the area based grant funding. CAMHS are typically delivered from a wide variety of service locations from hospitals to community locations, primary care, schools and youth facilities. Many of these services have witnessed dis-investment over the last 2-years.

- Average waiting times have increased consistently since the first report published in January 2011. This may reflect increasing levels of demand for CAMHS as alternative services come under pressure and the impact of new capacity limitations through QIPP initiatives and restrictions on ABG funding. Data from 2012/13 shows that maximum waiting times for specialist CAMHS average 15 weeks across the participating providers. This has increased from 14 weeks recorded in 2011/12. Waiting times for accessing urgent CAMHS services have show a 3-week median wait. This confirms that many CAMHS services can offer rapid access to appointments although 3 weeks waiting time for an emergency appointment is a lengthy wait for a service user with urgent needs. This should also be seen in the context of the lack of crisis response services in CAMHS with less than 40% of CAMHS offering rapid access through crisis pathways.

- The most commonly reported activity measure for CAMHS was total contacts with an average of around 12,962 contacts per 100,000 population in the 0-18 age groups. A noticeable range in activity was observed around this average that perhaps reflects both differences in service demand, funding and capacity arrangements.

- Community CAMHS has a conversion rate of around 81% of patients assessed going on to receive interventions. The average patient on the CAMHS tier 1-3 caseload receives 6 interventions per annum. Average duration on the CAMHS caseload is also around 12 months. This may provide opportunities for performance improvement in the QIPP context with scope for enhanced group work and interventions delivered in partnerships with other members of the child health team. As demands on CAMHS increases the ability to step-down patients into other services and hand back to primary care and schools will be increasingly important. This dynamic should be matched by rapid access arrangements to specialist CAMHS should children and families need to re-access services. Clear eligibility criteria and good care pathways create scope for discharging patients who can access services in future should needs require. This also reinforces the need to maintain good access routes into CAMHS and good patient flow management to ensure eligibility criteria are clear and discharge arrangements are defined and adhered to.
Executive summary – Tiers 1-3 (cont)

- DNAs in tier 1-3 CAMHS show a wide range from 2% to 25%, with an average for the sample of 11%. Cancellation of appointments by patients averages 8% and cancellation by services averages 3% of all appointments. DNA rates have fallen from a rate of 12% in 2012 but continue to represent a QIPP improvement opportunity for most participants in the project.

- The average workforce for all grades of CAMHS staff in tiers 1-3 averages 47 WTE per 100,000 population in the 0-18 age groups. The CAMHS multi-disciplinary team is broad with many disciplines represented. The most frequently represented professional groups are Nursing, Clinical Psychology, and Administrative staff. Medical staff and Mental Health Practitioners are also evident in the CAMHS MDT. Community CAMHS has a relatively rich skill-mix with most Nurses being qualified and experienced staff. Clinical Psychology and Psychotherapy are also well represented in the CAMHS MDT and comprise almost a quarter of the workforce.

- Analysis of tier 1-3 CAMHS funding confirms average revenue budgets for 2012/13 of around £3.4m per 100,000 population in the 0-18 age group. CAMHS are required to deliver cost improvement programmes with the average value of these programmes being 4% of CAMHS budgets for 2012/13.

- The cost per contact with tier 1-3 CAMHS is a relatively crude benchmark and shows an average median cost of £240 per contact across the 65 participating organisations. It is acknowledged that there are a wide range of contact types within this which reflect local service models. Related NHS Benchmarking Network on benchmarking adult mental health services shows an average cost per contact for adult mental health Early Intervention Team services is £238 per contact.

- Outcomes data is routinely collected in 95% of participating CAMHS services. This is a positive position and has increased from 88% in the previous year. Around 70% of participants also confirmed that they follow the principles of children and young peoples Improving Access to Psychological Therapies.

- Staff in CAMHS report satisfaction levels with service quality at around the same levels as staff who work in adult mental health services. Data from the latest NHS staff survey suggests a staff satisfaction rate at around 76%.
Executive summary – Tier 4

- The provision of tier 4 beds is determined by specialist commissioning strategies and also by an element of market provision by NHS providers. Tier 4 beds are widely traded across the NHS with NHS providers competing amongst themselves and also with the independent sector. A wide range of tier 4 benchmarks around bed provision, utilisation, workforce and costs are illustrated in the report. The ability to step-down tier 4 patients into other support arrangements can be a constraining factor that impacts on overall use of inpatient services.

- The mean average level of provision for tier beds is 16 beds per provider. Analysis of age profiles for these beds suggests the typical age profile for tier 4 beds is to serve the population in the age group 11-18. Some services are exceptions to this profile and serve only younger children.

- Bed occupancy rates are generally high for CAMHS tier 4 inpatient services. A small number of outlier positions are reported by Trusts but overall bed occupancy (including leave) is 88% (92% in 2012). Occupancy excluding leave is 72%.

- Average length of stay for tier 4 CAMHS shows an expected level of variation given different service models. The average length of stay for 2013 shows 58 days for patients excluding leave, 68 days when leave is included, and 115 days for secure CAMHS services.

- Analysis of the tier 4 CAMHS workforce shows that it is medically led but that most of the workforce comes from a nursing background. Medical staff comprise 6.7% of the tier 4 workforce, whilst nurses and support workers account for 73%. Specialist therapists are less evident in the CAMHS MDT with just 4% of staff being from Clinical Psychology and Psychotherapy. The grades of staff employed in tier 4 CAMHS are also lower than those employed in community CAMHS tiers 1-3.

- Analysis of finance data for tier 4 services shows an indicative annual full cost per bed of around £186,000. This translates into a cost per episode median cost of around £38,000, and a median cost per bed day of around £847. Readers need to be aware of the range of service models and associated costs in interpreting the finance data.

- A range of new comparisons are presented for 2013 on service quality. These include a wide range of measures including prescribing errors, medication incidents, ligature incidents, use of seclusion, restraint, and incidence of violence. Participants should use the desktop benchmarking toolkit to test their position on these metrics against other participants. As this is the first year that this data has been collected it is noted that some gaps in data are evident. Many participants have confirmed that they will work during 2013 and 2014 to put effective systems in place so that these measures can be collected more systematically in future.
Section 2: Background to the CAMHS project
NHS Benchmarking Network members identified mental health services as a key theme in local service commissioning and provision with a need to make coherent plans to better manage mental health services and ensure optimal care and value is obtained in future years. CAMHS was raised as a particular area of interest for members given the lack of definitive national benchmarking data in this area and the recognised importance of early detection and intervention as a strategy for improving outcomes in mental health.

The history of the NHS Benchmarking Network project can be traced back to expressions of interest made by NHS Benchmarking Network members during 2009/10 to benchmark mental health services. The benchmarking project’s objectives and data specification were scoped out with member organisations during a series of workshops.

A pilot phase of the project was completed in November 2009. Further versions of the CAMHS template have been issued on a regular basis.

The project’s structure and content was reviewed by the Mental Health reference group who supervise all NHS Benchmarking Network mental health projects. The group includes membership from 25 NHS Trusts and is chaired by Edward Colgan, Chief Executive of Somerset Partnership NHS Foundation Trust. In addition to the input of reference group members the CAMHS project also received input on content from a number of CAMHS professionals from across the NHS. The main development for the 2013 benchmarking cycle is the development of specific methodologies to better reflect tier 4 comparisons.

This benchmarking project report aims to document current approaches to delivering CAMHS, produce structured performance comparisons, and identify ongoing good practice in the management of mental health conditions for young people.

Findings from the work were presented at a national conference in November 2013 which was attended by around 150 delegates. Amongst the speakers at this event was Dr Geraldine Strathdee, National Clinical Director for Mental Health.

A further specific event on CAMHS benchmarking and good practice will take place in 2014.
Participants (1/2)

The project received contributions from 65 service providers. This includes NHS statutory services and the independent sector. Some Trusts made multiple submissions to reflect borough based services given that CAMHS commissioning does vary significantly across neighbouring areas.

- 5 Boroughs Partnership NHS Trust
- Alder Hey Children’s Hospital
- Berkshire Healthcare NHS Foundation Trust
- Black Country Partnership NHS Trust
- Bradford District Care Trust
- Central Manchester University Hospitals NHS Foundation Trust
- Central North West London NHS Trust
- Central North West London NHS – Mother and Baby Unit
- Cheshire & Wirral Partnership NHS Foundation Trust
- Cornwall Partnership NHS Foundation Trust
- Coventry and Warwickshire Partnership NHS Trust
- Cumbria Partnership NHS Foundation Trust
- Cwm Taf Local Health Board
- Derbyshire Healthcare NHS Foundation Trust
- Dorset HealthCare University NHS Foundation Trust
- East London NHS Foundation Trust
- Greater Manchester West Mental Health NHS Foundation Trust
- Hertfordshire Partnership NHS Foundation Trust
- Homerton University Hospital NHS Foundation Trust
- Humber NHS Foundation Trust
- Isle of Wight NHS
- Lancashire Care NHS Foundation Trust - Central Lancashire
- Leicestershire Partnership NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Liverpool CCG - ADHD Foundation
- Liverpool CCG – Barnardos
- Liverpool CCG - Young Persons Advisory Service
- Liverpool CCG - Merseyside Youth Association Ltd
- Liverpool CCG - PSS Spinning World
- Norfolk and Suffolk NHS Foundation Trust
- North East London NHS Foundation Trust
- North Essex Partnership NHS Foundation Trust
- North Staffordshire Combined Healthcare NHS Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottingham City CCG
- Oxford Health NHS Foundation Trust - Bath and North East Somerset Tier 2
- Oxford Health NHS Foundation Trust - Buckinghamshire
Participants (2/2)

- Oxford Health NHS Foundation Trust - Buckinghamshire Tier 2
- Oxford Health NHS Foundation Trust – Oxfordshire
- Oxford Health NHS Foundation Trust - Oxfordshire Tier 2
- Oxford Health NHS Foundation Trust – Swindon
- Oxford Health NHS Foundation Trust - Wiltshire & Bath and North East Somerset
- Oxford Health NHS Foundation Trust - Wiltshire Tier 2
- Oxleas NHS Foundation Trust – Bexley
- Oxleas NHS Foundation Trust – Bromley
- Oxleas NHS Foundation Trust – Greenwich
- Pennine Care – Bury
- Pennine Care – Oldham
- Pennine Care – Rochdale
- Pennine Care – Stockport
- Pennine Care - Tameside and Glossop
- Plymouth Community Healthcare CIC
- Rotherham Doncaster and South Humber NHS Foundation Trust – Doncaster
- Royal Free Hampstead NHS Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust - North Lincolnshire
- Somerset Partnership NHS Foundation Trust
- South Essex Partnership Trust
- South Staffordshire & Shropshire Healthcare NHS Foundation Trust
- South Tyneside NHS Foundation Trust
- South West London and St George’s Mental Health NHS Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Surrey and Borders Partnership Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Torbay and Southern Devon Health & Care NHS Trust
- West London Mental Health NHS Trust
Section 3: CAMHS benchmarking comparisons
Tier 1-3: Service models and provision

Raising standards through sharing excellence
Service models
Service Provision

Provision of CAMHS Services

- CAMHS contains much service variation due to its broad range and number of targeted services that have accumulated over many years.
- Services that have high levels of provision and are delivered by over 80% of providers include: mental health promotion, training to tier 1 staff, CAMHS outpatient clinics and community services, family therapy and group work, out of hours on-call services, provision to specialist schools, support to YOTs, Looked After Children, and Eating Disorders.
- Services that are delivered on an infrequent basis include: ante and post-natal support, BME services, forensic CAMHS, sensory impairment teams, and crisis intervention services.
ADHD is an increasingly diagnosed condition which is responded to in different ways in different health systems. Lead responsibility frequently lies with CAMHS but can also be picked up by either community or hospital based paediatric medical services. Feedback from members also indicated a range of other professionals provide lead services on ADHD and autism including Child Development Teams and Speech and Language Therapy.

The benchmarking results confirmed that 80% of CAMHS services provide ADHD services. Where CAMHS do not provide specific support for ADHD, 6% reported that this is lead by Paediatric medical services, and 13% by other services.
Section 3: CAMHS benchmarking comparisons
Tier 1-3: Access

NHS Benchmarking Network

Raising standards through sharing excellence
**Access**

**Number of referrals received – per 100,000 registered population**

- CAMHS referral rates for tier 1-3 services vary across the NHS.
- Referral rates average 1,857 per 100,000 population in the age groups 0-18.
- The range is from less than a hundred to over 5,700 in a large acute trust provider.
- Referrals rates are often influenced by historic capacity levels. Where service capacity has been commissioned at high levels, referral rates tend to be high and vice-versa.
Access
Number of accepted referrals – per 100,000 registered population

- CAMHS referral acceptance rates for tier 1-3 services also vary.
- Referral acceptance rates average 1,469 per 100,000 population in the age groups 0-18. This creates an average referral acceptance rate of 79%.
- This rate is similar to that seen in adult community mental health services.
- Referrals acceptance rates will be influenced by service capacity levels and the eligibility criteria and acceptance thresholds used.
Access

Number of re-referrals – per 100,000 registered population

- Re-referrals average 338 (around 20% of referrals).
- This may reflect access constraints in particular services.
Access

Maximum waiting time (routine) – per 100,000 registered population

- Maximum waiting times for specialist CAMHS average 15 weeks across the participating providers. This has increased from 14 weeks recorded as the average in 2012.
- The indicative 18 week RTT target is adhered to in all but 9 organisations responding. Two organisations report routine waiting times of over 40 weeks. Three organisations are able to offer routine appointments within 5 weeks of referral.
- Average waiting times have increased consistently since the first report published in January 2011. This may reflect increasing levels of demand for CAMHS as alternative services come under pressure and the impact of new capacity limitations through QIPP initiatives and restrictions on ABG funding.
- The wide range in waiting time performance confirms differential access arrangements for CAMHS which are not typically seen to such an extent in other healthcare services across England.

Maximum waiting time in weeks for routine appointment

- Acute trust
- Mental health trust
- Other
- Mean
- Lower Quartile
- Median
- Upper Quartile

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Access

Maximum waiting time (emergency) – per 100,000 registered population

- Analysis of maximum waiting times for emergency CAMHS appointments reveals a mean average position of 9 weeks and a median average position of 3 weeks.

- The 3-week median confirms that many CAMHS services can offer rapid access to appointments although 3 weeks waiting time for an emergency appointment is a lengthy wait for a service user with urgent needs. This should also be seen in the context of the lack of crisis response services in CAMHS with less than 40% of CAMHS offering rapid access through crisis pathways.
Access
Conversion rate

- The conversion rate benchmarks shown in the chart opposite reflect the percentage of service users who are assessed who then go on to receive an intervention from CAMHS.
- The mean average is that 81% of referrals result in a pathway where the patient receives interventions from CAMHS.
- The range is from 100% (7 providers) down to 24% in the provider with the lowest conversion rate.
Section 3: CAMHS benchmarking comparisons

Tier 1-3: Activity

NHS Benchmarking Network

Raising standards through sharing excellence
Activity

Total contacts – per 100,000 registered population

- Activity levels in this analysis are reported as CAMHS contacts during 2012/13. There is a high level of variation observed in relative activity which reflects a number of issues including demand and available funded capacity.

- Average contact levels are at the rate of around 12,962 contacts per 100,000 registered population in the age groups 0-18. The desktop benchmarking toolkit can also be used to develop parallel views on the data using weighted population as a denominator.

- CAMHS providers and commissioners also report a range of commissioning models with some contracts still being purely block contract in nature, others being activity based, and many providers using a combination of block, grant, and activity based contracts.

- NB – Total contacts includes both face-to-face contacts and all non-face-to-face contacts.

- The mean provision level for face to face contacts is 9,823 i.e. 76% of total contacts.
There is a high level of variation observed in relative activity levels. Average face to face contact levels are at the rate of around 9,823 contacts per 100,000 population. Some participants reported that face to face contacts are the only currency used locally for CAMHS.
Non face to face contacts are reported by most participants (up from two thirds of project participants in 2012). Non face to face contacts rates average 2,809 contacts per 100,000 population.
Activity

Number of discharges – per 100,000 registered population

Data on CAMHS discharge rates was requested from participants. The mean number reported was 2,261 per 100,000 population. This compares to a referral rate of 1,857 and referral acceptance rate 1,469. This indicates some possible problems in data quality on this indicator. The median discharge position of 1,468 may be a more reliable indicator and indicates a "run-rate" for CAMHS throughput of around 12 months duration in the service for an average service user (from referral acceptance to discharge).

Each CAMHS tier1-3 patient receives an average of 5.7 contacts whilst in the CAMHS service.
Activity
DNA Rates

- Average DNA rates for CAMHS is 11% across the project’s participants (down from 12% in 2012). Variation is evident across health economies with the lowest rate at 1% and the highest rate at 18%. CAMHS and wider mental health systems have amongst the highest rate of DNAs in the NHS.

- Whilst it is acknowledged that securing good clinic utilisation rates will always be a challenge this may offer a QIPP opportunity for commissioners and providers in considering some of the successful methods that have reduced DNA rates in other areas of secondary care (e.g. use of booking centres, SMS messaging, and pragmatic approaches to clinic booking in school summer holidays)
Activity
Cancellation by patient

Patient cancellations average 8% of all appointments offered by CAMHS. Variation extends from 1% of appointments to 21% of appointments.
Activity
Cancellation by service

Cancellation rates by CAMHS teams average 3% across participants. The range is from 1% to 18%.
Section 3: CAMHS benchmarking comparisons
Tier 1-3: Workforce

NHS Benchmarking Network

Raising standards through sharing excellence
The chart opposite shows the number of staff employed in CAMHS for tiers 1-3 per 100,000 registered population in the 0-18 age group.

This has a mean average of 47 staff although the level of variation is high with quartile ranges from 23 WTE staff to 69 WTE staff per 100,000 population.

The desktop toolkit allows detailed analysis of all CAMHS professional disciplines. For example, this provides an ability to profile the level of Psychiatry (5 WTE) and Clinical Psychology (10 WTE) input per 100,000 population.
Workforce Tiers 1-3
Staff groups

- The desktop benchmarking toolkit can be used to view the CAMHS MDT workforce profile of each participant against the overall database average from the 65 providers that have taken part in the project.
- The chart opposite shows the profile for the overall CAMHS MDT. The blue line plots the overall average, whilst the red line plots the position of an individual participant.
- The CAMHS MDT is broad with many disciplines represented. The most frequently represented professional groups are Nursing, Clinical Psychology, and Administrative staff.
Workforce Tiers 1-3

Nursing

- The desktop benchmarking toolkit can also be used to view the CAMHS workforce profile of participants for each professional discipline against the overall database average from the 65 providers that have taken part in the project.

- The chart opposite shows the profile for CAMHS Nursing by agenda for change banding. The blue line plots the overall average, whilst the red line plots the skill-mix position of an individual participant.

- CAMHS Nursing has many band 6 and 7 staff present with very few unqualified Nurses.
Workforce Tiers 1-3
Clinical Psychology

- The desktop benchmarking toolkit can also be used to view the CAMHS workforce profile of participants for each professional discipline against the overall database average from the 65 providers that have taken part in the project.
- The chart opposite shows the profile for CAMHS Clinical Psychology by agenda for change banding. The blue line plots the overall average, whilst the red line plots the skill-mix position of an individual participant.
- Clinical Psychology has a rich skill-mix with most staff employed at Band 8A, followed by Bands 7, 8B, and 8C.
CAMHS services provide training to other professionals, service users and parents as part of intervention packages and wider development work.
Section 3: CAMHS benchmarking comparisons
Tier 1-3: Finance

NHS
Benchmarking Network

Raising standards through sharing excellence
Finance

Total costs of service – per 100,000 registered population

CAMHS service costs for tiers 1-3 average £3.4m per 100,000 registered population.
The range in costs is from £0.8m to £12.3m per 100,000 population.
Finance

Total pay costs – per 100,000 registered population

CAMHS service pay costs for tiers 1-3 average £2.6m per 100,000 registered population.
The range in costs is from £0.6m to £8.7m per 100,000 population.
Finance

Total non-pay costs – per 100,000 registered population

CAMHS service non-pay costs for tiers 1-3 average £0.4m per 100,000 registered population. The range in costs is from less than £50k to £1.7m per 100,000 population.
Finance

Cost per contact – Tier 1-3 CAMHS

CAMHS service cost per contact is skewed by high cost data from two providers. Average mean costs per contact is £334. The median average cost may be more representative at £240 per contact.
Finance

CIP

CAMHS cost improvement programmes average 4% of total CAMHS budgets for tiers 1-3.

Not all services reported having a CIP target during 2012/13.

CAMHS has also been subject to dis-investment following the ending of the area based grant.
Section 4: CAMHS benchmarking comparisons
Tier 4: Service models and provision

Raising standards through sharing excellence
Service models
Service Provision

Provision of Tier 4 CAMHS Services

- Around half of the contributors to the CAMHS benchmarking project provide tier 4 services.
- Tier 4 CAMHS contains interesting service models that are much wider than a core of specialist inpatient services. Targeted services are evident within tier 4 portfolios.
- Services that have high levels of provision and are delivered by over 60% of providers include; inpatient beds, eating disorders services, transition services, and intensive outreach which is offered by 63% of providers.
- More niche services that are delivered on an infrequent basis include; day units, community based crisis support, family preservation schemes, and home treatment services.
Service models
Secure Provision

- Very few of the participants in the benchmarking study deliver secure CAMHS services. This aligns with the small number of providers who deliver secure care.
- Around 28% offer low secure services and 3% offer medium secure services.
Service models

Maximum age

- Analysis of the age range of tier 4 CAMHS services reveals that most services extend to 18 years of age.
- Some services close at 17 years and just two services finish at 14 years and under.
Analysis of the age range of tier 4 CAMHS services reveals that most services begin at 12 or 13 years of age.

Just 3 services target younger children and begin at 5 years of age.
Service models

Total T4 beds

A total of 31 services reported providing inpatient beds. The number of beds provided ranges from 7 to 36.

The mean level of beds provided is 16 and the median is 14.
Day units are infrequently provided and only a small number of participants were able to provide details. Nine participants provided details on the number of places provided. This ranges from less than 10 to over 200 places.

The mean position for provision is that 43 patients attended day units during 2012/13.
Section 4: CAMHS benchmarking comparisons

Tier 4: Activity

NHS Benchmarking Network

Raising standards through sharing excellence
Tier 4 inpatient activity cannot be benchmarked in terms of catchment population served as definitive catchment populations cannot be calculated due to crossover between catchments, the role of the private sector as a prominent provider to the NHS, and the commercial nature under which many NHS tier 4 beds are purchased.

The mean average number of admissions for each tier 4 unit in 2012/13 was 63, which should be compared against the mean average for beds provided of 16.

The range in admissions approximates the level of bed provision and ranges from 11 admissions to 151 admissions.
The mean number of occupied bed days (excluding leave) per tier 4 unit is 3,094.

The number of bed days used approximates the ratio for number of beds provided and should be compared with bed occupancy rates which are outlined on subsequent pages.

The benchmarking toolkit can also be used to profile data including or excluding leave positions, and also adjusting for the impact of secure places.
Activity
Average length of stay

- Average length of stay (excluding leave) is 58 days.
- The quartile range runs from 36 days to 67 days.
- The toolkit can be used to adjust for outliers due to secure provision and also to adjust for the impact of leave days.
- When leave days are included the average length of stay increases to 68 days.
- When secure episodes are analysed, this reveals an average length of stay of 115 days.
Activity
Average length of stay profile

- This chart illustrates how a provider’s tier 4 average length of stay profile can be compared against the total “market” for tier 4 provision across project participants. This can be accessed in the benchmarking toolkit.
- The chart illustrates how the selected provider has proportionately more long stay patients at 60 days plus than the average profile. This also impacts on other elements of the bed utilisation profile with far fewer short and medium stay admissions than seen elsewhere.
Section 4: CAMHS benchmarking comparisons
Tier 4: Workforce

NHS Benchmarking Network

Raising standards through sharing excellence
Workforce

Total T4 Staffing per 10 beds

Total staff numbers per 10 beds average 34 on CAMHS T4 units. The range is from 17 staff to 56 staff per 10 beds.
Clinical Staff

- Clinical staff numbers per 10 beds average 31 on CAMHS T4 units. The range is from 16 staff to 51 staff per 10 beds.

- Non-clinical staff profiles can be accessed in the toolkit and average just 2.5 staff per 10 beds with a range from 0.5 to 6 staff per 10 beds.
The desktop benchmarking toolkit can be used to view the T4 CAMHS MDT workforce profile of each participant against the overall database average from the 31 providers that have taken part in the Tier 4 component of the project.

The chart opposite shows the profile for the overall T4 CAMHS MDT. The blue line plots the overall average, whilst the red line plots the position of an individual participant. The T4 CAMHS MDT is less diverse than that seen in tiers 1-3. Relatively few disciplines are represented. The most frequently represented professional groups are Nursing which comprises over 60% of staffing, followed by administrative staff, medical staff (6.7%), and support workers.

Nurses and Support Workers together account for 73% of the T4 workforce. Clinical Psychology and other therapy services are not well represented in the tier 4 MDT with just 4% of the total belonging to this group.
Workforce
Nursing

- The desktop benchmarking toolkit can also be used to view the CAMHS workforce profile of participants for each professional discipline against the overall database average from the 31 tier 4 providers that have taken part in the project.

- The chart opposite shows the profile for T4 CAMHS Nursing by agenda for change banding. The blue line plots the overall average, whilst the red line plots the skill-mix position of an individual participant.

- CAMHS Nursing has many band 5 and 3 staff present with proportionately fewer qualified Nurses than tier 1-3 services.

- T4 CAMHS has a far less rich skill-mix than tier 1-3 services and a less diverse MDT. The typical profile of a tier 4 workforce is that it will be led by a Consultant Psychiatrist and Ward Manager, and contain a number of qualified band 5 nurses and band 3 and 2 assistants and support workers. Specialist therapists have not been reported in CAMHS T4 MDTs in noticeable numbers. Clinical Psychology and Psychotherapists comprise just 4% of the T4 CAMHS workforce but comprise 24% of the workforce in tiers 1-3.
Section 4: CAMHS benchmarking comparisons
Tier 4: Finance

NHS Benchmarking Network

Raising standards through sharing excellence
Finance

Total costs of service – per 10 beds excluding secure provision

• Total costs per 10 T4 beds (excluding secure provision) average £1.86m (i.e. £186k per bed). This includes all corporate costs and overheads.
• The range is from £450k for 10 beds up to £3.4m.
• There may be some ongoing validation issues with these costs – which have been certified by all project participants. The range may also reflect the diversity in provision and the different service models offered.
Finance

Total direct cost of service – per 10 beds excluding secure provision

- Direct service costs per 10 T4 beds (excluding secure provision) average £1.55m (i.e. £155k per bed). This excludes corporate costs and overheads.
- The range is from £400k for 10 beds up to £2.9m.
- There may be some ongoing validation issues with these costs – which have been certified by all project participants. The range may also reflect the diversity in provision and the different service models offered.
Finance

Total pay costs – per 10 beds excluding secure provision

- Pay costs per 10 T4 beds (excluding secure provision) average £1.39m.
- Non-pay costs average £184k per 10 T4 beds.
Finance

Total cost per episode

• Analysis of the cost of CAMHS episodes reveals a median average position of £38,000 per episode.

• The mean average cost of £77,000 per episode is influenced by a small number of high cost / intensive services.

• The desktop toolkit can be used to generate further cost based comparisons.
Cost improvement programmes in T4 CAMHS averaged 5% in 2012/13. The range was from 3.5% to 8% of total T4 budgets.
Section 5: Quality and Outcomes
Quality & Outcomes
Quality, Effectiveness and Safety

CAMHS is a service that has collected outcome measures for many years. Many providers are involved with national outcomes systems such as CORC (CAMHS Outcomes Research Consortium). In total 95% of the 65 contributors to the project reported that they routinely collect outcomes information. 70% of contributors also reported that they follow the principles of Children and Young Persons Improving Access to Psychological Therapies.
Quality & Outcomes
Complaints

- CAMHS services averaged 7 complaints per service in 2012/13. The benchmarking toolkit can be used to benchmark this with a choice of denominators including number of community contacts, and number of bed days.
Quality & Outcomes

Compliments

- Compliments appear to be well documented by CAMHS services with an average of 47 recorded by services in 2012/13. The ratio of compliments to complaints is higher than that normally seen on other healthcare benchmarking work undertaken by the NHS Benchmarking Network and may reflect more systematic recording practices within CAMHS.
Quality & Outcomes

NHS Staff Survey

NHS Staff Survey results % feeling satisfied with the quality of work and patient care they are able to deliver

- NHS staff survey results have been analysed for participants. This uses the question “percentage of staff feeling satisfied with the quality or work and patient care they are able to deliver”.
- The mean satisfaction rate reported is 76%. This is exactly the same as the 76% score reported by staff who work in adult mental health services in the most recent national staff survey.
- There is an interesting range within the results with much grouping around the 80% median position. Representatives from the independent sector report both the highest and lowest levels of satisfaction.
Quality & Outcomes

Serious Incident investigated

- Analysis of the extent to which Serious Incidents (SIs) are investigated and resolved within 45 days revealed a strong core or providers who achieve 100% compliance with this target.

- The mean position is 85% investigated and resolved within 45 days which is impacted by four providers where only a third or less of SIs are investigated and resolved within these timeframes.
Quality & Outcomes

Quality and safety (ligature incidents)

- The desktop benchmarking toolkit allows a range of safety and quality measures to be analysed in detail.
- These can be profiled using either bed days or community contacts as benchmarking denominators.
- In practice most of these measures relate to inpatient care.
- Many providers were unable to collect this data due to a lack of current systems to reliably count types of incidents.
- Further analysis will be conducted on all of these measures in 2014 following provider observations that recording system improvements will be put in place for 2014.
Quality & Outcomes

Quality and safety (incidents of actual physical violence to patients)

- The desktop benchmarking toolkit allows a range of safety and quality measures to be analysed in detail.
- These can be profiled using either bed days or community contacts as benchmarking denominators.
- In practice most of these measures relate to inpatient care.
- Many providers were unable to collect this data to a lack of current systems to reliably count types of incidents.
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Further analysis will be conducted on all of these measures in 2014 following provider observations that recording system improvements will be put in place for 2014.
Section 6: Good Practice

Raising standards through sharing excellence
Good Practice

As part of the benchmarking process all participants were invited to provide details of local good practice initiatives that have helped to improve service quality, access, outcomes, value or performance. The emphasis within this is to describe those initiatives that have made a positive difference to services and service users and carers.

Participants responded positively to this request with many examples provided. Twenty three participants provided detailed information of these good practice initiatives which are summarised at Appendix A of this report.

The main themes evident in the good practice analysis are:

- Improving service access
- Measuring outcomes
- Service user involvement
- Training to other children’s professionals
- Early intervention & partnership working
- IAPT
- Improving capacity and efficiency

NHS Benchmarking Network member organisations who wish to make contact with any of these providers to find out more about these initiatives can do so through the Network’s knowledge exchange service.
Section 7: Conclusions and next steps

NHS Benchmarking Network

Raising standards through sharing excellence
Conclusion and next steps

- The 2013 CAMHS benchmarking project has produced interesting findings. We are delighted that 65 organisations have taken part in this year’s project. This high level of member involvement has created the critical mass upon which any successful benchmarking project depends. We would like to thank members for their involvement in this year’s project.

- The breadth and depth of findings create the strongest evidence base currently available on the scale and nature of NHS funded CAMHS provision. This year’s benchmarking allows independent analysis of tiers 1-3 and tier 4 to give greater understanding of the nature of both local and specialist services. The desktop benchmarking toolkit can also be used to drill-down into detailed comparisons.

- The benchmarking results paint an interesting picture of CAMHS provision in 2013. Access to services appears to have become more difficult in the last year with waiting times for non-urgent CAMHS now averaging 15 weeks. Urgent response times now average 3-weeks and less than half of CAMHS support a crisis pathway to access services. The average CAMHS service user remains with services for around 12 months and receives 6 contacts with community based teams. The skill-mix and depth of MDT of community based CAMHS teams is relatively rich when compared to tier 4 services and also adult mental health services.

- Tier 4 services vary enormously in their nature and scale. NHS provided places are relatively few in number. When admitted, patients average 59 day lengths of stay, or 68 days when leave is taken into account. Services are targeted mainly at adolescents with relatively few places available for younger children.

- CAMHS services are aware of the challenge of integration and planning effective transitions to adult services. It is encouraging to report that the number of services formally collecting outcome measures has risen to 95% in 2013. The impact of children and young people’s improving access to psychological therapies is also becoming more evident with 70% of services reporting that they now follow IAPT principles.

- A large number of good practice examples have been provided by participants. These illustrate the diversity within CAMHS and the extent to which services have been able to innovate.

- The benchmarking project will continue in 2014 and all CAMHS providers will be invited to take part. The next cycle of data collection will use 2013/14 year end positions and will take place during September 2014, with reports published in November 2014. The content of the 2014 benchmarking project will be overseen by the mental health reference group.

- Members requiring further information on the project should review the Network’s website www.nhsbenchmarking.nhs.uk or contact Lindsey Ashley at lindsey.ashley@nhs.net. Questions about overall project content and interpretation of results should be addressed to Stephen Watkins s.watkins@nhs.net
Appendix A: Compendium of Good Practice

This section summarises the good practice observations provided by participants.
Good Practice Submissions

5 Boroughs Partnership NHS Trust
Alder Hey Children's NHS Foundation Trust
Berkshire Healthcare NHS Foundation Trust
Central and North West London NHS Foundation Trust
Central Manchester Foundation Trust
Derbyshire Healthcare NHS Foundation Trust
Dorset HealthCare University NHS Foundation Trust
East London NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Isle of Wight NHS Trust
Young Persons Advisory Service
North East London NHS Foundation Trust

Oxford Health NHS Foundation Trust
Oxleas NHS Foundation Trust
Pennine Care NHS Foundation Trust
Plymouth Community Healthcare CIC
Rotherham Doncaster and South Humber NHS Foundation Trust
Royal Free London NHS Foundation Trust
Somerset Partnership NHS Foundation Trust
South Tyneside NHS Foundation Trust
Surrey and Borders Partnership Foundation Trust
Torbay and Southern Devon Health and Care NHS Trust
West London Mental Health NHS Trust
Good practice (1)

- **5 Boroughs Partnership NHS Trust**: Recently undergone improvement plans in all CAMHS T3 services and reduces waiting times in all stages of CAPA model. This resulted in an average reduction of 66% in waiting times. From September the next stages of improvement will be implemented resulting in a further overall reduction of 85% in waiting times (from 18 weeks to 2 weeks).

- **Berkshire Healthcare NHS Foundation Trust**: CPE for all new referrals across Berkshire so it provides a consistent approach to triage linked in to LA tier 2 services. One telephone number for all professionals and clients to use for consultation and/or advice. Urgent care team embedded in CPE for DSH assessments.

- **Central and North West London NHS Foundation Trust**: All patients will have A Care Programme Approach (CPA) meeting to keep involved professionals up to date with the progress and needs of the patient. These are arranged for 2/3 weeks after admission and again prior to discharge. A letter informing GP’s of the patient’s admission is sent out within 24 hours of admission. A Discharge notification is sent to GP within 24 hours A Discharge summary is sent to the receiving clinician and GP within 20 working days of discharge. A fortnightly meeting to offer a forum for father’s to be able to share, discuss their thoughts and experiences and receive peer support and feedback with the addition of seeking information / clarification from Unit staff. If as part of multidisciplinary care planning it is felt appropriate for father’s to stay overnight in the Unit to support their partner/child then this can be offered. For residential Parenting Assessments – we admit Couples (the only Unit in London to do so).

- **Central Manchester FT**: Robust Risk Management procedures in place - both clinical and management including audit process and Risk Assessment Management Meetings to support staff and all agencies involved with high risk families and young people. We have lots of active and accredited (by Lancaster/Leeds/Manchester Universities) courses designed and run by the Directorate - 12 week intro to CAMHS/Family Therapy- that can be accessed externally. Our Adolescent Consultant provides training to Tier 1 staff. We are leaders in ADOS training and ADHD and Webster Stratton to name a few. We have developed a number of DVD training packages that fellow Trusts purchase. We structure all professionals with a mentorship framework that enables progression through 2 grades as skills obtained. We have a copyright licensed to staff - Beating the Blues CBT Currently leading on 2 National Projects - SHIFT and IMPACT Trials. There are lots of audits undertaken and service user feedback with strong participation group that response to findings are actioned and service change implemented. Teams hold You’re Welcome status.
Good practice (2)

- Derbyshire Healthcare NHS Foundation Trust: CAMHS uses outcome measures in order to track progress. There are participation groups which influence service provision and practice. Care bundles are being developed in order to ensure consistency of practice. CAMHS are available for training other statutory agencies and also the third sector agencies through our tier 2 service which also offers consultation and support to both children in care and also to the pupil referral units-school provision. We work in conjunction with community paediatricians as to ensure a smooth transition and good working relationship. We hold regular meetings to aid consultation and smooth transfer. CAMHS have good risk assessment policies and work well through multi agency approaches in order to manage risk of children and young people. CAMHS offers support to students and the local university to support education attainment and give students availability to work within CAMHS both from a nursing and also from a social work background. CAMHS have specific therapies available to support a wide range of difficulties and diagnoses such as Systemic (Family) therapy, Cognitive Behavioural Therapy, Parenting therapy, Dialectical behavioural therapy and Eye movement desensitisation and reprocessing therapy. CAMHS also are able to offer assessments specifically for autism spectrum disorder and have staff both trained in the ADOS assessment and also the DISCO assessment. CAMHS has the early intervention team as part of its services and have fluid pathways into and out of the service in order to support assessment or treatment of those children with psychosis. CAMHS can offer choice of case manager where needed in relation to client preference for needs of the child or young persons difficulties, cultural or diversity needs.

- Dorset HealthCare University NHS Foundation Trust: The service has many examples of good practice in 2012/13, including the following: 1. Introduction of Behavioural Management Nurse in Weymouth to work with young people with ASD and challenging presentations; 2. Introduction of single point of access to CAMHS; 3. Introduction of family therapy sessions delivered jointly by a CAMHS and Adult Family Therapist for parents with Mental Health Problems and their children who are being seen in CAMHS; 4. Delivery of Psycho-education ASD workshops by a medic for parents; 5. Introduction of Integrated Social Workers into CAMHS teams to focus on children in care, fostering & adoption, children on the edge of care and care leavers; 6. Development of emotional literacy package for schools in collaboration with Social Care; 7. Young people trained in recruitment and sitting on interview panels for to appoint all staff; 8. Parents developed and deliver with staff ‘Thinking Differently Workshops’ to introduce treatment to families and young people; 9. Two staff seconded from Adult Services to work in CAMHS specifically to develop skills and educate adult team on return.
Good practice (3)

- **East London NHS Foundation Trust**: Training programme for Tier 1 workers; Embedded CAMHS team in Social Care and youth services; Outreach workers, including workers based in Alternative Education Provision; ‘Mind the Gap’ group for parents with mental illness and their children; ‘Autism Workshops’ for parents of children newly diagnosed with ASD; Parent Infant Psychotherapy Service; Outreach project at DOST for young refugees and migrants; Consultation and Clinical Supervision for Early Help Plus staff; Outreach worker in Youth Offending Team, Father's Group; Joint project (Dove) with local authority and AFRUKA on spirit possession; Parents/carers service user involvement group, ASD clinics, Good multiagency partnership working including complex case discussion forums with social care colleagues, comprehensive outcome monitoring; standard comprehensive assessment, recording of non client and consultation activity, lunch time seminar programme for staff; Outdoor Gardening Project with third sector; member of CORC using client feedback and GBOs; Urgent duty systems to ensure services are responsive to emergency and urgent cases; multidisciplinary working Trust has an MST service seeing clients on the edge of care or custody. Tier 4 good practice includes: Hope Wall project, recovery focused project. Treatment pathways development Poetry, music expression workshops. Dance classes from Olympic legacy group. QNIC excellence accreditation. Tower of London project in education.

- **Hertfordshire Partnership University NHS Foundation Trust**: HPFT are currently developing a specific CAMHS website and we have involved service users, carers and other professionals, such as education in its development. The website will have specific areas for Young Children, Older Children, Parents/Carers and Professionals, so that they can access information that is relevant to them. For the Young Children’s section we have produced doodle art videos to portray what it is like coming to CAMHS and some of the different problems children may experience that we are able to help with. This will enable children who are unable to read to understand a bit about the service and what to expect before they arrive. We have also been working in partnership with students from North Herts College on the development of Apps covering 8 key areas: anxiety, OCD, depression, eating disorders, ADHD, bipolar, self-harm and anger & rage. Once these are ready, we will be able to upload them to the older children’s section of the website, for them to download to their phones.
Good practice (4)

- **Homerton University Hospital NHS Foundation Trust**: Early Intervention Community Psychology service has reduced number of cases referred to Tier 3 and 4.

- **Isle of Wight NHS Trust**: 1) Community CAMHS Isle of Wight produces a termly Newsletter that is distributed to partners in the community (Schools, GP's, Council and Children Centres), this includes contributions from Service Users and CAMHS staffs. 2) We subscribe to CORC and use snapshot at present, this gives us a good indication of how the service is performing locally and nationally. 3) We use an activity dashboard to review work carried out, this delivers data to management to show trends and peaks and troughs in clinical work carried out. 4) We run an SMS appointment reminder service for our patients.

- **Young Persons Advisory Service**: Good practice includes the complimentary working models underpinned by both specialist CAMHS services and 3rd sector providers. We have generated an array of partnerships and collectively contribute to the comprehensive CAMHS pathway, with an integrated approach.

- **North East London NHS Foundation Trust**: The tier 4 service operates an MBT model, which is internationally recognised for quality, supported by an interact community outreach service, which facilitates discharge through to tier 3 and or other appropriate levels of service. 3 of the 4 NELFT boroughs have been successful in being accepted for the CYP IAPT programme, and NELFT is part of a pilot for CAMHS pbr. each of the four NELFT boroughs deliver a range of comprehensive CAMHS services across tiers 1 to 3.

- **Nottingham City CCG**: Our tier 2 CAMHS service run by the local authority and jointly commissioned by the LA and health has a single point of access that sits at tier 2, all CAMHS referral apart from emergency come via the single point of access. Regular meeting with tier 3/4 to discuss case work.
Good practice (5)

- **Oxford Health NHS Foundation Trust**: Children and Young Peoples Improving Access to Psychological Therapies (CYP-IAPT): In October 2011, The Department of Health announced a major programme of service development: Children and Young Peoples Improving Access to Psychological Therapies (CYP-IAPT). After a competitive process Oxford Health NHS Foundation Trust, in collaboration with Reading University, were selected as one of the first wave CYP-IAPT sites with training starting in December 2011. The aim of CYP-IAPT is to transform existing child and adolescent mental health services to ensure they are more child-centred, evidenced based and outcome focused. By July 2013 Oxford Health will have trained 25 professionals in the delivery of Cognitive Behaviour Therapy or Parenting, supported by 7 clinical supervisors and 22 senior managers and professionals in leadership. Service changes so far have included the implementation of session by session, routine outcome measures, self referral pilots, expansion of evidence based practice and enhanced clinical and managerial leadership across services. Pathways and Technology: Oxford Health NHS FT are remodelling CAMHS Community Eating Disorder Pathways to improve clinical outcomes for young people, including reducing need for admission and length of stay in inpatient services. This is a whole service change which will see the development of dedicated ED services in each area of delivery. A pilot of a dedicated young people’s service (18-25 years) is due to commence in Oxfordshire in September 2013, in order to provide a safer and more effective way of managing the transition to adult hood for those Young People with emerging mental health needs. CAMHS have commenced a pilot to introduce video calls as part of an overall package of care with young people. The pilot is in its early stages but feedback from young people and staff has been positive so far. All Oxford Health NHS FT CAMHS clinicians will have iPads by September 2013 and it is anticipated the offer of video calls as part of a risk assessed package of care will be made available to a wide range of young people and their families. Other pilots include the use of assistive technology to promote engagement with community service via a text messaging service.

- **Oxleas NHS Foundation Trust (Bexley)**: Utilisation of CORC to inform service provision. Service works closely with Oxleas community services to share knowledge and learning. CAMHS provides supervision to community staff to enable management of issues. Outreach service has been extended to provide more outreach work to adolescents at risk of admission to Tier 4. NVR parenting groups are accessed for families with specific need.
Good practice (6)

- **Oxleas NHS Foundation Trust (Bromley):** Utilisation of CORC to inform service provision. Service is piloting triage model to ensure that children are seen and signposted earlier. NVR parenting groups are accessed for families with specific need.

- **Oxleas NHS Foundation Trust (Greenwich):** Utilisation of CORC to inform service provision. Service works closely with Oxleas community services to share knowledge and learning. CAMHS provides supervision to community staff to enable management of issues. Service is piloting CAPA model to ensure that children are seen and signposted earlier. Due to new service structure more integration has been possible with community services which has resulted in shorter waiting times for ADHD and ASD service. NVR parenting groups are accessed for families with specific need.

- **Pennine Care NHS Foundation Trust (Bury):** Strong partnership working with the local CYP IAPT Tier 1 and 2 service, assisting with the delivery of specialist mental health training programmes to Tier 1 staff. Contribution to the development of a Trust wide CAMHS directorate Workforce Plan with a view to ensuring that all CAMHS staff have a minimum competency skill set in the delivery of assessment, formulation and intervention with a view to developing a specialist skill set in Family Therapy and CBT. Development of an ASD pathway and treatment protocol "in house" that all staff deliver to a competent level which is supervised by a dedicated worker thus up skilling team members in the assessment and some post diagnostic work in ASD. Successful and annual delivery of "Attachment" and "Impact of Parental Mental Health on Children " training as part of the LSCB training pool. All team members have received Level 3 Safeguarding training, Core Skills training, and "E" learning on Adult safeguarding and Information governance training that is aligned to the Trust's Safeguarding policy/agenda. Ongoing contribution to the development of the national award winning Trust wide handbook and website for young people "WITHUINMIND" that provides information and advice on mental health difficulties. Plans to complete a virtual tour of department as part of the Young Persons Participation Strategy and Trust website development. Attendance at local Children' Trust network events and contribution to the development of schools protocol on the management of deliberate self harm in schools. Continued delivery of a social skills group to LAC children in a local school where we had identified an over representation of this vulnerable group. Participation as part of a CAMHS Directorate wide IAPT Tier 2/3 national programme in collaboration with Salford university with an aim of up skilling existing staff in CBT and Parenting. Continued delivery of an 11 week course to foster carers "Fostering Change" in the evening to ensure maximum uptake from carers. Development of award winning "With U in Mind" package, a resource book and website that provides information regarding mental health at a universal level. Development of a resource directory for GPs and ongoing development of referral templates for GPs following feedback from a CAMHS 360 degree stakeholder review.
Good practice (7)

- **Pennine Care NHS Foundation Trust (Oldham):** Current Work and Developments within CAMHS: Single point of entry established for working with Children and Young People with a diagnosis of Autism - this comprises Children with Disabilities Service (Woodfield), CAMHS and Community Paediatric Team. Decision made here as to support that may be delivered for families with the establishment of group work programme involving professionals from a number of different teams focusing on behaviours and difficulties that children and young people experience. The aim is for these to run bi-monthly. Work is ongoing to look at a similar model for the assessment phase. Training and input continues with the LSCB – these courses operate with the aim of attracting a multi-agency/discipline audience of participants to understand about mental health, impact of parental mental health on children and the role that CAMHS can and should play - courses took are to take place in May and June 2012. Monthly liaison with Waterhead Academy regarding pupils involved with CAMHS and on roll at Waterhead - the sharing of information is proving important in managing cases. The Adult Parenting Mental Health Support Worker is well established and providing a robust service. Located in one of the CMHTs, this worker holds a caseload but is the link between children’s and adult services where the parent or carer is experiencing mental health difficulties. A Webster Stratton parenting course with the worker and a CAMHS practitioner took place between Sept and Dec 2011. Another is to be explained for autumn 2012. Ad hoc training delivered to schools by CAMHS Primary Care Workers. For example, session to take place at with the YOS in June 2012. A Sunday clinic is in place to assess young people who have been admitted to the paediatric ward following an overdose attempt or have suffered significant self harm and been admitted to the paediatric ward. This aims to provide a more timely intervention for young people who have been admitted to enable swifter discharge. Pennine Care is involved with the IAPT programme for CYP. This is currently training practitioners in CBT and parenting. Training will be completed towards the end of the year with significant service transformation to take place with participation, outcome measuring and referral pathways over the next 18 months.

- **Pennine Care NHS Foundation Trust (Rochdale):** Active young person participation group to help service development and contributing to all CAMHS recruitment. Primary Mental health input into Public Health Project - Books on Prescription considering CYP emotional and psychological wellbeing. Care pathways in process of being revised as new service model is prepared for September roll-out. On-going post diagnostic ASD support offered to parents and carers upon diagnosis. Weekly consultation sessions in place with CAMHS LAC Psychology and residential units and foster carers. Excellent relationships with t4 colleagues to facilitate referrals into and discharge from t4 psychiatric units. Effective 24 hr. on call system. Directorate remain involved with delivery of IAPT with a number of returning trainees and 3 trainees currently involved with the training this academic year. Building and consolidation of new and existing links with local authority colleagues to encourage further integration of services in initiatives such as 'Early Break'. Imminent launch of CAMHS website aimed at all key stakeholders including children and young people.
Good practice (8)

- **Pennine Care NHS Foundation Trust (Stockport):** 1. CAPA implemented effectively to manage demand and capacity. 95% of referrals accepted for Choice. Referenced as example of good practice in implementation in the CAPA manual. 2. Investment in DBT training using resources bid for from Psychological Therapies development monies. Very effective management of high risk chaotic young people and consequent reduction in use of Inpatient beds and IROR. 3. Successful bid to be a Phase 1 partner in the North West collaborative for CYPIAPT. 4. Continued implementation of a multi agency ASD assessment pathway that meets the NAS guidance. 5. Development of integrated pathway for LAC young people. 6. Development of robust Emergency assessment pathway that can avoid inappropriate admissions to children’s medical beds.

- **Pennine Care NHS Foundation Trust (Tameside):** 3 currently completing IAPT, 1 nurse has completed masters in FT, 1 support worker has completed play therapy training, 2 SW are AMHPS. Development of multi-agency single point of entry for YP requiring assessment for a diagnosis of ASD. CAMHS link workers integrated into newly established multi-agency early intervention teams. Training and on-going input with LSCB. Monthly liaison with special schools. Comprehensive training packages delivered to a range of Tier 1 professionals. Implementation of evidence based group work for a range of problems e.g. DBT, CBT. Development of award winning "With U in Mind" package, a resource book and website that provides information regarding mental health at a universal level. Development of an integrated care pathway for parental infant mental health. Provision of a locally developed attachment awareness DVD and booklet to all new parents. On-going participation of young people in service design and evaluation of delivery.

- **Plymouth Community Healthcare CIC:** This CAMHS service provides a very robust model focusing on early identification and prevention as well as longer term more complex work. Plymouth CAMHS has The Early Intervention Team, who work from the antenatal period with Mother’s who have bonding issues with their unborn child through the postnatal period. Then working with children and young people who display risk taking behaviour (i.e. offending behaviour, substance misuse, emergence of psychosis), neurological developmental concerns, severe learning disability and those children and young people who are looked after by the local authority and in need of rapid access to targeted mental health services to avoid the deterioration of their mental health. The two Longer Term Work teams are a reflection of the early intervention team with pathways throughout the continuum to ensure the child receives the right treatment at the right time. The Early Intervention team deliver ante-natal to mothers with bonding issues, postnatal they deliver a therapeutic postnatal depression group alongside partner agencies. Mental Health promotion to universal services. By delivering Targeted Mental Health in schools programme which delivers Target group work, ELSA and SAMHS training for school staff. Alongside this the Early intervention service provides various Professional consultation – Professional to professional with young person or parental consent. Triangular consultation -A meeting is then held with a PMHW, professional and a parent/care present. It is a solution focused meeting which is review 6 weeks later. Group Consultation - provides a setting which a high number of cases can be discussed by a team with a PMHW present with Child/parental consent. They also deliver training to universal services through the introduction to Child and Adolescent Mental health. The longer term team provide the child day programme which is an intensive assessment programme for children with a complex presentation. These also provide longer term therapies.
Good practice (9)

- **Rotherham Doncaster and South Humber NHS Foundation Trust**: Peer Support Workers have been recruited within the business division, these are people who have a lived experience of mental health problems - these experiences are used as part of the care plan to share experiences with young people, particularly those aged 17 and above who are either leaving the service to continue their care into adult services or are being discharged from CAMHS. The introduction of routine outcome measures and session by session measures are being introduced across the services, with CYP-IAPT trainees initially being the main providers of data, this is being rolled out across the business division. Some outcome measures particularly promote the principles of recovery - mainly the goals based outcomes (GBO's) where the young person identifies their own goals, which they measure progress against each session. Each young person has a personalised care plan in addition to the GBO's.

- **Royal Free London NHS Foundation Trust**: Intensive eating disorder service pilot for 10 young people at any one time concluded in March 2013 following a 2 year intervention, service now fully commissioned to provide an intensive service for young people from five CCGs, a total of 14 commissioned places with increased staffing for 2013/14.

- **Somerset Partnership NHS Foundation**: On 1 August 2011 Somerset Partnership acquired Somerset Community Services, formerly part of Somerset PCT. This acquisition included Children Integrated Services, which has resulted in opportunities to develop holistic services for Children and Young People Services.

- **South Tyneside NHS Foundation Trust**: The provision of universally available ante natal sessions delivered by our early years workers, focussing on promoting a tuned communication between primary care givers and their babies, to facilitate secure attachments, has been recognised as an example of good practice. Also the delivery of our service from school bases, as well as supporting the development of school based counselling. The development and delivery of a CAMHS/CBT framework of practice/training/supervision, including the delivery of training in the FRIENDS programme. The comprehensive delivery of Incredible Years(Webster-Stratton) groups, including the Babies, Children, Parents and Teacher programmes.

- **Surrey and Borders Partnership Foundation Trust**: TAMHS (Targeted Mental Health in Schools). Mindful Service. CAMHS children in Care plus a Sexual Trauma and Recovery Resource. Session by Session Monitoring. Early Intervention in Psychosis reducing duration of untreated psychosis to 35 days. Access CAMHS-single point of referral.

- **Torbay and Southern Devon Health and Care NHS Trust**: Further developments of care pathways, LD/CAMHS, Eating Disorder, ADHD, Perinatal mental Health, Trauma Pathway, anxiety and depression, Sexual Harmful Behaviour
Good practice (10)

- **West London Mental Health NHS Trust (1):** WLMHT CAMHS is a member of (CORC) and as such the service routinely collates clinician and service user based outcome measures including SDQs, ESQs, CGAS and HoNOSCA. In 2012/13 we have reinvigorated this agenda by employing Assistant Psychologists to improve time 2 data quality. Data obtained is analysed by CORC and is used by the service to inform clinical teams, commissioners, users and other relevant stakeholders of quality of care provided by the service, and to inform service development. Some of our teams have also started to introduce session by session outcome monitoring in accordance with the Children’s IAPT model, and with a successful bid for Children’s IAPT in 2013 we plan to roll this out across the service. In 2012 WLMHT CAMHS became a pilot site for the national CAMHS Payment by Results project, which involves capturing significant amounts of data on problem descriptors, complexity factors and clinical outcomes to inform the future of CAMHS commissioning. During 2012/13 WLMHT CAMHS has also registered each of our three sites for peer-level accreditation with the Quality Network for Community CAMHS (QNCC) and through this process we will gain a better insight into our compliance with essential quality standards and learn from good practice in other CAMHS services. Two key quality initiatives implemented during 2012/13 include the implementation of a physical healthcare protocol to provide guidance for CAMHS staff on the expectations for managing physical healthcare of their patients, and the development of a transition protocol in conjunction with adult services and young people who had recently experience transition, to ensure clear standards for effective transitions. User/ carer involvement is a key area of good practice in the service. During 2012/13 key initiatives include: Participation events including events specifically aimed at under 11s Recruitment panel training, with young people routinely involved in recruitment. Implementation of the Meridian system to collect real-time user feedback via IPads in the waiting room. Development of a film with young people called ‘Welcome to CAMHS’ which is on YouTube and signposted on all appointment letters.

- Young people involved in service transformation through representation on the CAMHS Project Board and various other forums. Carers facilitating ADHD support groups and co-delivering medical student teaching. Young people supporting the design of the new Ealing CAMHS building. Safeguarding and child protection remains a priority agenda in terms of patient safety and risk management. This is achieved by: A regular safeguarding slot in weekly team meetings to discuss safeguarding concerns and actions needed to be followed through. A safeguarding clinical lead in each CAMHS team who effectively links with local children services and the trust safeguarding structures to ensure that safeguarding children agenda remains a patient safety priority. All safeguarding referrals are collated and monitored by the safeguarding leads. Clear lines of escalation have been established in cases where referrals to Children’s Services raise concerns about the outcome of the referral process. 
Good practice (11)

- Safeguarding children issues are incorporated into the CAMHS risk assessment processes. Staff are up to date in their basic and specialist safeguarding training. Staff follow the DNA protocol to ensure follow up for non-attendance. Effective joint working with children services has been achieved through secondment of a Children’s social worker into CAMHS. Patient safety is continually improved by reporting and monitoring incidents and disseminating the learning to all staff through the Clinical Governance structure. All of our patients routinely have a risk assessment and management plan at assessment. Any risk information entered in progress notes is highlighted via the significant event checkbox. Multidisciplinary reviews of risk issues in identified children are held routinely in team meetings. Risk related to child protection concerns are discussed in team meetings and with safeguarding leads. Referrals to children services are routinely followed through and if outcome unsatisfactory then concerns escalated via appropriate channels. Work is ongoing to reduce inpatient admissions and length of stay through intensive outpatient care to make clinical changes, and to support families to keep their C&YP at home during treatment of some severe mental health problems.

- If a YP has to go into hospital because assertive /enhanced OP care packages are no longer appropriate, the community worker does intensive and assertive in reach to the inpatient unit. They become a virtual member of the inpatient team, working actively both with staff and the YP. During 2012/13 there have been further innovative developments in Tier 2 CAMHS services in partnership with the local authorities, CCGs and schools. These include continued investment in Primary Mental Health Worker Teams and other early intervention services, Looked After Children services, Learning Disability services, Parenting services, TAMHS Projects and other school-based services, Youth Offending Teams, specialist teachers and social workers based in CAMHS teams, and Assertive Outreach and In reach for young people with severe mental health difficulties. These services ensure early intervention and a collaborative approach to meeting the needs of hard to reach and vulnerable groups. They also offer Tier 1 training to aid early identification and effective management of mental health problems in children and young people. In Ealing the Intensive Therapeutic Short Break Service was commended in the Department of Health’s Winterbourne View review as an example of excellent practice in learning disability care, and as a result the intensive intervention model has been adapted with further investment for a new pilot project in the Looked After Children team to reduce placement breakdown. A single point of access was implemented in 2012/13 to ensure efficient access to the most appropriate service at the point of referral. A strong ethos of local audits which inform good practice and service development, trust wide audits related to relevant NICE guidance and service evaluations is in place. In 2012/13 audits were undertaken on depression, ADHD, ASD and the use of antipsychotics in children and adolescents, action plans were implemented and results and learning points were presented at local academic programmes and clinical governance meetings. Local academic programmes remain an important forum for learning with clinical case discussions, presentations on evidence based practice, updates on NICE guidance and learning from audits and incidents. In 2012 the first CAMHS-wide academic workshop was held and feedback was very positive, so this will now be an annual event.