Child psychiatrists - the need for leadership, innovation and sustainability

Dr Elaine Lockhart, Dr Anupam Bhardwaj and Dr Dush Mahadevan,

CAP Faculty Executive committee

RCPsych Child and Adolescent Faculty conference,

Manchester 25th September 2025

Conflict of interests

- None to declare
- We will each introduce ourselves and explain our backgrounds and roles with the CAP Faculty Exec committee

Introduction

- The mental health of children and adolescents in the UK has significantly deteriorated over the past two decades.
- Only a minority of children and young people can access timely and effective treatments.
- Additional investment in children and adolescent mental health services (CAMHS) does not meet the pace of the increase in demand.
- Significant workforce challenges for all profession, particularly for Child and Adolescent Psychiatrists (CAP's)
- We have a choice and do have agency in taking on these challenges; to implode as a speciality or innovate on our terms?

Key statistics

- Prevalence of all disorders was already increasing pre COVID-19 pandemic (Sadler, K. et al, 2018).

- During the pandemic, the incidence of mental disorders in 5 to 16 year olds rose from 10.8% in 2017 to 16.0% in July 2020 across age, gender, and ethnic groups in England (Newlove Del-gado et al, 2020).

- There was an exponential 787% increase in the incidence rate of an autism diagnosis in England between 1998 and 2018 (Russell et al, 2021).

Key statistics (contd.)

- Worldwide, routine and urgent referrals for eating disorders to child and adolescent mental health services (CAMHS) doubled after the COVID-19 pandemic (Solmi et al, 2021).

- Only a minority of children and adolescents with a mental disorder in the UK receive treatment (NHSD, 2022) with treatment coverage unchanged since 2004.

- Findings from the STADIA study

Workforce Challenges

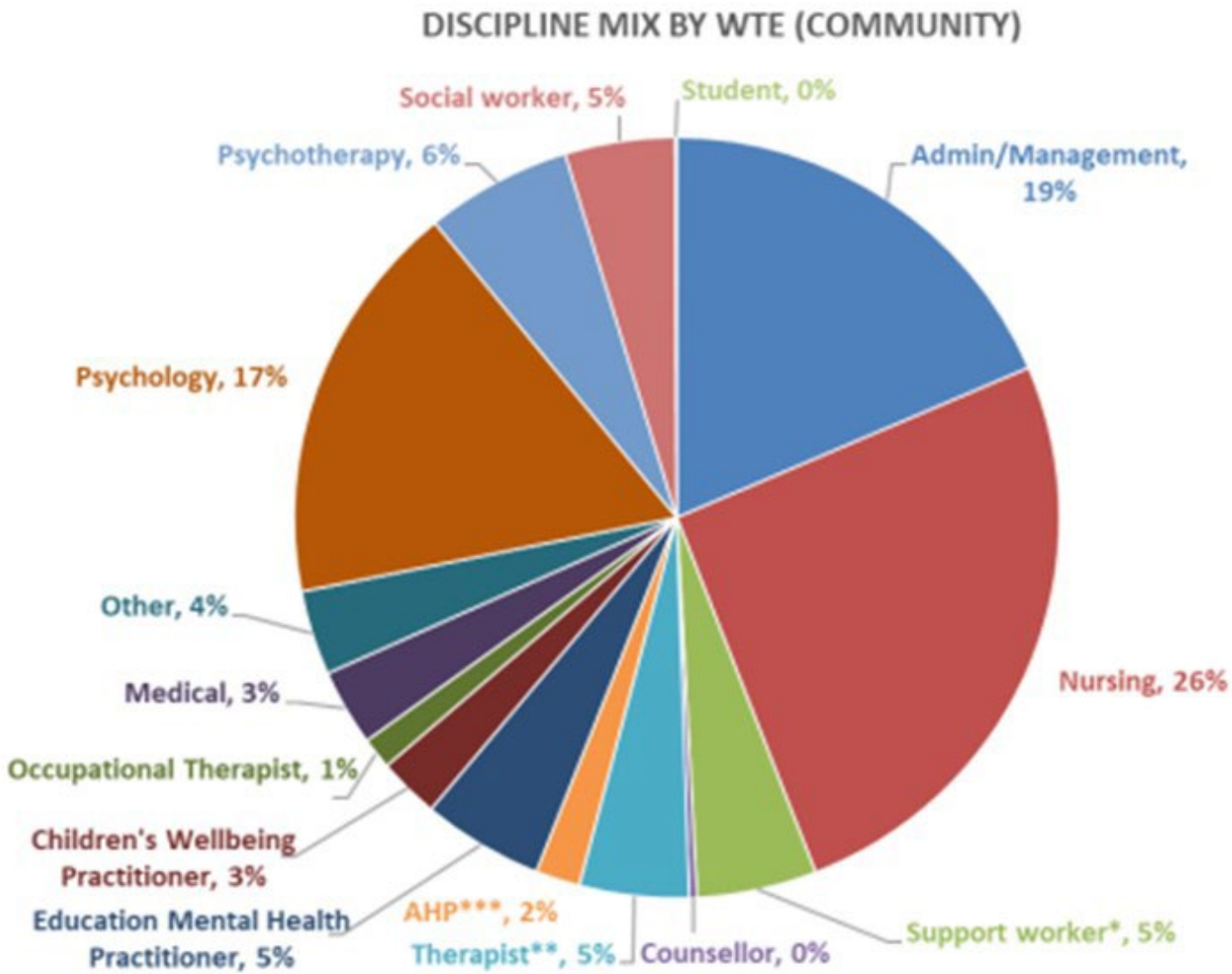
- The number of child and adolescent psychiatrists in the UK increased 0.9% between 2010 and 2021 (GMC data, Data Explorer, 2021).

- From 1,486 doctors registered in the specialty (CAP) in 2021, 855 (57.6%) were aged 55 and over (GMC data, Data Explorer, 2021)

- The GMC's report on the State of Medical Education (2024), highlights significant increases in job dissatisfaction, burnout, plans to leave the NHS, and risk of moral injury

- Medical staff represent only 3% of the overall CAMHS staff provision

(GMC data, Data Explorer, 2021).


DISCIPLINE MIX BY WTE (COMMUNITY)
Social worker, 5%
Student, 0%
Psychotherapy, 6%
Admin/Management, 19%
Psychology, 17%
Other, 4%
Medical, 3%
Occupational Therapist, 1%
Children's Wellbeing Practitioner, 3%
Education Mental Health Practitioner, 5%
AHP***, 2%
Therapist**, 5%
Counsellor, 0%
Support worker*, 5%
Nursing, 26%

Our thoughts about future directions

Commissioners:

- Funding should reflect population need, CAMHS should receive 2% of the total NHS spend over the next 5 years.
- CAPs' clinical time should be funded to provide consultation, teaching and training to medical students, trainees, wider MDT and other partner organisations.
- Focus on the recruitment and retention of a CAMHS workforce.
- Embed a participation strategy informing every aspect of designing and delivering CAMHS.
- Invest in research and meaningful quality improvement capacity

Our thoughts about future directions (cont.)

Service Managers:

- Support CAPs' job planning to provide as part of their direct clinical care sessions;

a)strategic and clinical leadership across integrated services

b)consultation, teaching and training within CAMHS, other healthcare, local authority and third sector organisations.

- Develop meaningful outcome-based CAMHS.
- Balance workforce with senior clinicians to support MDTs.

Our thoughts about future directions (cont.)

Specialist CAMHS:

- Use CAPs effectively, delegating all safe case management, clinical and admin tasks to other clinicians
- Support CAPs to provide clinical leadership, teaching, training, quality improvement (QI) and research activities which drive forward service improvement.
- Embed patient and clinician routine outcomes measures into practice and as part of QI activities.

Our thoughts about future directions (cont.)

Child and Adolescent Psychiatrists:

- Lead teams and services in understanding and delivering evidence-based treatments.
- Lead services, professional organisations and the wider care network to promote co-production and a participation strategy.
- Lead teams and services in providing and embedding values-based, compassionate, relational practice.
- Reduce direct clinical care to support partner agencies in their understanding, knowledge and skills to meet the mental health needs of the under 18’s.
- Provide leadership across children’s services for the prevention of mental illness and early intervention for infants, children and young people.

Some questions to consider in our discussion

- Is the current working model for CAP's sustainable?
- Is there a need for radical transformation of CAPs' practice to meet the actual and predicted population need?
- If we work differently, will this help or hinder recruitment and retention?
- How can we develop new working practices which are sustainable, avoid burnout and further workforce losses?

STADIA: STAndardised DIagnostic Assessment for children and adolescents with emotional difficulties: a multi-centre randomised controlled trial

stadia@nottingham.ac.uk

University of Nottingham
UK | CHINA | MALAYSIA

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Outline

- Trial Background
- Headline Results
- Clinical & Research Implications

Setting

- NIHR HTA Funding Award to: **Nottinghamshire Healthcare** NHS Foundation Trust (£1.8m; 2018-2026)

- 8 NHS Sites:
  - Berkshire Healthcare
  - Cambridgeshire & Peterborough
  - Central & North West London
  - Pennine Care
  - Gloucestershire Heath and Care
  - Surrey & Borders Partnership
  - Rotherham, Doncaster & South Humber

- Co-ordinating Centre: Nottingham Clinical Trials Unit

FUNDED BY

NIHR | National Institute for Health and Care Research

This study is funded by the National Institute for Health and Care Research (NIHR) Health Technology Assessment programme (Grant Reference Number 16/96/09). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Background

NHS decision problem & context:

- Evidence-based interventions available for anxiety, depression, OCD & PTSD (NICE).
- But … anxiety and depression often missed in practice.
- CAMHS assessments – highly variable within and across services and professional groups.
- But … professionals uncertain about the clinical value of diagnostic assessment tools.
- Also… Societal / Commissioner / Referrer concern about “rejected” referrals.

RCT Research question

- What is the **clinical and cost effectiveness of a SDA tool**, alongside usual clinical care, in diagnosing emotional disorders among CYP with emotional difficulties referred to CAMHS?

Two-arm RCT of:

Assessment as usual + SDA tool (the DAWBA) **vs.**

Assessment as usual

(Plus nested **qualitative** and implementation studies)

Model

Assessment
(gathering some info in advance; timely conclusion)

↓

Diagnostic decision

↓

Intervention
(allows evidence-based intervention to be offered)

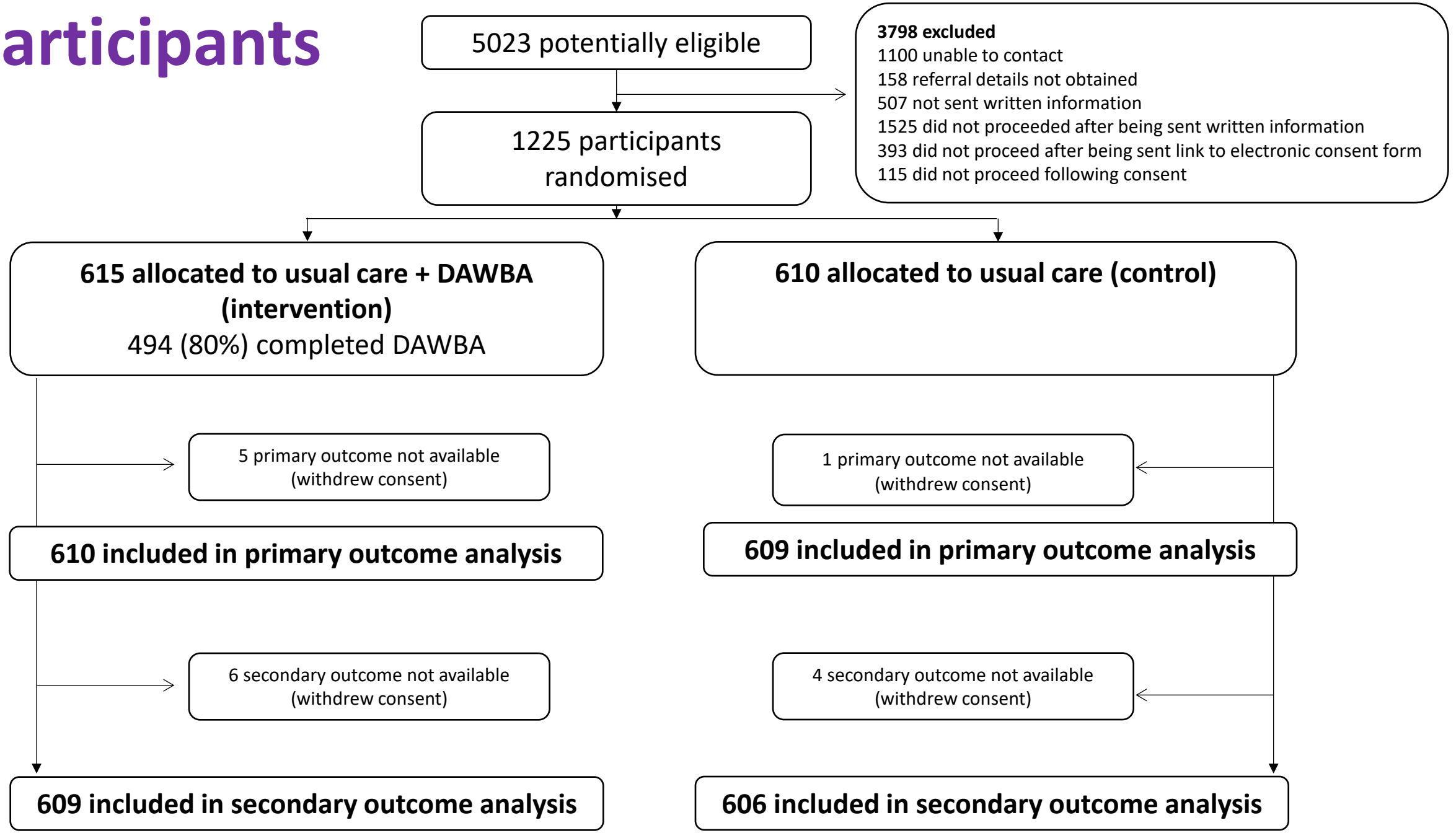
↓

Better outcomes?

↓

More cost-effective?

Participants



Trial Protocol

Open access Protocol

BMJ Open

STAndardised DIagnostic Assessment for children and young people with emotional difficulties (STADIA): protocol for a multicentre randomised controlled trial

Florence Day ,[1] Laura Wyatt,[1] Anupam Bhardwaj,[2] Bernadka Dubicka ,[3,4] Colleen Ewart,[5] Julia Gledhill,[6] Marilyn James,[1] Alexandra Lang ,[7] Tamsin Marshall,[8] Alan Montgomery,[1] Shirley Reynolds,[9] Kirsty Sprange ,[1] Louise Thomson,[10] Ellen Bradley,[10] James Lathe,[1] Kristina Newman,[11] Chris Partlett,[1] Kath Starr ,[1] Kapil Sayal [10,11]

Intervention

- SDA tool - **Development & Well-Being Assessment** (DAWBA).
- DAWBA completed by the parent (and child, aged 11+).
- DAWBA completed **online** (or telephone option) before the referral has been accepted.
- One-page summary report of DAWBA findings are fed back to:

  i) participants and

  ii) CAMHS team (incl. triage clinician and assessing clinician)
- As an adjunct to usual clinical practice **(+ assessment as usual**).

DAWBA Report template

- **Close to average** / **Slightly raised** / **High** / **Very high** for worrying a lot about different things (general fears and worries)
- **Close to average** / **Slightly raised** / **High** / **Very high** for worries about separation from key "attachment figures" such as parents (separation anxiety)
- **Close to average** / **Slightly raised** / **High** / **Very high** for specific fears (specific phobia)
- **Close to average** / **Slightly raised** / **High** / **Very high** for social fears (social anxiety)
- **Close to average** / **Slightly raised** / **High** / **Very high** for panic attacks
- **Close to average** / **Slightly raised** / **High** / **Very high** for fears of crowds, public places, open spaces etc (agoraphobia)
- **Close to average** / **Slightly raised** / **High** / **Very high** for stress linked to particularly frightening events (post-traumatic stress)
- **Close to average** / **Slightly raised** / **High** / **Very high** for obsessions or compulsions
- **Close to average** / **Slightly raised** / **High** / **Very high** for depression or loss of interest
- **Close to average** / **Slightly raised** / **High** / **Very high** for disruptive and uncooperative behaviours (troublesome behaviour)
- **Close to average** / **Slightly raised** / **High** / **Very high** for antisocial or aggressive behaviours that can get people into serious trouble (troublesome behaviour)

Close to average

In the general population most children / young people (roughly 80 out of 100) are in the “close to average” category.

Slightly raised

If the ratings are in the “slightly raised” category this means the difficulties are slightly higher than average. Roughly 10 out of 100 children / young people are in this category.

High

Around 5 in 100 children / young people score in the “high” category. This means that the difficulties are more severe than average.

Very high

Around 5 in 100 children score in the “very high” categoryThis means that the difficulties appear to be more severe than we find in 95 out of every 100 children / young people.

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A DAWBA report...

Your ratings:

- **Very high** for worrying a lot about different things (general fears and worries)
- **Close to average** for worries about separation from key "attachment figures" such as parents (separation anxiety)
- **Close to average** for specific fears (specific phobia)
- **Close to average** for social fears (social anxiety)
- **Close to average** for panic attacks
- **Close to average** for fears of crowds, public places, open spaces etc (agoraphobia)
- **Close to average** for stress linked to particularly frightening events (post-traumatic stress)
- **Close to average** for obsessions or compulsions
- **Slightly raised** for depression or loss of interest
- **High** for disruptive and uncooperative behaviours (troublesome behaviour)
- **Very high** for antisocial or aggressive behaviours that can get people into serious trouble (troublesome behaviour)

Comparator

- Assessment as Usual

Outcomes assessed

- **Clinician-made diagnosis** decision about the presence of an **emotional disorder** (within 12 months)
  - *Depression*
  - *Anxiety*
  - *OCD*
  - *PTSD*
- Referral acceptance
- Treatment/intervention offered, started (and time till start)
- Self-harm
- Oppositional / Conduct problems
- Functional impairment
- Quality of life
- Parent anxiety / depression

Patient and Public Involvement (PPI)

- Active contribution to all aspects of the research
- Parent co-applicant and Trial Management Group member
- Independent Trial Steering Committee PPI members
- Two Advisory Panels:
  - Parent/carer
  - Young people - STADIA Youth Lab Workshop

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DAWBA Completion

	Intervention group (n=615)
DAWBA fully or partially completed by either child or parent/carer	494 (80%)
DAWBA report generated	494 (80%)
DAWBA report sent to primary participant	493 (80%)
DAWBA uploaded to CAMHS records	490 (80%)

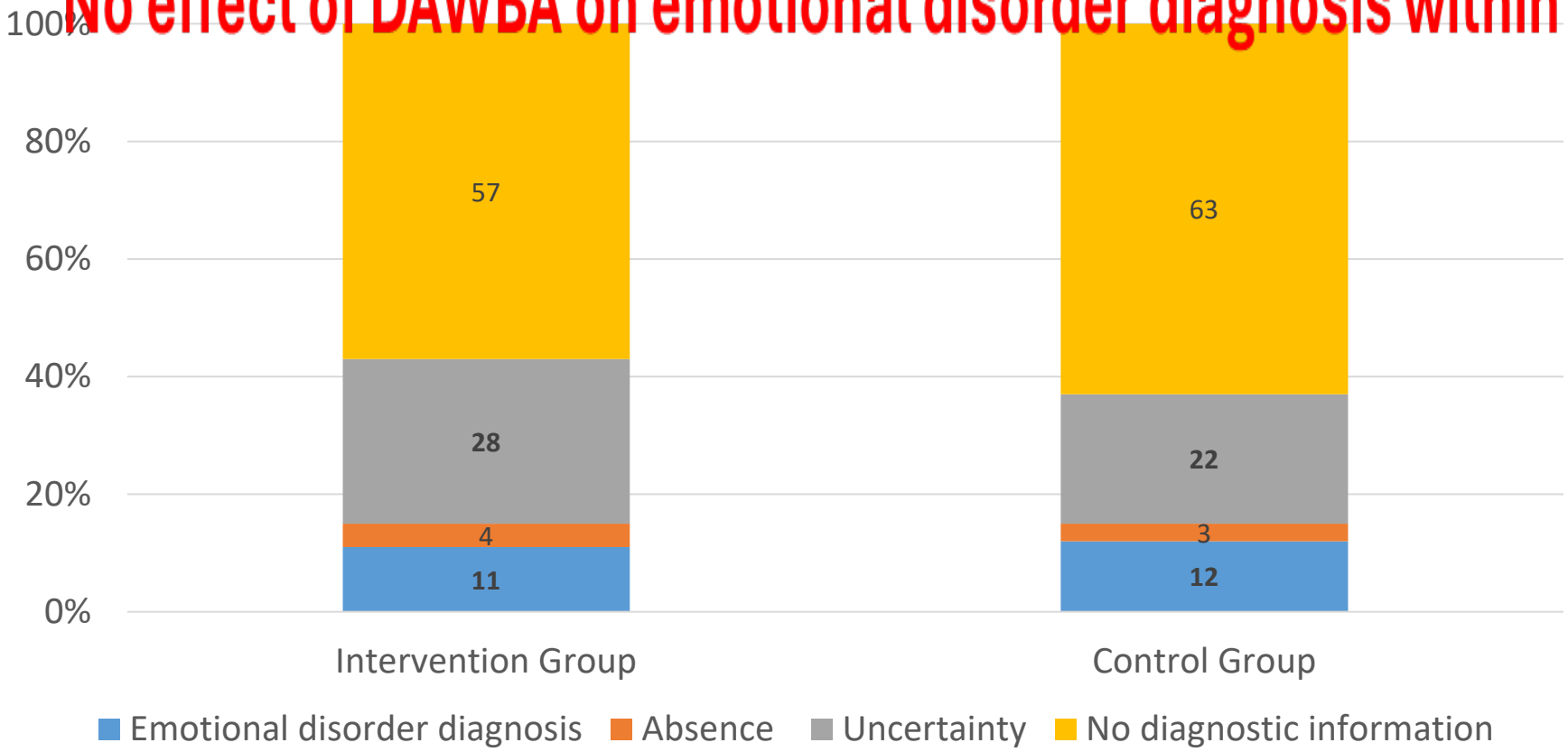
DAWBA Summary – High need

	n	Close to Average	Slightly raised	
Separation Anxiety	461	223 (48%)	178 (37%)	
Specific Phobias	479	323 (67%)	1 (<1%)	
Social Phobia	478	187 (39%)	90 (19%)	
Panic Attacks	478	298 (62%)	84 (18%)	
Agoraphobia	478	277 (58%)	97 (20%)	
Generalised Anxiety	479	48 (10%)	141 (29%)	
Obsessive Compulsive Disorder	480	368 (77%)	41 (9%)	
Post-Traumatic Stress Disorder	477	410 (86%)	20 (4%)	
Depression	484	186 (38%)	10 (2%)	
At least one emotional disorder domain scoring "Very High"	494			
Oppositional Defiant Disorder	428	74 (17%)	101 (24%)	

What was the impact of the DAWBA?

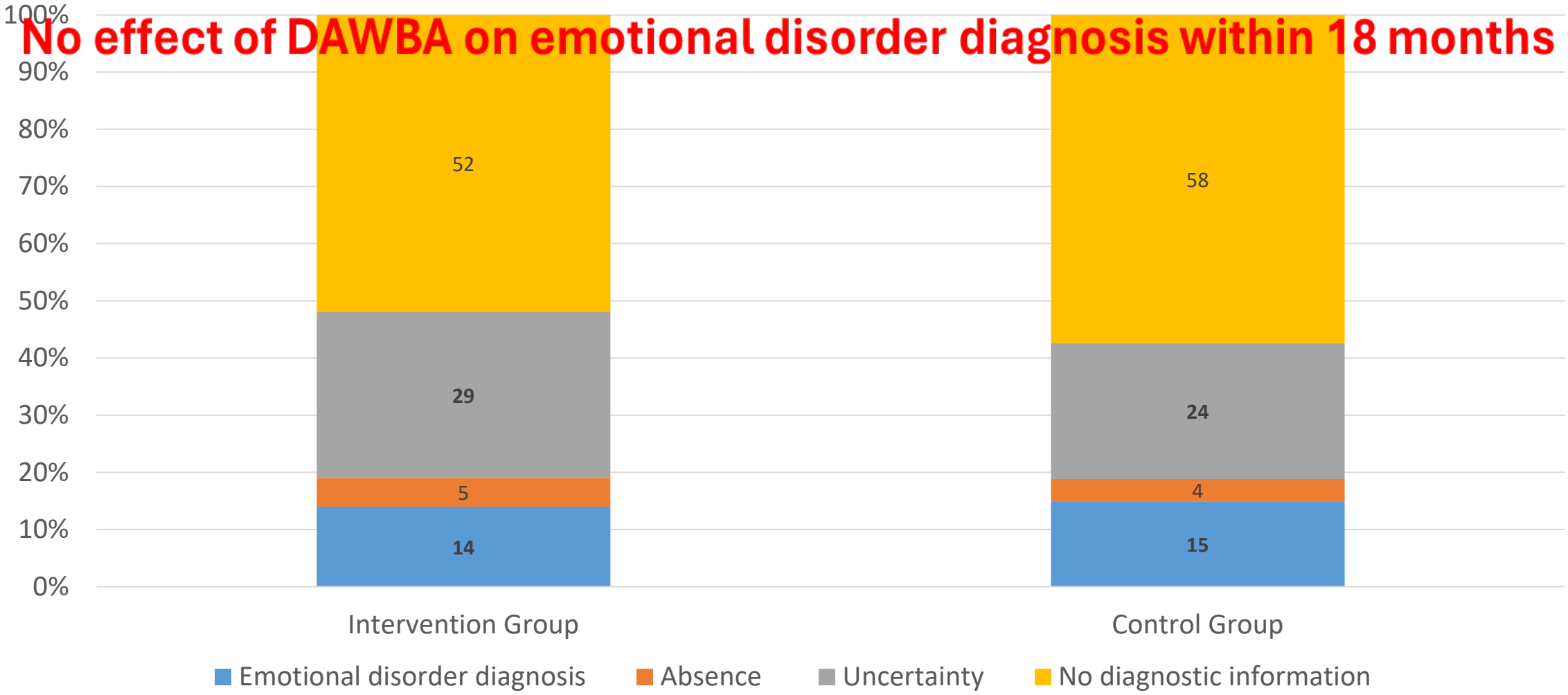
Primary Outcome

No effect of DAWBA on emotional disorder diagnosis within 12 months

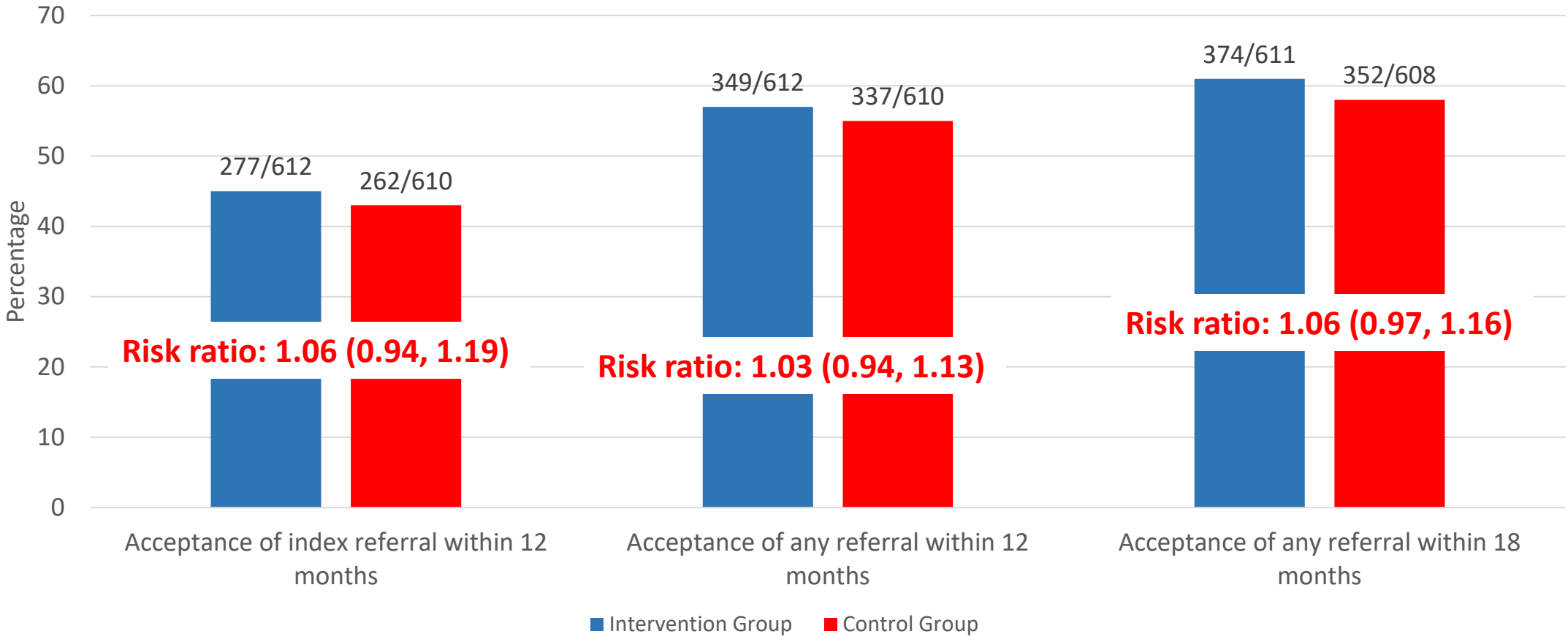


Secondary outcomes from CAMHS records

Diagnosis at18 months



Referral acceptance



Interventions

	12 Months			18 Months		
	Intervention Group	Control Group	Total	Intervention Group	Control Group	Total
Intervention Offered	254/610 (42%)	238/609 (39%)	**492/1219 (40%)**	292/609 (48%)	278/606 (46%)	**570/1215 (47%)**
Intervention Started*	164/610 (27%)	169/609 (28%)	**333/1219 (27%)**	198/609 (33%)	195/606 (32%)	**393/1215 (32%)**

* doesn't include medication data as exact start date not known

Participant-reported secondary outcomes

Follow-up Data from either informant: 78%

Participant-reported depression (MFQ)

A significant deterioration in depression* over 12 months

	12 months	
Self-report	**Intervention Group (n = 142)**	**Control Group (n = 144)**
Yes	33 (23%)	36 (25%)

*Defined as a score indicative of depression (27 or above) on the MFQ completed at follow-up, where this represents a deterioration from baseline of 5 points or more

Participant-reported functional impairment (SDQ)

		Baseline	12 months
Self-reported (Age 11-17)	Intervention Group	4.9 [2.6] (n=139)	3.8 [3.1] (n=147)
	Control Group	3.9 [2.5] (n=231)	3.7 [2.9] (n=147)
	Adjusted difference in means (95% CI)		**0.07 (-0.57, 0.72)**
Parent-reported (Age 5-17)	Intervention Group	5.8 [2.8] (n=424)	4.4 [3.2] (n=405)
	Control Group	4.9 [2.9] (n=551)	4.5 [3.3] (n=406)
	Adjusted difference in means (95% CI)		**-0.07 (-0.49, 0.34)**

Participant-reported self-harm

Have you hurt yourself on purpose in any way in the last 6 months?

	6 months		12 months	
	Intervention Group (n = 133)	**Control Group (n = 115)**	**Intervention Group (n = 142)**	**Control Group (n = 143)**
Have you hurt yourself on purpose in any way in the last 6 months?				
Three or more times	36 (27%)	28 (24%)	36 (25%)	33 (23%)

Ongoing Work…

Longitudinal Findings

- Predictors of Referral Acceptance – who gets seen?
- Predictors of Intervention receipt – who gets help?
- Predictors of Outcomes – who gets better?

- Ongoing 3-year follow-up

For Consideration:

Clinically-referred sample with very high levels of need

Trial findings…

- No impact of the DAWBA on any of the outcomes
- Possibly contributed to 3-6% increase in referrals being accepted
- 11% of sample received an emotional disorder diagnosis

How do we train future Child Psychiatrist to meet this demand?

- Current emphasis is largely on training skilled clinicians
- Skills needed to improve Productivity ?
  - Consultation skills
  - Hold risks in multi-system context
  - Taking leadership to develop and deliver care in other sectors/ services
  - More exposure to service development
  - Engaging with professional networks and commissioners
  - Health Promotion—how to meet the needs of those not open to CAMHS
- Does Current Assessment framework enable us to assess such skill development ?

Acknowledgements

- This research was funded by the NIHR Health Technology Assessment (ref 16/96/09). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the DHSC.

- Thank you to the parent/carers, children and young people participating in the trial

- Site Researchers & Clinicians

- Independent members of the trial steering committee and data monitoring committee

- Trial Sponsor, Nottinghamshire Healthcare NHS Foundation Trust

STADIA Team

Kapil Sayal
Chief Investigator

Tamsin Marshall
Berkshire PI

Anupam Bhardwaj
Cambridgeshire PI

Julia Gledhill
London PI

Bernadka Dubicka
Pennine PI

Helen Bould
Gloucestershire PI

Asifa Zainab
Surrey PI

Mike Seneviratne
RDaSH PI

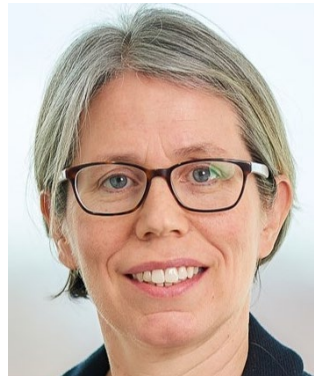
Alan Montgomery
Senior Statistician

Marilyn James
Health Economist

Colleen Ewart
Co-PPI Lead

Kirsty Sprange
Assistant Prof

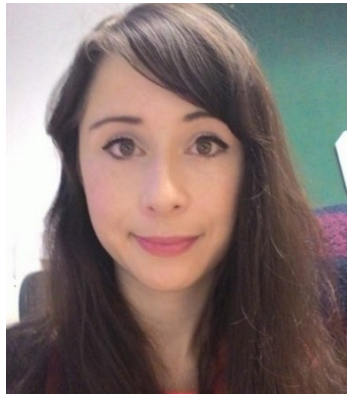
Alex Lang
Co-PPI lead



Louise Thomson
Qualitative lead

STADIA Team

Clare Upton
Senior Trial Manager



Laura Wyatt
Trial Manager

Sebastian Moody
Trial Coordinator

Chris Partlett
Senior Statistician

Grace Holt
Statistician

Matt Keane
Health Economist

Data management
Stella Tarr, Senor Data Manager
Lisa Evans, Data Manager

Database programmers
Nina Clayton, Clinical Trials Database System Developer
Nick Hilken, Senior Systems Manager

Health Economics
Ed Cox, Senior Health Economist

Institute of Mental Health
Kristina Newman, Qualitative Researcher
Ellen Bradley, Research Assistant

STADIA Team: site researchers

Paula Brown
Nottinghamshire

Becky Coales
Nottinghamshire

Matea Svigac
Nottinghamshire

Raj Shokkar
Berkshire

Joe Gilbert
London

Lucy Carr
Pennine

Amber Takle-Webb
Gloucestershire

Maria Del Piccolo
Surrey

Nottinghamshire
- Lydia Wigginton
- Rhianne Bostock
- Angela Holland
- Cate Jeynes
- Sandra Simpson
- Abby Campbell

Berkshire
- Sammy Morris

Cambridgeshire
- Emma Tudor
- Sophia Khas

Central North West London
- Julia Marcinkowska

Gloucestershire
- Sue Laishley

Rotherham, Doncaster & South Humber
- Mark Shakespeare

Papers

The Journal of Child Psychology and Psychiatry

Journal of Child Psychology and Psychiatry **:* (2025), pp **–** doi:10.1111/jcpp.14090

The clinical and cost effectiveness of a STAndardised DIagnostic Assessment for children and adolescents with emotional difficulties: the STADIA multi-centre randomised controlled trial

Kapil Sayal,[1,2] Laura Wyatt,[3] Christopher Partlett,[3] Colleen Ewart,[4] Anupam Bhardwaj,[1,5,6] Bernadka Dubicka,[7,8,9,10] Tamsin Marshall,[11] Julia Gledhill,[12] Alexandra Lang,[13] Kirsty Sprange,[3] Louise Thomson,[1,2] Sebastian Moody,[3] Grace Holt,[3] Helen Bould,[14,15,16] Clare Upton,[3] Matthew Keane,[3] Edward Cox,[3] Marilyn James,[3] and Alan Montgomery[3]

European Child & Adolescent Psychiatry (2023) 32:2657–2666
https://doi.org/10.1007/s00787-022-02115-2

ORIGINAL CONTRIBUTION

Mental health in clinically referred children and young people before and during the Covid-19 pandemic

Kapil Sayal[1,2] · Christopher Partlett[1] · Anupam Bhardwaj[3] · Bernadka Dubicka[4] · Tamsin Marshall[5] · Julia Gledhill[6] · Colleen Ewart[1,2] · Marilyn James[1] · Alexandra Lang[7] · Kirsty Sprange[1] · Alan Montgomery[1]

European Child & Adolescent Psychiatry
https://doi.org/10.1007/s00787-025-02678-w

RESEARCH

Barriers and facilitators to using standardised diagnostic assessments in child and adolescent mental health services: a qualitative process evaluation of the STADIA trial

Louise Thomson[1,2] · Kristina Newman[2,3] · Colleen Ewart[2] · Anupam Bhardwaj[4] · Bernadka Dubicka[5,6] · Tamsin Marshall[7] · Julia Gledhill[8] · Alexandra Lang[1] · Kirsty Sprange[1] · Kapil Sayal[1,2]

SSM - Mental Health 6 (2024) 100343

Contents lists available at ScienceDirect

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journal homepage: www.journals.elsevier.com/ssm-mental-health

Snakes and Ladders: The experience of being referred to and seen by Child and Adolescent Mental Health Services

Kristina L. Newman [a,b,c,1], Kapil Sayal [d,a], Colleen Ewart [e], Alexandra Lang [f], Anupam Bhardwaj [g], Bernadka Dubicka [h,i], Tamsin Marshall [j], Louise Thomson [d,*]

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Papers

The Journal of Child Psychology and Psychiatry

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stadia@nottingham.ac.uk

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Leadership, innovation and sustainability in Child Psychiatry: a view from East Lancashire

Dr. Dush Mahadevan
Consultant in Child & Adolescent Psychiatry
Deputy Chief Medical Officer
Lancashire & South Cumbria Foundation Trust

East Lancashire?

Outline

- Contexts
- What do our roles look like – now and in the future?

- Personal
- Examples of work done in Lancashire

- As a new Consultant
- Overview and outputs of a service development (Primary Care MH team)
- Integration of roles with service delivery (ELCAS)

- Snapshot of recent activity

Background

- ELCAS
- ‘Pennine Lancashire’
- 566,000 (13 PCNs)

- Started 2016
- ELHT (acute) - CD
- Transferred to LSCFT in 2024 – Deputy CMO

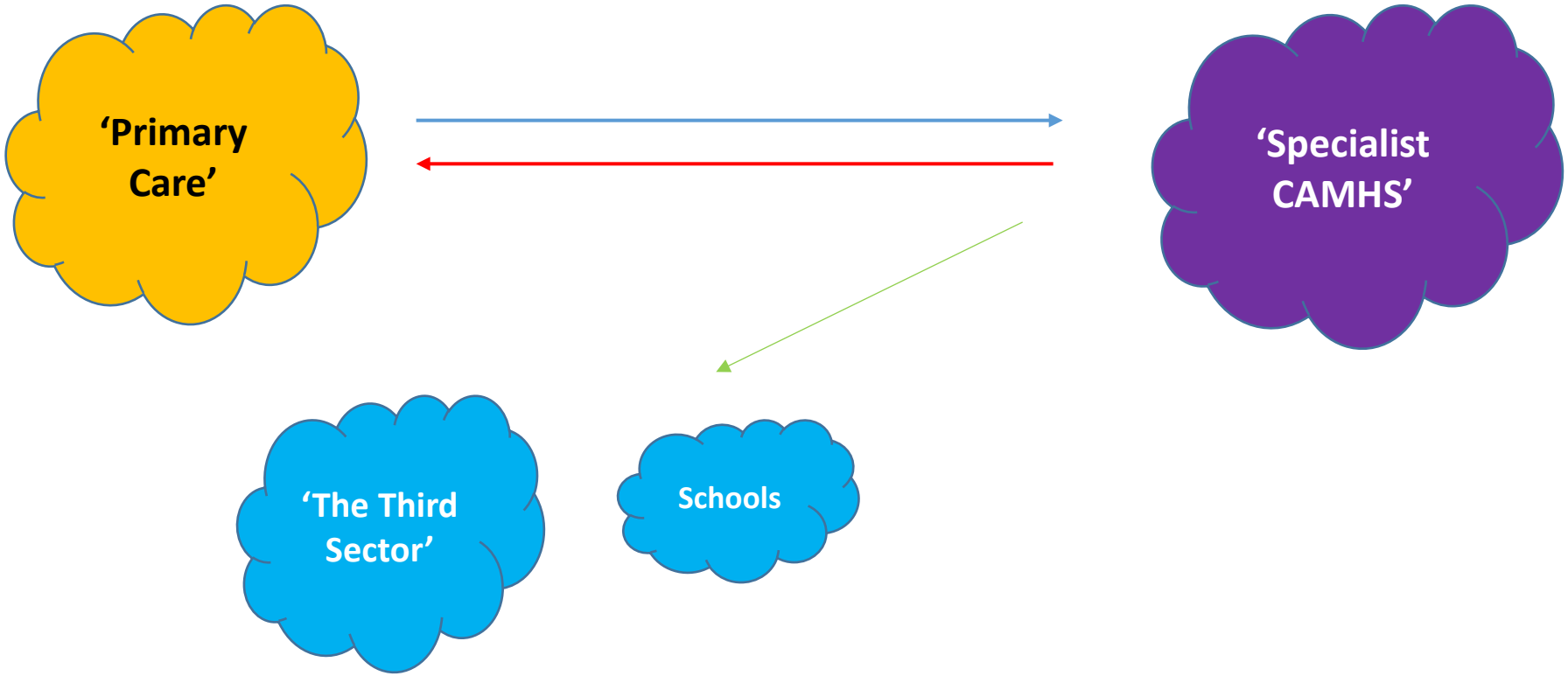
The Consultant job at ELCAS (from 2016)

- Consultant-led community teams (Tier 3)
- Responsible for overall delivery and development
- Explicit focus on quality (QNCC)

- Core job – Consultant lead for Tier 3 team
- Scope for special interest (80/20)

- Interview – primary care integration
- Pilot funding with commissioners
- IAPT co-lead

The Gap (2016)



Primary Mental Health Worker (PMHW) roles

- Based in GP practices

- Training
- Consultation and advice to professionals across the PCN
- Assessment and brief intervention where indicated

- 50/50 job plans
- All PMHWs link as MDT in specialist CAMHS

Assessment, Consultation and Brief Intervention (ACBI)

Developed by Dr. Leo Kroll and Dr. John Stancombe in the North West of England

www.acbi.me.uk/lms/

- Person-centred model of consultation
- Brief case management delivered by experienced clinicians
- Clinical care typically delivered in up to 3 sessions (model formerly known as 2&1)

- 'Getting Advice'

  "at least a proportion of this group find relatively few contacts, even one single contact, enough to normalise their behaviour, reassure families that they are doing the right things to resolve the problem without the need for extra help and to signpost sources of support"

Thrive Elaborated; second edition (Wolpert et al 2016)

ACBI in practice

- Assess children in base practices when appropriate, and from across PCN following consultation

- PMHWs have flexibility to deliver targeted care in their PCNs
  - referral criteria based on nation T2/3 spec
  - structured operational model

- Added value?
  - less severe difficulties
  - when it is unclear whether there is a role for specialist CAMHS
  - or whether this is is wanted by children and families

Developing the team

- Demonstrated acceptability and impact in evaluation (UCLAN)
- Link to CAMHS Transformation

- 10 PMHWS
- Band 6/7 practitioners with a range of skills
- GP Specialty Trainee
- 2 Parent training practitioners
- Pilot CYP Wellbeing Practitioner (ARRS)
- Virtual MDT with Psychiatry (c1PA)

- Drop-in clinics
- Personal Health Budgets (NHSE pilot)
- Engagement with neighbourhood developments (at multiple levels)

NHS England » Guidance on neighbourhood multidisciplinary teams for children and young people

The ELCAS Primary Care team (2023)

Impact

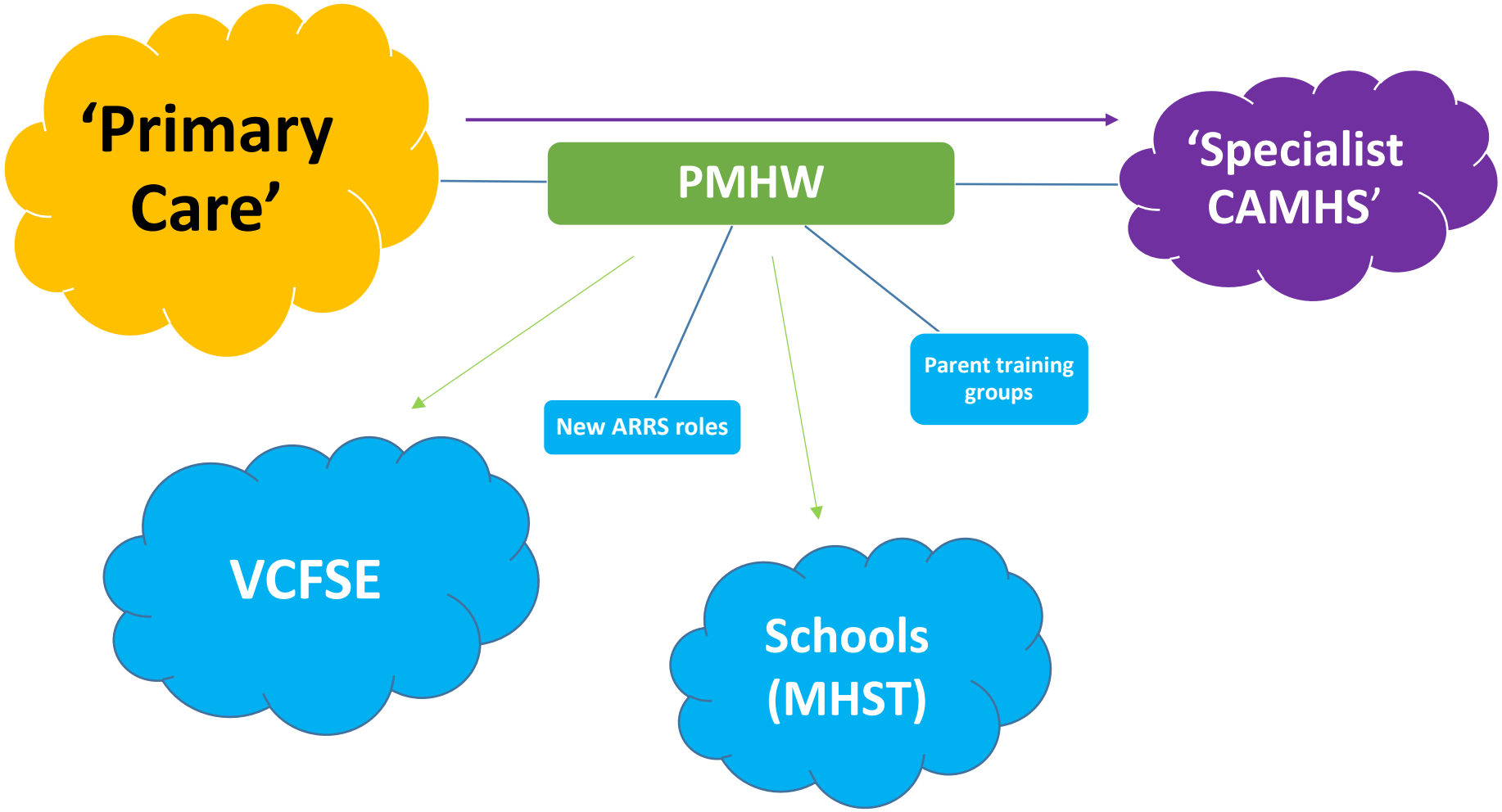
- Outcomes from ACBI
  - Service evaluation poster – at this conference! (Dr. Anjuli Clough, GPST)
  - 80% do not require referral to 'core CAMHS'
  - Patient outcomes from ACBI comparable with those in core CAMHS (though differences in patient population)

- Access
  - Statistically significant increases in referral and acceptance rate in host practice
  - Referral rate sustained during Covid-19 pandemic (marked contrast to comparator)

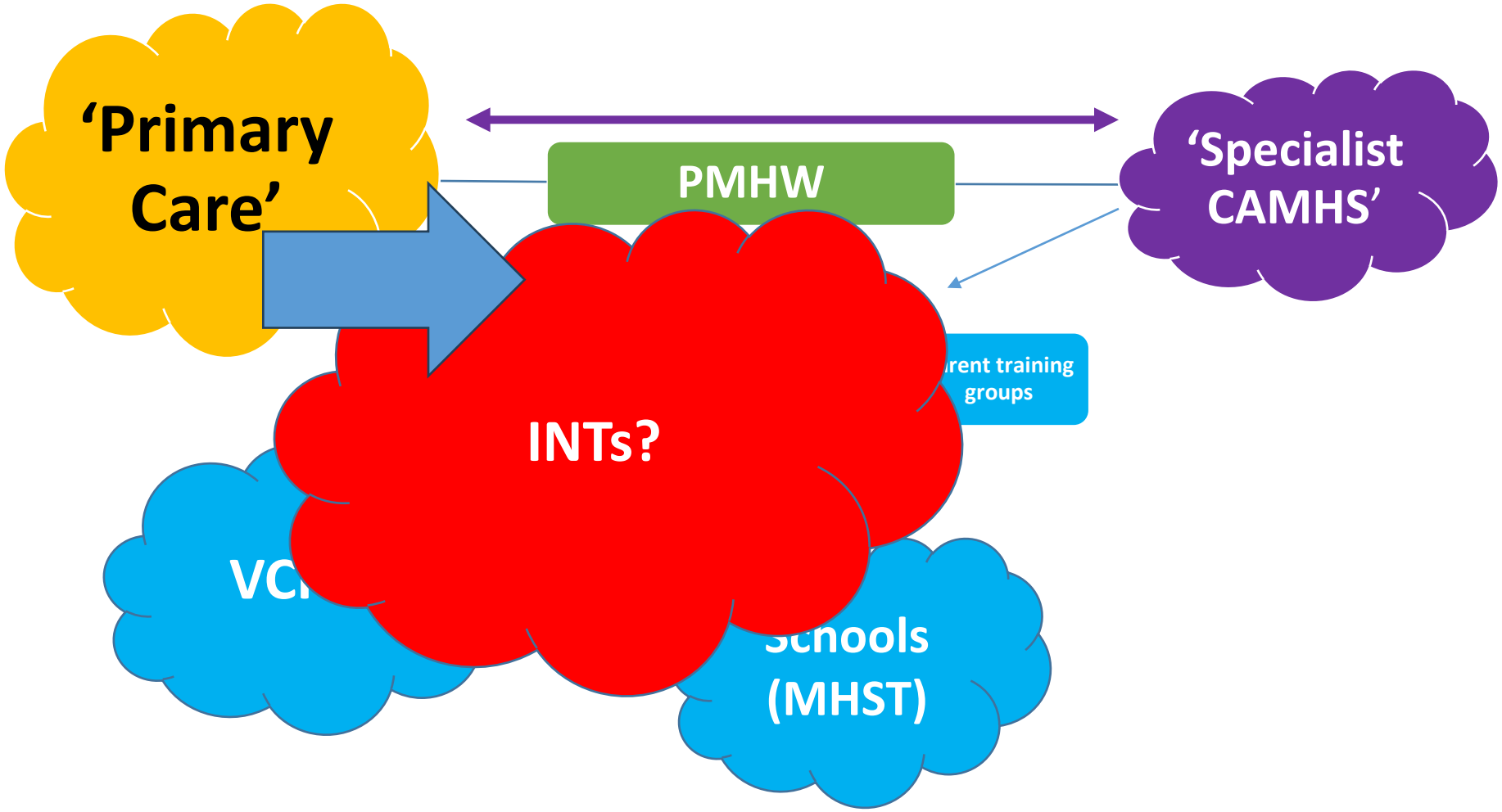
- Evaluation of service user experience (with UCLAN, Healthwatch, National Children's Bureau)

GP perceptions of community-based children's mental health services in Pennine Lancashire: a qualitative study
AK Lambert, AJ Doherty, N Wilson, U Chauhan and D Mahadevan (BJGP Open 2020)

A Bridge (2023)



A Bridge (2026?)



ELCAS development 2017 - 2025

- QNCC and CQC
- Maintaining integration (medical leadership)
- Outcomes-orientation (CORC)
- Service expansion (MHST and RAIS)

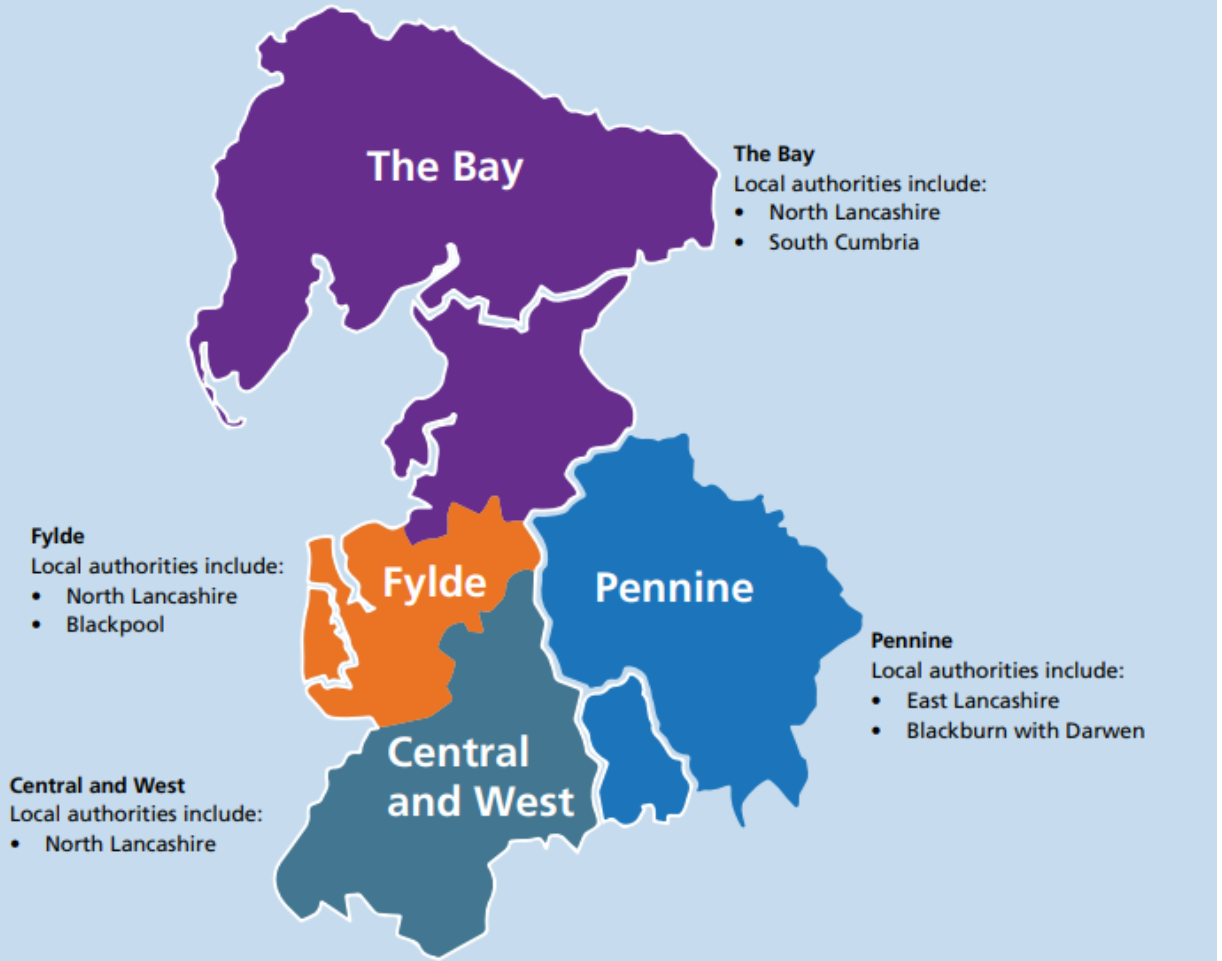
- Development of training offer (from 2 to 7 residents)
- Consultant recruitment and strong retention (from 4 to 10 Consultants)

- Managing transfer
- Regional transformation and new roles
- GIRFT

LSCft Overview

NHS
Lancashire &
South Cumbria
NHS Foundation Trust

The area we serve



The Bay
Local authorities include:
- North Lancashire
- South Cumbria

Fylde
Local authorities include:
- North Lancashire
- Blackpool

Pennine
Local authorities include:
- East Lancashire
- Blackburn with Darwen

Central and West
Local authorities include:
- North Lancashire

We are LSCft

Key aspects

- Clarity of vision
- Robust and cohesive leadership
- Horizon-scanning and orientation to external standards
- Job planning (inc. service level) with clear objectives
- Evaluation of outputs

- Team as the unit of delivery
- Psychiatrists as leaders
- Outcomes orientation

Challenges – and rewards

- Being (part of) ‘the management’
  - Strategic and operational management tasks
  - Managing change (anxiety)
  - Working with system (opportunity – and frustration!)
- Influencing at multiple levels

- Balance of work (flexible)
- Deployment and development of skills (e.g. systemic and relational)
- Agency and purpose
- Energy through innovation

Snapshots of recent work

- W/c 8th September 2025….

- 1PA for CYP MH Transformation
- Flexibility in Deputy CMO role (though overstretched!)

Lancaster University

A new system connection…from a conversation

Outputs:

Specific projects
Developing infrastructure
Research/clinical engagement – ongoing planning
University Hospitals

Medical leads (locality/system)
Development of clinical academic post (Fylde)

Fleetwood

King's Fund
Listening to communities
Translation (INTs)

Child Psychiatry input (pilot)
Data-sharing

The Valley Leadership Academy

The school

School select families
GP-led cookery class

Health promotion, engagement, case identification

Support – clinical, research

Consultant and PMHW service delivery in schools

"There can be multiple hurdles in delivering health interventions to a population like this….
the more hurdles I have come across, the more I know I need to be at that school"

Dr. Emma Gladwinfield, GP

Developing leaders

- RCPsych Leadership and Management Fellowship
- Trust Fellowships
- Residents (STs, SAS)

- Values-based approaches
  - Psychiatrists as leaders in LSCft
  - Integration in MDT
  - Focus on patient outcomes

Conclusions

- Feasible – conventional?
- Led by a small group at a service level (influencing at others)
- Consistency over time (adapt to system requirements)
- Alignment of values and cohesion key

- Roles stimulate and reward as befit our training
- Can support recruitment, retention and professional development
- Can support the delivery of innovative and high quality services

Questions for us to consider and discuss

- Is the current working model for CAP's sustainable?
- Is there a need for radical transformation of CAPs' practice to meet the actual and predicted population need?
- If we work differently, will this help or hinder recruitment and retention?
- How can we develop new working practices which are sustainable, avoid burnout and further workforce losses?
- What are the barriers to change? For example regulatory framework, zero suicide, requirements for safe prescribing etc.

How do we train future Child Psychiatrist to meet this demand?

- Current emphasis is largely on training skilled clinicians
- Skills needed to improve Productivity ?
  - Consultation skills
  - Hold risks in multi-system context
  - Taking leadership to develop and deliver care in other sectors/ services
  - More exposure to service development
  - Engaging with professional networks and commissioners
  - Health Promotion—how to meet the needs of those not open to CAMHS
- Does Current Assessment framework enable us to assess such skill development ?