CAMHS Clinical Care Pathways

Psychosis Pathway

Dr Guy Northover
and Alun Lewis

Patient's Story

Video of Harriet

Problem Statement

The Berkshire Health Care CAMH service has long waiting times, a low level of clinical contacts, low staff morale and high turnover.

There is no consistent use of outcome metrics or understanding of the clinical offer for a specific formulation resulting in little understanding of service demands or efficacy.

However: this is not just a local problem but a national one to.

National Picture

EIP teams don't support to YP with psychosis presenting before age of 14

EIP teams have Little understanding or support for ARMS in CYP

Psychosis admissions account for 24% of all admissions to CYPMH units

No consistent approach to delivery of care

No consistent approach to delivery of care

Q5. Select the option that best describes the main model of provision for children and young people (CYP) with first episode psychosis (under 18) in your locality.

In 2020/21 teams were able to select multiple models so total percentage may be >100%. However in 2021/22 audit this was restricted to one model.

	2021/22 (n=151) % (n)	2021/22 (n=150) % (n)
Specialist CYP EIP practitioners embedded within CYP mental health services	5% (7)	10% (15)
Specialist CYP EIP team	6% (9)	6% (9)
Adult and young people's EIP service with staff that have expertise in CYP mental health	25% (37)	34% (51)
Adult EIP service with joint protocols with CYP mental health services	45% (68)	52% (78)
Other	16% (24)	11% (16)
No EIP team CYP provision for under 18 years	4% (6)	3% (5)

The National Picture NCAP audit
for CYP:

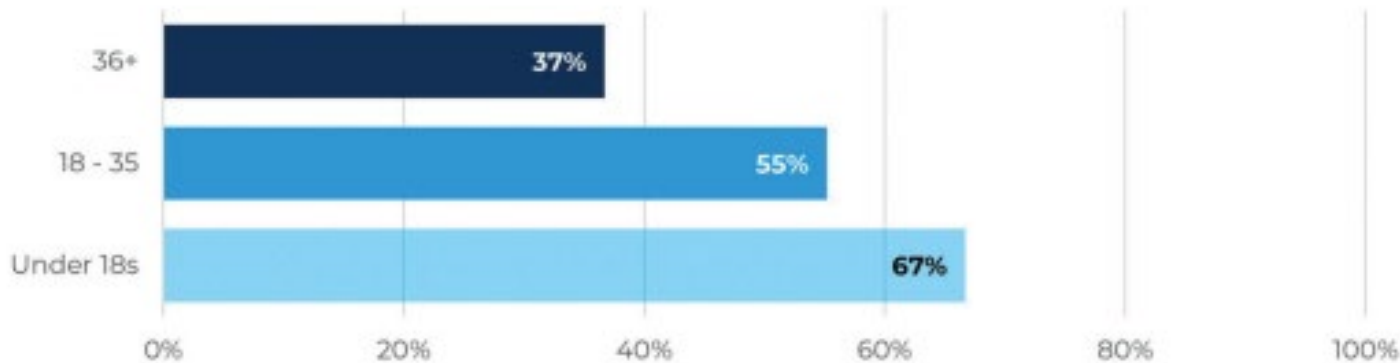|				
Offer of clozapine better than in adults by 13%	**Take up of carer education and support programmes (7%)**	**Physical health monitoring (+16%)**	**Physical health interventions (+12%)**	**Outcome measures (+13%)**
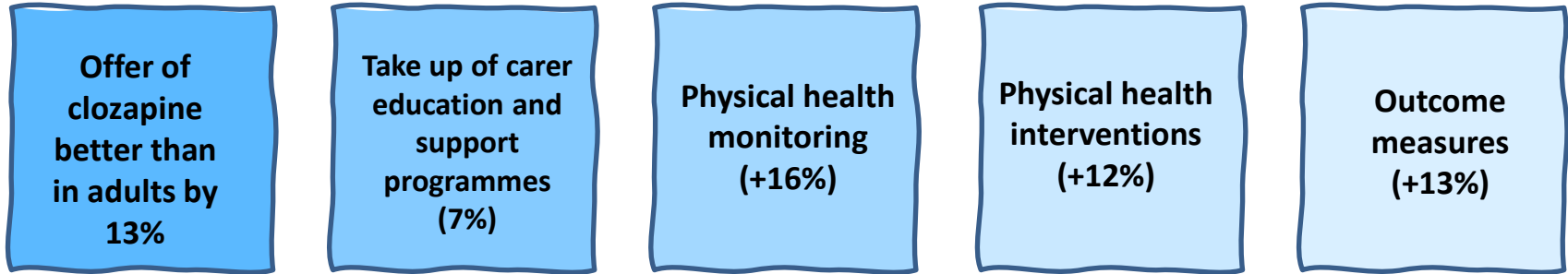
Figure 27. proportion of people in different age groups that were offered Clozapine after 2 unsuccessful trials of other antipsychotic medication (n = 1058)

Average CYP caseload for psychosis 2021

Q15. Total caseload by age ranges
Mean (range)

Under 14

FEP	<1 (0-5)	<1 (0-1)
ARMS for psychosis	<1 (0-1)	<1 (0-2)
Suspected FEP	<1 (0-2)	<1 (0-1)

14-17

FEP	4 (0-20)	5 (0-23)
ARMS for psychosis	1 (0-23)	1 (0-11)
Suspected FEP	1 (0-22)	1 (0-11)

18-35

Medication

Q8. How is medication managed for CYP?

In 2020/21 teams were able to select multiple options so the total percentage may be >100% however in 2021/22 audit this was restricted to one model.

	2021/22 (n=151) % (n)	2021/22 (n=150) % (n)
CYP team prescribers with specific EIP training and experience prescribe for CYP	34% (52)	37% (55)
CYP team prescribers advise and support EIP team prescribing for CYP	13% (19)	27% (40)
CYP team prescribers do not have specific EIP prescribing training and experience and do not have a protocol or routine access to specialist EIP prescribing advice	11% (17)	16% (24)
EIP team prescribers with specific CYP training and experience prescribe for CYP	8% (12)	24% (36)
EIP team prescribers advise and support CYPMH team prescribing for CYP	24% (36)	39% (59)
EIP team prescribers do not have specific CYP prescribing training and experience and do not have a protocol or routine access to specialist CYP prescribing advice	10% (15)	9% (13)

Available Provisions

Q9. Are the following provisions from appropriately trained practitioners available for CYP, aged 14-17 years, with early onset psychosis and who provides it?

Total percentage may be >100% due to some teams having multiple provisions

Cognitive behavioural therapy for psychosis (CBTp)

Provided by CYP MH team	25% (37)	25% (37)
Provided by EIP team	79% (120)	81% (121)
Provided by CMHT	0% (0)	0% (0)
Provided by Other	0% (0)	0% (0)
No CYP EIP provision	4% (6)	2% (3)

Family Intervention (FI)

Provided by CYP MH team	30% (46)	35% (52)
Provided by EIP team	79% (120)	81% (122)
Provided by CMHT	0% (0)	0% (0)
Provided by Other	1% (1)	0% (0)
No CYP EIP provision	2% (3)	<1% (1)

Equality and Diversity

People who identified as black were:

| less likely to receive all seven physical health screenings | to have two or more outcome measurements recorded |
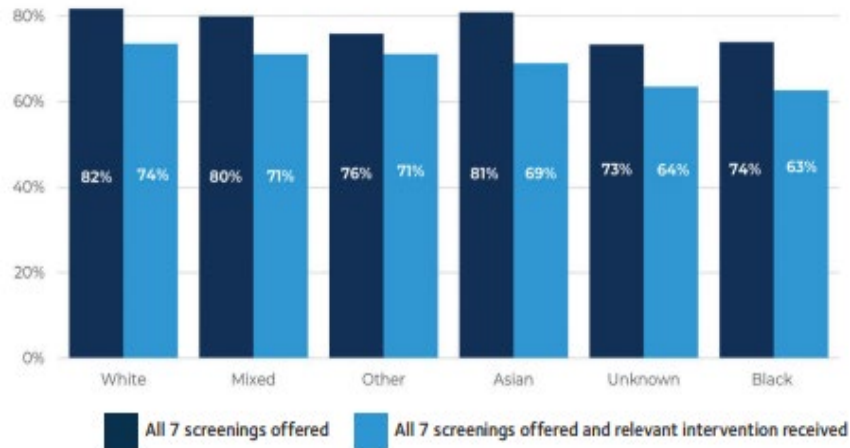
Figure 31. proportion of people with FEP from different ethnic backgrounds that received all 7 physical health screenings (n=10,557) and were subsequently offered the required intervention (n=10,557)
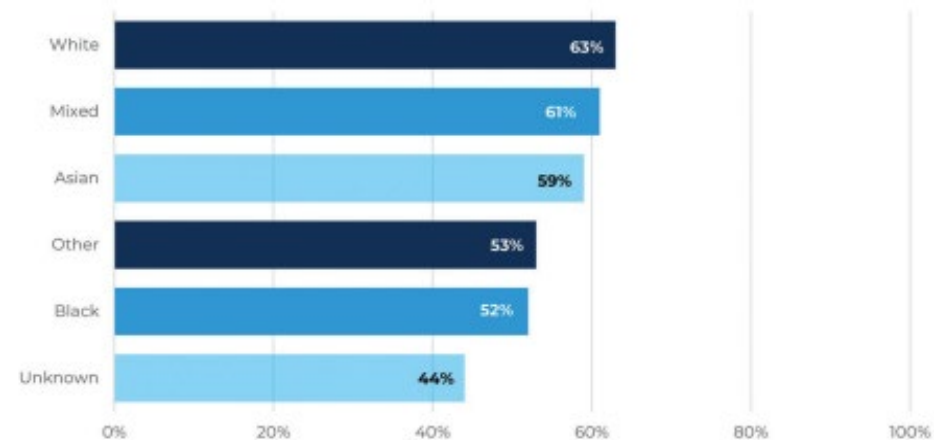
Figure 32. Proportion of people with FEP from different ethnic backgrounds that had 2 or more outcome measurements recorded more than once (n=10,557)

Developing Pathway

- Review of relevant guidance

- Focus on crisis and acute care

- Cross organisational/service line pathway

- Stakeholder consultation

- Identification of clear data points (flow)

Guidelines

- NICE CG 155

- NICE QS 102

- RCPsych QS for EIP 2nd Edn

- CQC-Physical Healthcare in Mental Health Settings

- National Clinical Audit of Psychosis

- NHSE AWT EIP Guidance update (2020)
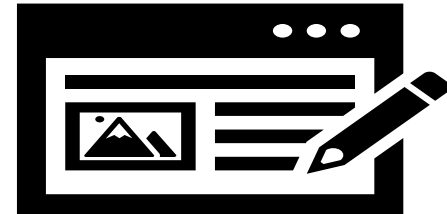
Stakeholder consultation

- NCAP clinical reference group

- NHSE policy teams

- NHSE specialist commissioning teams

- Learning disability and autism teams
  - Main feedback has been to include ARMS within pathway and more focus on discharge/transition (work ongoing!)

Psychosis in Children and Young People

Mental Health - Children and Young People

GIRFT — GETTING IT RIGHT FIRST TIME

Co-badging body logo

Initial referral

- Probable psychosis referral received at CAMHS
- Triage referrals in a timely manner (5)
- Face to face assessment, assessment of symptoms of psychosis, assessment of physical state
- Psychosis pathway suitable?
  - No → Discharge/signpost
  - Yes →
    - Requiring routine support
    - Requiring crisis support
    - Requiring inpatient support

Routine management

- Specialist assessment (1)
- Holistic assessment
- Psychosis pathway suitable?
  - No → Discharge/signpost to ARMS
  - Yes →
    - Start treatment within a timely manner
    - Medication management (2) → Number/types of antipsychotics tried → Clozapine initiation
      - Clozapine standards (1, 5)
    - Family intervention (2, 5)
    - Appropriate psychological therapy (2, 5)
    - Allocation of care coordinator
    - Carry out investigations to exclude organic cause
    - Physical health monitoring and interventions (2, 3, 5)
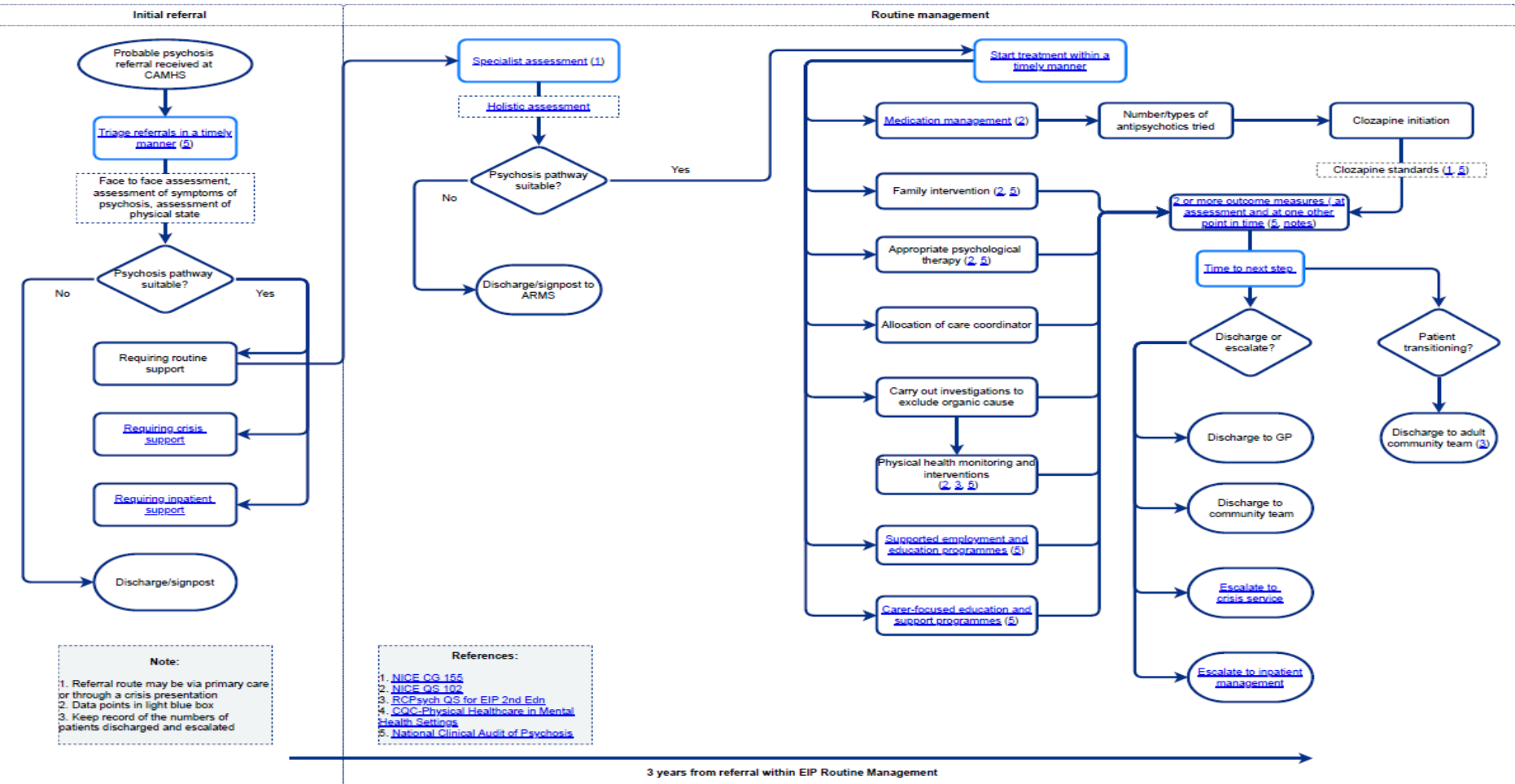   - Supported employment and education programmes (5)
    - Carer-focused education and support programmes (5)

- 2 or more outcome measures (at assessment and at one other point in time (5, notes)
- Time to next step
  - Discharge or escalate?
    - Discharge to GP
    - Discharge to community team
    - Escalate to crisis service
    - Escalate to inpatient management
  - Patient transitioning?
    - Discharge to adult community team (3)

3 years from referral within EIP Routine Management

Note:
1. Referral route may be via primary care or through a crisis presentation
2. Data points in light blue box
3. Keep record of the numbers of patients discharged and escalated

References:
1. NICE CG 155
2. NICE QS 102
3. RCPsych QS for EIP 2nd Edn
4. CQC-Physical Healthcare in Mental Health Settings
5. National Clinical Audit of Psychosis

Psychosis in Children and Young People

Mental Health - Children and Young People

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Crisis service management

Referral from EIP service

- Yes
- No

Best practice points:
- Good liaison with EIP team regards concerns
- Develop crisis plan
- EIP care coordinator to maintain care coordination responsibility

Specialist assessment within 4 hours

Carry out investigations to exclude organic cause

Medication review within 72 hours

Best practice point:
Confirm diagnosis (Liaise with EIP specialist)

Best practice points for OUTREACH to include:
- Medication monitoring
- Risk management plan with family
- Social care engagement
- Family intervention (2, 5)
- Risk monitoring
- Daily engagement with daily activities
- Additional medication
- Discharge to home treatment team - if suitable

Initiate medication

Time to next step

Apply crisis service standards

Discharge or escalate?

Discharge to EIP Team

Escalate to inpatient management

Note:
1. Data points in light blue box
2. Keep a record of the numbers of patients discharged and escalated

Inpatient management

Referral from EIP service

- Yes
- No

Best practice points:
- Good liaison with EIP team regards concerns
- EIP care coordinator to maintain care coordination responsibility

Specialist assessment within 4 hours

Carry out investigations to exclude organic cause

Medication review within 72 hours

Best practice point:
Confirm diagnosis (Liaise with EIP specialist)

Best practice points:
- Implementation of effective inpatient treatment including Clozapine standards
- Appropriate psychological therapy (2, 5)
- Family intervention (2, 5)
- Exclusion of organic causes

Carry out physical health investigations (4)

Patient accepted under EIP service?
- Yes
- No

Allocation of care coordinator

Time to next step

Discharge to EIP Team

Discharge?

Discharge to crisis service

Discharge/signpost

Standards:
1. Mental health act
2. Capacity assessment
3. Distance from home
4. Restrictive interventions

Psychosis in Children and Young People

Mental Health - Children and Young People

To be read in conjunction with GIRFT Children and Young People's Mental Health Services report and guidance indicated in the pathway

Co-badging body logo

Routine management

Specialist assessment must be carried out within 14 days of receiving referral

Collect data on percentage of patients **starting treatment and time taken to start treatment**

Offer **Clozapine** where 2 antipsychotics have proven ineffective

Psychological therapy to be offered in conjunction with antipsychotic medication, and family intervention

To **exclude organic causes**, all appropriate investigations should be carried out including those for autoimmune encephalopathies, brain injury, systemic physical injury or other clinical condition known to cause schizophrenia type presentations

Physical health to be monitored at least once a year

Time to next step
Collect data on time in service to monitor how long patients remain within the service

2 or more outcome measures
Whilst the National Clinical Audit of Psychosis indicates 2 or more outcome measures from HoNOSCA, DIALOG, QPR are recorded, for the remit of this pathway any other relevant outcome measures would be appropriate

Crisis management

Collect data on time taken to **initiate medication**

Time to next step
Collect data on time in service to monitor how long patients remain within the service

24/7 age appropriate crisis provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions

To **exclude organic causes**, all appropriate investigations should be carried out including those for autoimmune encephalopathies, brain injury, systemic physical injury or other clinical condition known to cause schizophrenia type presentations

Inpatient management

Time to next step
Collect data on time in service to monitor how long patients remain within the service

To **exclude organic causes**, all appropriate investigations should be carried out including those for autoimmune encephalopathies, brain injury, systemic physical injury or other clinical condition known to cause schizophrenia type presentations

Discharge standards

Service users who are **discharged from hospital** to the care of the early intervention in psychosis service are followed up within one week of discharge, or within 48 hours of discharge if they are at risk

Upon transfer of care or discharge, the service provides the service user's GP and the accepting service (if relevant) with the following information about the service user:

- Summary of history
- Diagnosis and personal formulation
- Medication or psychological therapies undertaken, and advice on future management
- Assessment of current safety
- Crisis plan including relapse signs

Transition standards

There is a clear protocol to minimise and effectively **manage transitions** of care for children and young people

There is **active collaboration** between Child and Adolescent Mental Health Services (CAMHS) and Working Age Adult Services for service users who are approaching the age for transfer between services. **This starts at least 6 months before the date of transfer**

If the service works with children and young people between the ages of 14-18 with first episode psychosis, they are able to support them for at least the duration of the full three years **avoiding premature transitioning to alternative services**

The A3

Title of Improvement Project/Problem Solving Item:

Team Members:

Step 1: Problem Statement:

Step 2: Current Situation:

Step 3: Vision/Goals:

Step 4: Analysis. Issues and Root Causes:

Step 5: Countermeasures:

Step 6: PDSA Cycles:

Step 7: Outcomes:
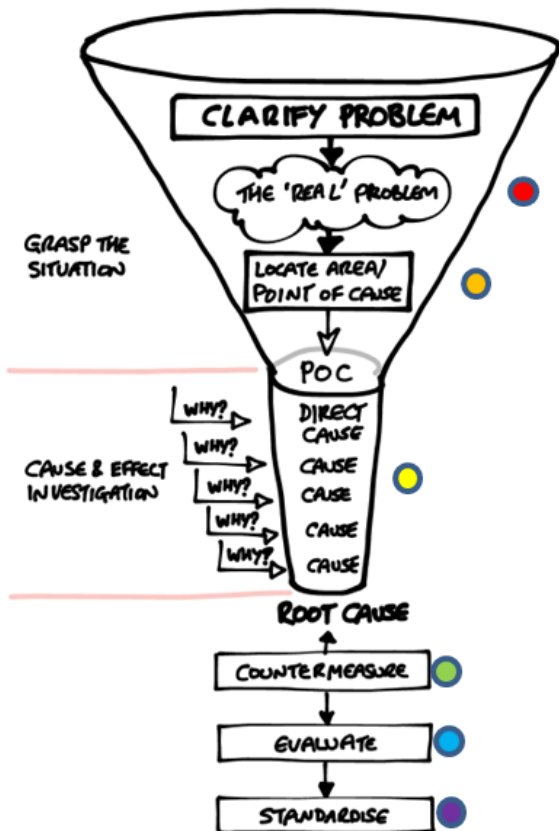
Step 8: Insights:

Go slow to go fast

Name refers to the minimum sized paper used to report the process.

A structured framework with methodology to support following a step-by-step **process** that helps ensure you **understand the problem** and **root causes** before jumping to a solution.
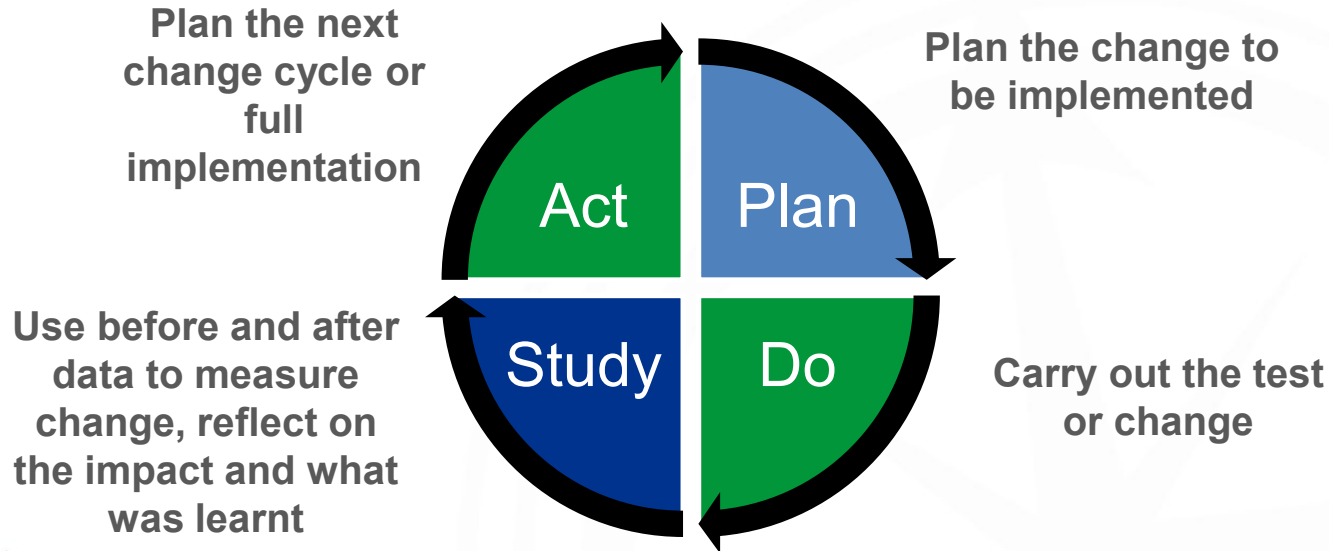
Part of our
Quality Improvement programme

A3 Thinking – inch wide, mile deep

Berkshire Healthcare
NHS Foundation Trust

Based On The PDSA Cycle

- Framework for developing, testing and implementing changes
- Test out changes on a small scale, building on the learning from these test cycles before full implementation

Plan the next change cycle or full implementation

Plan the change to be implemented

Use before and after data to measure change, reflect on the impact and what was learnt

Carry out the test or change

Act

Plan

Study

Do

Title of Improvement Project/Problem Solving Item:

CAMHS Pathways

Team Members: Bridget Gemal, Louise Noble, Karen Cridland, Jayne Reynolds, David Townsend, Fiona Carey, Tamsin Marshall, Hayley Clarke, Tracy Gilzene, Karen Watkins

Step 1: Problem Statement:

CAMHS has long waiting times, low recorded contact rates, low staff morale and high turn-over, and limited useable information on clinical efficacy and outcomes.

There is a lack of clarity regarding inclusion criteria, the clinical offer, structures and processes to support this and it's difficult for the leadership to effectively manage flow into and through CAMHS services; to understand or address capacity and skills needs; or to evidence the need for new investment .

Step 2: Current Situation:

A comprehensive review of performance, operational, and national benchmarking data, two workshops with staff, and a review of the CAMHS heatmap found a number of factors contributing to the problems above:

- Unclear commissioned remit; patient cohort, inclusion criteria and clinical offer.
- Variable processes within and between teams.
- All teams have difficulties in managing access, interfacing with other teams, feeling clinically competent and supported, and maintaining staff morale.
- Some areas are highly focused while others struggle to manage increasingly complex referrals and interfaces.
- Staff report that their time is focused on managing acute risk to the exclusion of preventative and recovery work.
- CAMHS CPE struggles with a high number of inappropriate referrals.
- The Specialist Teams find it particularly difficult to define their clinical offer and focus their provision.

A review of the numerous initiatives being undertaken by managers and staff in response to specific problems supports the view that the challenges do not originate in one aspect of the service and cannot be addressed by initiating change within one team or one process.

Step 3: Vision/Goals:

The overall vision for the programme is to enable CAMHS services to deliver high quality, effective clinical care in a timely and cost effective way to manage demand and provide positive outcomes for patients.

The goals of the CAMHS Pathways Project are to:

A) Gain a clear understanding of the commissioning remit.
B) Have an appropriate, evidence based and recovery focussed clinical offer (pathways) to meet the needs of the patients CAMHS is commissioned for.
C) Map how the clinical offer is provided and accessed
D) Define capacity, skill mix and support required to meet remit and demand.
E) Identify any gaps in delivery (evidence to support proposal for new investment if relevant)
F) Enable a seamless and effective patient experience through defined pathways
G) Systems (including electronic) are in place to understand the efficiency and effectiveness of the clinical provision in a way that can be utilised to improve care.

Step 4: Analysis and Root Causes:

Referrals to BHFT CAMHS are in line with the national mean, which has increased significantly since 2012/13. However, most other trusts include Tier 2 and 3 provision while BHFT is commissioned predominantly at Tier 3, hence all referrals should be severe and complex.

Waiting times to first appointment are near the national mean but there are long waits for treatment, which staff report are affected by patients who present with risk consuming significant capacity. The total CAMHS caseload and number of patients seen are average but workforce and number of contacts are in the lower quartile although each clinician carry an above average caseload.

It is evident from the analysis that the causes of the waiting times are multi-faceted, complex and inter-related as shown in the fishbone diagramme. Significant management time is committed to service projects to address these problems.

CAMHS Causes
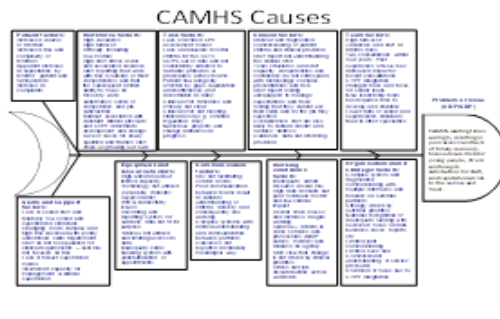
Step 6: Actions and Risks:

Workstream 1 – Clinical Pathways Specification

	By		Status	Start	End
Identify workstream leads and support requirements	BG	LN		01/03/2019	31/03/2019
Engage commissioners in process	BG/KW	KC/LN		14/05/2019	14/06/19
Carry out a detailed caseload review exercise with the whole SCT patient cohort	BG	LN		20/05/2019	30/08/19
Review commissioning remit and service specification	BG	LN/KC		01/06/2019	30/08/19
Review best practice pathways and national models to identify the clinical pathways	HC	LN		20/05/2019	01/08/19
Specify core clinical interventions	HC	TBC		01/07/2019	31/10/19
Clinical offer agreed	BG/HC	TBC		01/11/2019	20/01/20
Identify any supplementary clinical pathways	HC/BG	LN/KC		01/01/2020	28/02/20
Agree outcome measures for clinical pathways and report data on Tableau	TG	TBC		01/08/2019	01/03/20

Workstream 2 - Capacity, Process and Delivery Review

	By		Status	Start	End
Review current clinical pathways provision	HC/TG	TBC		01/09/2019	30/09/2019
Review and quantify demand	TG	TBC		01/09/2019	01/11/2019
Identify skill mix required to deliver the clinical pathways (skills gap analysis)	TBC	TBC		15/11/2019	31/01/2020
Review the delivery model to provide pathways	TBC	TBC		01/02/2020	31/03/2020
Review clinical supervision process and supervision model	TBC	TBC		01/05/2020	31/05/2020
Finalise, agree and commence the delivery model	TBC	TBC		01/05/2020	31/06/2020

Workstream 3 - Clinical Reporting Systems Development

	By		Status	Start	End
Review clinical systems and current reports	TG/BG	TBC		01/10/2019	15/11/2019
Review outcome measures currently in use	TG/BG	TBC		01/11/2019	15/11/2019
Confirm requirements for ePathways development	TBC	TBC		01/11/2019	30/11/2019
ePathways design & development	TBC	TG		01/12/2019	15/01/2019
ePathway testing and user training	TG / Informatics	TBC		16/01/2020	28/02/2019
ePathway live for new patients from 1st March	TG Transformation	TBC		01/03/2020	01/03/2020
Confirm Tableau reporting requirements and access levels	TG / Informatics	TBC		01/02/2020	01/03/2020
Build Tableau reporting suite	TG / Informatics	TBC		01/02/2020	01/03/2020
Review technology (SHaRON/Website/Skype online)	TBC	TBC		01/09/2019	31/03/2020

Title / Description	Current Status (RAG)	Mitigating actions	By when
Failure to engage and loss of support from key stakeholders, incl. Commissioners.		Stakeholder mapping and development of a stakeholder management plan. Regular communications with key stakeholders	July 19 and ongoing
Failure to communicate key messages effectively, leading to opposition and challenge, e.g. from service users, carers and families.		Teams will have Standard work around the dissemination of the key messages. Development of a communications plan	Sep 19
Insufficient Greenbelt and leadership capacity to lead on project elements		Greenbelt identified to lead project PMO resource will be allocated to support the project	July 19
Teams will vary in opportunities available to embark on the required transformation. Some teams may struggle to adhere to a standard timeline (in part due to the perceived impact on some roles)		Early engagement with localities to ascertain issues and pinch points within the project. Support for teams throughout the process.	Sep 19
Countermeasures do not improve flow and accuracy of signposting		Countermeasures will be redefined through the PDSA process and PDSA cycles repeated as required	Oct 19
Lack of coherence with other programmes / initiatives		Programme to be reported to the MH Development Group and Executive Business & Strategy Group. PMO mapping of projects and their interfaces. Regular review of the Strategic prioritisation and project boards.	Ongoing

Step 5: Future State and Counter Measures:

Concern	Cause	Countermeasure	Owner	Due Date	Status
The patient cohort, service criteria and scope, and system interfaces are poorly defined and fragmented.	The commissioning remit and local delivery framework is not explicitly defined or applied to provide clear, boundaried and shared expectations for delivery.	Review and clarify contractual arrangements and obligations and set these in context of national guidance and frameworks for CAMHS services (e.g. THRIVE) to identify patient cohort, service scope, and relevant interfaces.	BG/LN	Sep 19	
The clinical offer and timelines are not clearly understood and not meeting the needs of patients and staff.	There is a lack of NICE concordant service delivery specifications to guide clinical delivery.	Develop NICE concordant clinical pathways that are well defined and aligned with the commissioning remit.	BG/HC/LN	Dec 2019	
Patients and staff report poor experiences of CAMHS, with long waiting times, disjointed interfaces, and clinical capacity dedicated to managing risk and crisis at the expense of early and recovery focused intervention.	Capacity, skills mix, structures and processes may not facilitate efficient delivery of the appropriate clinical offer in a timely and seamless way.	Identify the capacity, skill mix and clinical support required to deliver the CAMHS pathways, and ensure structures, processes and interfaces enable efficient and seamless delivery of quality care.	TG/LN/KC	Jan 2020	
Systems are not developed to monitor and report clinical provision, patient progress and outcomes in a way that enables this data to inform service developments.	Skills / capacity has not been available to develop systems for the reporting of provision and outcomes.	Develop e-pathways, and outcomes reporting that is clinically meaningful and enable managers and clinicians to understand and act on the clinical outcomes associated with interventions and activity to improve services.	TG/LN	Jan 2020	

Status Key — Planned / Being implemented / Implemented / Reviewed

Step 7: Cost/Benefit :

To be completed

Step 8: Insights

To be completed following PDSAs to test counter measures.

What are we trying to achieve?

NHS
Berkshire Healthcare
Children, Young People and Families services

This project in and of itself, will not provide a 'quick fix' to the waiting list challenges, but it will enable more clarity about what should be offered, what skills and resources are needed, and what the gaps are between demand and capacity.

Achievements	Long Term Benefits
• **Collaboratively defined, evidence-based clinical pathways**	Reduced waiting times and improved patient outcomes (Harm free care)
• **High quality, timely clinical interventions to meet the needs of children, young people and their families**	Improved staff morale and role satisfaction (Supporting our staff)
• **Appropriately skilled CAMHS clinicians, resourced to manage complex presentations and high demand**	Quicker access to evidence based effective interventions – clinical pathways (Good patient experience)
• **Outcomes understood and utilised to create positive outcomes for patients**	Meaningful data to inform service development and improve patient flow (Money matters)
• **Improved experience for everyone in CAMHS**	

NHS Healthcare People and s services

Screen/ Triage

EIP screening tool - presenting difficulties and risk

Therapeutic Assessment

EIP Common Assessment Tool/substance use assessment, risk review, education needs, ROMS, goals and initial formulation

Ongoing Assessment

EIP Common Assessment Tool, engagement, multi-agency and family approach, psychoeducation, risk review, ROMS, identify first episode psychosis/mania/ARMS

Psychological Interventions

ARMS: psychoeducation, symptom focused CBT with/without Psychosocial Family Interventions, alongside continued assessment/review up to 6mths**

Engagement/core tasks

Care co-ordination, care plan, risk assessment and safety plan, clinical/MDT reviews, multi-agency and family working/reviews, psychoeducation, review of goals, symptom and side effect monitoring, relapse prevention plan, physical health monitoring

Outcome of assessment

Formulation, confirm diagnosis* and any co-morbidities, risk assessment, signposting or allocation to clinical pathway and care co-ordinator, Offer medical assessment (start treatment within two weeks)

Psychological Interventions

Psychosis: CBTp, Psychosocial Family Interventions, Art Psychotherapies (negative symptoms)
Mania: CBT, Psychosocial Family Interventions

Pharmacological Interventions

Mental state examination, psychoeducation, Lester Tool including weight management protocol when starting new antipsychotic, diagnosis, blood tests, GASS, review adherence, tolerance, efficacy

Reviews

ARMS assessment - up to 6 months
Confirmed psychosis/mania – offer pathway up to 3 years, with care plan/CPA/risk reviews/ROMS at least 6 monthly

Endings

Smooth transition back to primary care /other services once treatment is completed. ROMS, risk assessment, discharge letter and relapse prevention plan

Transitions

Review at 17-17.5 yrs if transition to adult mental health services is required and follow policy

Outcome Measures
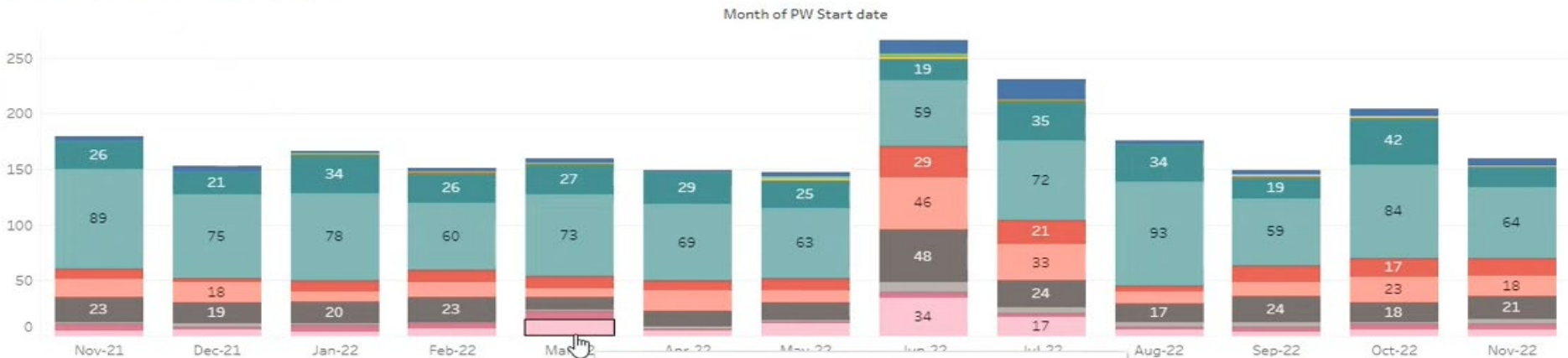
Current view, QPR, DIALOG, YMRS (bi-polar)

* Consider if MRI/EEG/autoantibodies required
** If ARMS – may also consider 'watch and wait' intervention

Pathways Started

- Psychosis In Recovery- Stable Psychosis (Cluster 11)
- CAMHS Anxiety Disorder
- CAMHS Autism
- CAMHS Eating Disorders
- CAMHS Emotional Dysregulation
- CAMHS First Episode Psychosis/Mania
- CAMHS Transition
- Clozapine Pathway
- Cognitive Impairment (Clusters 19/20/21)
- Memory Service (Clusters 18/19)
- Non Psychotic -Short term 12 month- (Cluster 4)
- Non Psychotic (Clusters 5,6,7)

Pathways Started Bar Graph

Month of PW Start date

PW Name: Psychosis In Treatment (Clusters 12/13)
Month of PW Start date: Mar-22
Number of Records: 14

Pathways Started Summary Table

PW Name	ExpectedDuration	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Grand Total
Memory Service (Clusters 18/19)	0m0H0D36M	89	75	78	60	73	69	63	59	72	93	59	84	64	938
Cognitive Impairment (Clusters 19/20/21)	0m0H0D36M	26	21	34	26	27	29	25	19	35	34	19	42	18	355
Non Psychotic-EUPD (Clusters 6,7,8)	0m0H0D36M	23	19	20	23	11	14	16	48	24	17	24	18	21	278
Non Psychotic (Clusters 5,6,7)	0m0H0D36M	16	18	9	13	8	18	11	46	33	11	12	23	18	236
Non Psychotic -Short term 12 month- (Cluster 4)	0m0H0D12M	10	4	10	12	11	9	11	29	21	6	16	17	16	172
Psychosis In Treatment (Clusters 12/13)	0m0H0D36M	5	6	4	7	14	5	11	34	17	6	6	6	6	125
Psychosis In Recovery- Stable Psychosis (Cluste...	0m0H0D24M	3	5	2	3	3	1	4	12	18	3	4	7	6	71
Psychosis - Early intervention (Cluster 10)	0m0H0D36M	6	3	6	5	9	2	2	6	4	3	5	5	5	61
Psychosis - Complex Needs (Cluster 16/17)	0m0H0D36M	1	2	1		1	2	1	8	5	3	3	1	4	32
CAMHS Transition	0m0H0D10M		1	1	1			1		2			1		7

Phases

Current Phases

Cluster 18/19 - Phase 1 Screening & Initial Assessment
870 Clients
34.8%

Cluster 19/20/21 - Phase 1 Screening and Initial Assessment
290 Clients
11.6%

Non Psychotic-EUPD (Clusters 6,7,8) Phase 1 - Assessment
262 Clients
10.5%

Non Psychotic (Clusters 5,6,7) - Phase 1 Screening and Initial Assessment
211 Clients
8.4%

Cluster 4 Phase 1 Screening & Initial Assessment
153 Clients
6.1%

Cluster 12/13 - Phase 1 Screening & Initial Assessment
124 Clients
5.0%

Cluster 18/19 - Phase 2 Treatment
102 Clients
4.1%

Intervention (Cluster 10) Phase 1
54 Clients

(Clusters 5,6,7) - Phase 2 Treatment

Complex Needs

Cluster 19/20/21 - Phase 2 Treatment
84 Clients
3.4%

Cluster 4 Phase 2 Ongoing

Early

Non

Non

Psychosis in Recovery- Stable Psychosis (Cluster 11) - Phase 1
72 Clients
2.9%

Phases Start Dates table

Name		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Grand Total
Cluster 18/19 - Phase 1 Screening & Initial Assessment		82	65	76	54	69	69	56	52	62	88	56	80	61	870
Cluster 19/20/21 - Phase 1 Screening and Initial Assessment		18	18	24	22	25	24	21	19	27	28	15	31	18	290
Non Psychotic-EUPD (Clusters 6,7,8) Phase 1 - Assessment		20	22	14	20	13	13	14	47	20	17	23	18	21	262
Non Psychotic (Clusters 5,6,7) - Phase 1 Screening and Initial Assessment		11	18	6	9	9	13	8	45	31	9	12	22	18	211
Cluster 4 Phase 1 Screening & Initial Assessment		10	4	8	8	7	7	10	28	20	4	13	17	17	153
Cluster 12/13 - Phase 1 Screening & Initial Assessment		4	12	3	6	13	5	10	34	16	6	4	5	6	124
Cluster 18/19 - Phase 2 Treatment		12	12	4	11	7	4	6	5	11	8	6	10	6	102
Cluster 19/20/21 - Phase 2 Treatment		7	4	5	3	6	5	8	2	3	7	7	17	10	84

What are our Operational challenges?

NHS Berkshire Healthcare
Children, Young People and Families services

Do we need to change service structure to implement the CCP's?

Do we have enough staff, with the right skills and expertise, to deliver the CCP's?

How do we help staff & system partners, hold and manage risk?

How do we implement the CCP's when we have such long waiting lists?

How do we keep staff communicated, engaged and implement change without destabilising our workforce?

How do we communicate and engage system partners/commissioners?

Interdependencies

- Service Specification Review

- Waiting List – Offer and Definitions

- Digital opportunities

- Training, Development and Workforce

- New Service lines/ Teams

Thank you

questions…