Report to Health Scrutiny & Policy Development Committee September 2012

Report of: Tim Furness- Associate Director of Business Planning and Partnerships

Subject: CAMHS waiting times and performance

Author of Report: Kate Laurance- Senior Commissioning Manager Children and Maternity NHS Sheffield

Summary:

Child and Adolescent Mental Health Services have been significantly redesigned between 2010 and 2012.

There has been a significant investment into specialised inpatient provision to meet national standards and ensure care is delivered closer to home for vulnerable young people. This means enhanced facilities for vulnerable groups and those with the most complex and significant needs.

There has been a decrease in investment into Tier 2 services (primary mental health services) and Tier 3 services community specialist services. This has required a redesign of community CAMHS to make the service more efficient.

There has also been a large increase in referrals during 2010/11 and this has significantly impacted upon waiting times for community services.

Work is still underway to reduce waiting times and improve access to and performance of community services.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	**V**
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	

The Scrutiny Committee is being asked to:
Review the progress and next steps planned to reduce waiting times within community CAMHS

Background Papers:

The Sheffield Emotional Wellbeing and Mental Health Strategy 2011-14 online at https://www.sheffield0to19.org.uk/professionals/ewbmh.html

Interim Budget Report 2010/2011 Report to Cabinet
http://meetings.sheffield.gov.uk/council-meetings/cabinet/agendas-2010/agenda-26-july-2010#download

Report to Healthier Communities & Adult Social Care Scrutiny Committee
20th February 2012

Category of Report: OPEN

Child and Adolescent Mental Health Service (CAMHS) Performance and waiting times

1. Performance Management of Tier Four CAMHS

1.1 Highly specialised inpatient CAMHS provision is performance managed by the Specialised Commissioning Group with support from NHS Sheffield.

1.2 The providers report monthly on activity, length of stay, presenting conditions/diagnosis, referrals not accepted as well as details of the profile of patients admitted.

1.3 By taking a regional approach to performance management, it is hoped that a more consist approach can be applied between providers and standards will become consistent across inpatient provision nationally.

2. Performance Management of Specialist Community CAMHS

2.1 Specialist Community CAMHS is performance managed jointly between NHS Sheffield and Sheffield City Council, through a series of monthly, quarterly and annual reporting. The analytical services team at Sheffield City Council map trends and changes in the activity and commissioners in NHS Sheffield and Sheffield City Council meet quarterly with CAMHS management and clinicians to discuss fluctuations in performance. The aim is to ensure access to services remains consistent particularly for vulnerable groups, reduce waiting times to a minimum but improve performance so all teams are working towards operating within 18 weeks. The framework also enables continued needs assessment to be undertaken by developing a profile of presenting problems and ethnicity range etc.

2.2 A performance reporting framework has been jointly agreed between NHS Sheffield, Sheffield City Council, and Sheffield Children's NHS Foundation Trust the schedule includes the following: -

a) Monthly reporting on

- Referrals accepted - numbers
  - source
  - number rejected
- Waiting times
- Waits over 18 weeks
- Primary Health Care Worker – activity in Tier 2
- Number of training sessions offered

b) Quarterly reporting on

- Team composition
- 24/7 crisis response
- Open Cases by age, gender, and ethnicity
- Number of open cases receiving regular treatment –

(a snapshot report of the number of open cases which had an appointment on average every 6 weeks)

- New to follow-up ratio
- Number of cases receiving brief treatment (i.e. 8 sessions)

c) Six monthly reporting on

- Number of cases 16+ on caseload
- Number of cases transitioned over to adult MH
- DNA by team
- Presenting problem at referral

d) Annual reporting on

- Training report
- Access to specialist CAMHS (Number of LAC, refugee, etc. on open caseload)
- Age range of open caseload
- Ethnicity profile of open caseload

2.3 The performance group will also agree 3 detailed reviews to be completed on specific issues or areas of delivery where a more detailed qualitative review could help improve performance or the service for specific groups of patients.

3. Waiting Times and current performance

Specialist community CAMHS is not subject to an 18 week referral and treatment target contractually, currently there is also no national directive to enforce 18 week performance targets of CAMHS. However it is a standard we seek to achieve locally which is why it features within the performance reporting locally.

3.1 Waiting times

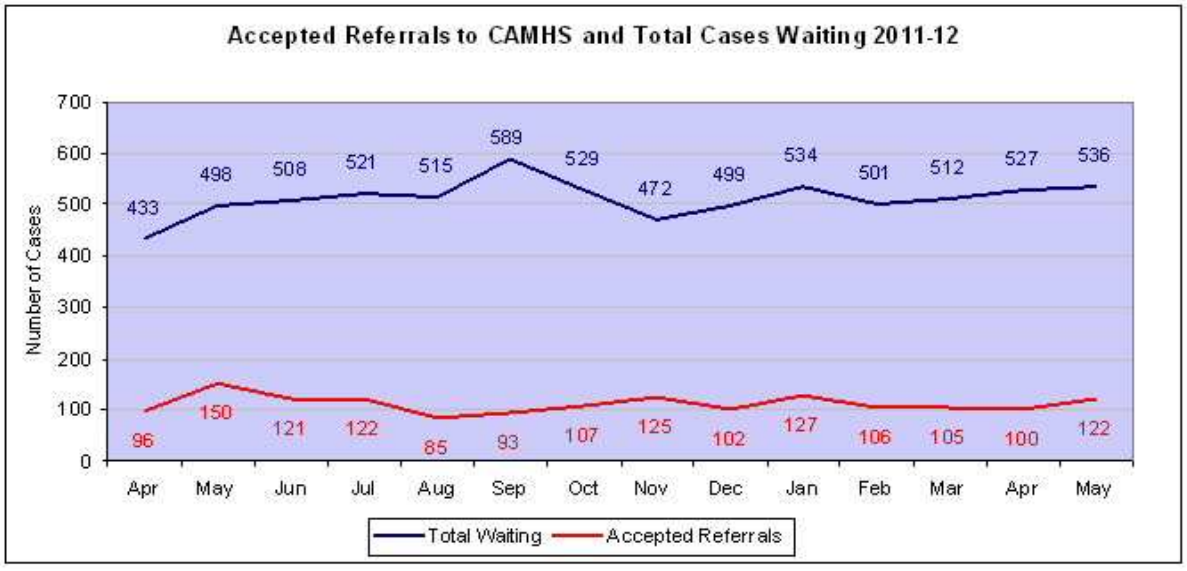
a. The Tier 3 'MAPS for Looked After Children', 'Forensic/Vulnerable Children's' and 'Learning Disability' – Mental Health services target specific sub-groups of our most vulnerable young people and are able to work closely with the relatively small group of professionals and referrers working with them. These teams have generally maintained low numbers waiting for an appointment, along with low waiting periods. Since January 2012, only one child waiting longer than 18 weeks for all of these services combined.

b. In contrast, the generic community teams, comprising just 33 practitioner staff, potentially respond to the full 11,000 children and young people in Sheffield with mental health problems and perhaps 1000 potential referrers of which 350 or more are general practitioners and family doctors.

c. Although the generic Community CAMHS services have generally experienced higher numbers waiting and longer waiting times, between 2006 – 2009 the service made significant progress in reducing the numbers of children waiting. This dropped from 359 children on the waiting list in 2006 to 105 in February 2009.

d. However, it was recognised that following the service redesign and the consequent service re-organisation, the generic Community Teams would see and did see an incremental rise in both the numbers waiting and the waiting times. The purpose of the redesign was to improve access to services and make them more efficient, with an understanding that the same activity could be achieved with reduced resources. However through any service redesign a dip in performance is expected. At the same time as the redesign referral to the service increased. Chart 1 below, shows the peak in the total number of children waiting in September 2011, the numbers subsequently reduced, but have begun to show a gradual increase since February 2012.

Chart 1 Accepted Referrals and Waiting Times 2011/2012



e. Chart 2 below, shows how the numbers waiting over 18 weeks for the specialist teams have remained generally low, but increased for community teams, peaking in September / October 2011, since which they have started to show a steady gradual decline**.** While chart 3 shows that the percentage of children waiting longer than 18 weeks showed an overall declined from October 2011 until March 2012, since which there has been a slight increase (see 4.2).

Chart 2: Numbers waiting over 18 weeks by team

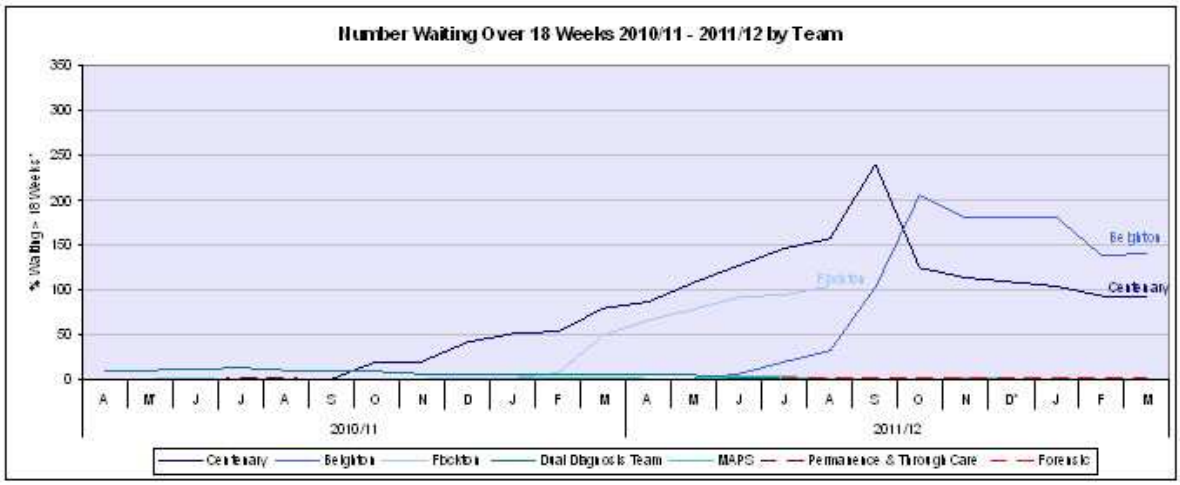
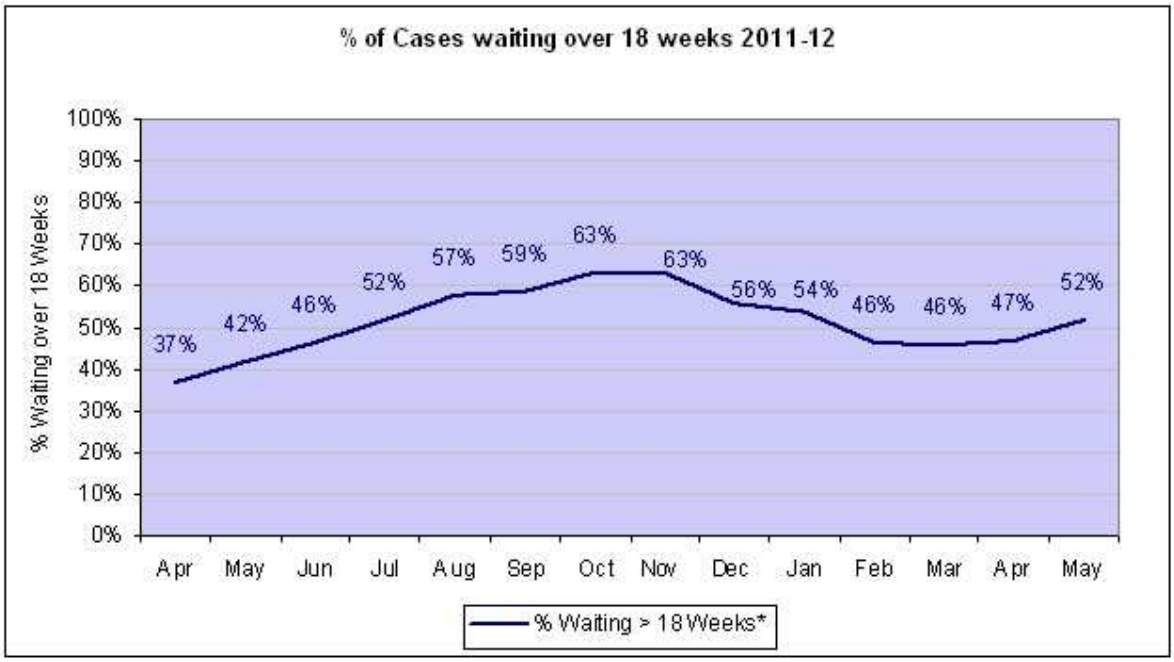


Chart 3: Percentage waiting over 18 weeks



4.1 Plan to improve Performance

a. The initial priority and focus was to ensure that the most vulnerable children currently receiving care and the most urgent cases waiting continued to receive a service which was both safe and effective. The service continued to offer consultation support to waiting families and their referrers; this includes the re-prioritisation of any cases which have become more severe and require an urgent response. A daily clinical triage takes place with all new referrals to enable urgency to be assessed.

b. The service has worked hard to ensure provision for the most vulnerable, and no untoward incidents have been reported. For those receiving a service, the feedback from a patient experience survey undertaken at the completion of the re-organisation moves in November 2011, was very positive

c. Subsequent to the re-organisation the Service has worked with the PCT to redesign service delivery in the long term. As part of this the specialist community CAMHS service is working closely with General Practitioners and MAST to ensure that children young people and their families can receive an effective and efficient service from an 'extended CAMHS' provision which offers timely support at the right level.

d. In the short term, following completion of the specialist CAMHS re-organisation in September, active steps were taken to address these detrimental waiting times. Sheffield Children's and NHS Sheffield agreed to establish and fund as part of the change arrangements a time limited, multi-faceted Waiting & Referral Intervention Project (WRIP) introduced from October 2011.

In October 2011 prior to the WRIP initiative, the waiting list at its peak comprised 655 cases with 67% of waits in excess of 13 weeks and some in excess of 52 weeks. Waiting list cases equated to 5 month's referrals for the entire service.

4.2 Waiting List & Referral Intervention Project (WRIP)

The WRIP provides re-triage, telephone intervention and brief intervention clinics or assessment (BIC) running both during the week and on Saturdays. All patients receiving brief interventions are asked for outcome and service experience feedback.

The first phase of the WRIP from October 2011 removed very substantial numbers from the waiting list but the numbers on the list reduced to a substantially lesser extent as the reorganisation after-effects were still ongoing. 496 patients had been involved with the WRIP at 29 May 2012 with 277 being discharged, 174 preferring to wait for 'treatment as usual' (now termed 'Extended Intervention') and 160 being seen by the Brief Intervention Clinic, (now 'Core Intervention'). Parents' understanding and ability to manage their family problems improved by more than 2 levels (of 6) and the majority of parents rated the helpfulness of the service

as 6 on a scale of 6. DNA rates at first appointment were less than 2% compared with 16% for treatment as usual.

The WRIP was staffed by 1.0wte existing staff practitioners extending their contracts or working overtime; the latter proved unsustainable and the WRIP has reduced to just 0.4wte until external recruitment has been achieved, in effect, from September 2012. (The Children's IAPT initiative is removing substantial numbers of suitable practitioners from the labour market on long term temporary contracts). WRIP phase 1 staffing costs have been approximately £70,000 including unsocial hours and overtime payments, and not including non-pay, management or indirect costs including additional building facility costs.

Over 4 months, the WRIP initiative reduced the waiting list by 201, reducing it from its peak of 655 in October 2011 to 453 in mid February 2012. However, as the WRIP wound down from March and many patients opted to wait the waiting list has risen to 531.

4.3 WRIP Phase Two 2012-13

Aim

To remove 300 patients from waiting list reducing the waiting list to approximately 200 cases (approx 6 weeks referrals) by April 2013, provided that referrals and capacity are brought into balance.

Plan

a. To increase and extend the WRIP to 3.0 wte practitioners (plus support staff) over 6 to 9 months at cost of £148,000, (including additional staff payments but excluding organisational costs, as above). Although some staff are already available, the timing and availability of external recruitment will make the WRIP fully operational from October 2012.

b. To remove at least 300 further cases from the waiting list. (Progress will be slower with fewer quick discharges and more, approximately 40%, requiring 'Extended Intervention').

c. To embed the approach within the Sheffield Model to improve efficiency and demand and capacity matching. It is intended that this will, at least, bring capacity and demand into balance.

d. To continue with and embed patient outcomes and experience monitoring

e. Not withstanding patient outcomes and risk considerations, it is essential that the project is completed and the numbers waiting reduced to approximately 1/12 annual number (ie 4 weeks of

referrals) in order to re-establish service efficiency. It is intended that the waiting list will be reduced by April 2013 but there will be a significant 'treatment overhang', particularly as a greater proportion will require extended intervention.

f. Embedding the learning

Key learning features of this project have informed the Sheffield Model CAMHS redesign including the administrative support & co-ordination, the core intervention & assessment clinic. Saturday working is highly valued by patients and clinically efficient for many cases but significantly more expensive in cash terms.

5. 2010/11 and 2011/12 Overall Funding and planned investment for 2012/13

Table 1: 2010/11 2011/12 and 2012/13 Sheffield Joint Funding into CAMHS for all tiers

	NHS Sheffield	***SCC***	***Total Investment***
2010/11	£7,591,400	£1,288,700	**£8,880,100**
2011/12	£10,386,737	£911,564	**£11,298,301**
2012/13	£10,991,149	£984,564	**£11,975,713**

Note that some of the SCC contribution is for internal services, or other contracts therefore not all of this amount goes to SC FT as the main provider

5.1 2012/13 Funding

Going into 2012/13 both SCC and NHS Sheffield (CCG) are working to protect future funding into community CAMHS provision and have committed to the 12/13 contract value to sustain the redesigned service. NHS Sheffield have also agreed to fund the WRIP to reduce the waiting times and with other plans to improve referral pathways and brief interventions and consultation at Tier 2 it is hoped capacity and demand within specialist community teams will balance from April 2013.

Summary

Specialist inpatient provision is now contract managed by SCG as a specialised commissioned service. This should enable equality of standards, access and outcomes to be aligned nationally.

Specialist Community CAMHS continues to be jointly performance managed by NHS Sheffield and Sheffield City Council as a jointly commissioned service.

Work is underway to reduce waiting times and improve access to specialist community CAMHS as well as continue to redesign services and develop MAST interventions for CAMHS and work with G.P's.

There are no plans to make further efficiencies within specialist community CAMHS, consideration of developing programmes to support early intervention and prevention are a key focus of the emotional wellbeing and mental health strategy for children and young people.

Report by Kate Laurance NHS Sheffield

On behalf of Tim Furness NHS Sheffield