

New Ways of Working in CAMHS

Implementing an extended model of service delivery



Contents

Forward	1
Executive Summary	4
CAMHS Out of Hours Model	12
Regional Developments	14
Roles & Responsibilities of Agencies	21
Pathway for Young People Aged 15 and Under who present to Accident & Emergency	23
Contact Details	26

Forward

New Ways of Working represents a cultural shift in the way that mental health services are delivered. It emphasizes person centred value based approaches where services are responsive and flexible to the needs of those that use them.

New Ways of Working is about developing new and enhanced roles for staff. It is about designing systems and processes that support staff in the delivery of care in a way that is personally, organizationally and financially sustainable. New Ways of Working supports the development of a flexible workforce which is adaptable to changing needs. These changes need to be underpinned by the needs of children, young people and their families so that their emotional health and psychological well being can be enhanced.

24 hour access to Specialist CAMHS expertise is a critical part of developing comprehensive child and adolescent mental health services that are responsive to the needs of young people and their families at times of need. Standard out of hours services with on call psychiatric staff are not sustainable for most services and do not make the best use of the available skills, competencies and capabilities of the whole Specialist CAMHS workforce. This project clearly demonstrates how using New Ways of Working principles and effective use of clinical resources can enhance services available to young people and their families. Increased investment was needed to implement this project but by carefully considering the needs of those that use the service this has been done in a sustainable way.

Making change can be difficult but this study highlights not only the potential benefits for those that use the service but also benefits for those providing services. New Ways of Working is about having the right people with the right skills in the right place in the right job at the right time and as demonstrated in this project working together to achieve a common goal.



Dr Tim Morris, *NWW CAMHS Project Lead*

e: timmorri@liverpool.ac.uk



Barry Nixon, *National Workforce Lead CAMHS*

e: Barry.Nixon@wwl.nhs.uk

Executive Summary

National guidelines are focused on developing services that match client need in terms of accessibility both in location and time. The cost and associated recruitment and retention issues around providing a traditional psychiatric on-call service make this model difficult to achieve. Developing the knowledge, skills and role of other practitioners within the professions allied to medicine will allow greater use of their capabilities.

This development also has the intention of developing the local CAMHS service philosophy beyond traditional psychiatric paradigms to encompass a community model of service provision based upon a bio-psycho-social understanding of difficulties encountered by children and young people.

Thus far we have achieved:

- We have extended normal opening hours from 8.30 am until 8.00 pm on two days per week.
- We offer a 24 hour 7 days a week telephone consultation to paediatric and other community services.
- Three groups for children, young people and their carers have been run under the umbrella of the extended hour's model.
- Extensive liaison between community CAMHS services and hospital based services to determine client need and to assist in recruitment of group participants.
- A regular Family Therapy Clinic runs as part of the extended hours model.

Introduction

There is an acknowledged need for paediatric and other non-specialist mental health services to have access to specialist child and adolescent mental health support and guidance throughout a 24 hours period.

Whilst recent investment from the CAMHS development grant has created a post for a Consultant Child and Adolescent Psychiatrist to work as part of the intensive support team. This is a 10 session job which will also take account of some of the work around the newly developed Liaison service aimed at meeting the specific needs 16 and 17 year olds. It did not seem that a traditional Psychiatric on-call system would be the best use of the team's skills and resources. Similarly, it was decided that the most appropriate services to provide outside of the traditional 'working day' would be therapy groups and services, delivered by members of the multi-disciplinary team. This model retains the benefits of supervision and consultation from the psychiatrist, but that support is provided during the 'working day'.

Of note, the agenda for change process has highlighted the need to consider job description, skill and knowledge rather than professional background. Within the intensive support team, practitioners have been re-graded to reflect their autonomy and skill mix. This emerging role, which carries the title "extended scope practitioner" has within its job description the need to provide the out of hours clinical consultation service and to act within the bounds of professional responsibility in an increasingly autonomous fashion. The professional backgrounds of staff currently employed in these posts reflect a range of training routes: registered mental health nurses; paediatric nurse specialists; art therapist and occupational therapists have occupied these positions

Aims & Objectives

Our overall aim was to:

- 1) Provide an adaptable service providing face to face contact beyond the hours of 9 to 5, and to
- 2) Offer a 24 hour specialist CAMHS response within the context of multidisciplinary/ multi-agency team working.

Outcome

We have extended normal opening hours from 8.30 am until 8.00 pm on two days per week and in addition we offer a 24 hour 7 days a week telephone consultation to other services.

Target groups

- a) **Service users** – adaptation of services and ways of working were used to better develop client led services. Extended opening hours and better access to services will work around social and educational circumstances and provide better access and choice.
- b) **Staff** – the motivation to consider alternative work methods and work streams was high e.g. to accommodate child-care. We proposed it would be beneficial to capture this and to act positively within a structured project to enhance services.
- c) **Education** – extended opening hours and alternative ways of working is likely to reduce the number of days lost within education for young people to attend CAMHS appointments.
- d) **Host provider** – East Lancashire Hospitals NHS Trust hosts acute paediatrics and A&E, where different ways of working within CAMHS will have a direct impact on other services.
- e) **Parents and carers** – the capacity to run services in other ways and out of standard working hours will provide some opportunities for those parents/carers who struggle to access services due to their own work and social commitments. This project gave a good base in which to explore alternative ways in which to achieve this.

The Project Outcomes

Objective: Provide an adaptable service providing face to face contact beyond the hours of 9 to 5

At the present time, two groups have been run under the umbrella of the extended hours model:

The pervasive developmental disorders group has run a parent and young persons group, focused on the development of social skills. This group ran for six weeks on Thursday evenings between 6 p.m. and 7 p.m. The venue was Mary Burbury Unit at Burnley General Hospital. The staff group consisted of two extended scope practitioner's (one registered mental health nurse, one paediatric nurse) and one mental health support practitioner. Each session was structured in order to have a beginning (warm-up) followed by the main topic and a final "cool-down". The sessions focused on promoting interaction and communication through group activities whilst encouraging the participants to use their imagination and creativity. Participants were encouraged to make choices and to explore different ways of thinking. There were eight referrals for this intervention from which six participants were selected. Referral sources were as follows: CAMHS sector teams; primary care and education. Two candidates were excluded for reasons of insufficient preparation.

The attendance record records that other than one child who missed two sessions due to a pre-planned holiday all participants attended all sessions.

Qualitative information in the form of participants responses was recorded. Responses were positive and a repeated theme was that the participants would have liked more and longer sessions.

The practitioners reported a good level of satisfaction with what the participant children derived from the groups. Practitioners felt that the consistent attendance confirmed this. There were some reported barriers e.g. the provision of childcare. Parents were reported to have been struggling to come to the parents support group due to having to care for other children. Staff reported wishing to take the group into other venues in East Lancashire.

The affective disorders group has run a young persons group. This group focused on the development of anxiety management strategies. The staff group consisted of two extended scope practitioner's (one registered mental health nurse, one paediatric nurse). The participant group consisted of only two children and was aimed directly at the young people and no parents support group was offered in parallel.

Overall, this group feel that the participant benefited from the intervention but there are development issues in terms of preparation and group mix. Both clients who attended had a dual diagnosis of attention deficit hyperactivity disorder and anxiety disorder. This provided the practitioners with difficulties in differentiating the programme.

In addition, one participant joined the group after a week and this caused some difficulties. However, participant satisfaction was consistently positive.

Overall, practitioners felt the programme needed to be six to eight weeks in duration with clients of a similar age and psychological difficulties. The barriers to uptake were reported to have been the venue. Several potential participants were unable to travel to the venue in Burnley.

In addition to the two groups that have been successfully run, there have been additional clinical appointments and family therapy sessions that have been conducted under the "safety" umbrella of the system.

The CAMHS service has provided a 24 hour telephone consultation service to A&E and paediatric services in East Lancashire. This service has been accessed on several occasions and the end user satisfaction is high

Challenges/Opportunities

The following challenges and or opportunities were identified:

- The use of a single venue has caused some practitioners and service users concern. Reportedly, recruitment of group participants has been negatively affected by the need to travel.
- One group in particular reported that the participants were too heterogeneous in presentation and this created difficulties.
- Groups need to be closed groups and to have a narrow focus.
- Recruitment took considerably longer than anticipated, the expected rate of referrals from the community teams did not meet expectations.
- Identifying potential recruits required input from the community teams that was not available within the required time-scale.
- Identification of more venues in the communities provided logistical i.e. moving physical resources including practitioners and safety issues. The model required that at all times a super-numery manager was on site to provide support and 'housekeeping' e.g. simply answering the door to the unit, as well as a safety function. At the present time this role could not be replicated for the many community venues, which also work on a traditional 'working day' model of access.
- Community teams require clear referral guidance fro attributing clients to groups.
- Where venues have to be centralised the provision of transport needs to be considered.
- With reference to the 24 hr on call system, absence and sickness issues created some difficulties. Whilst there were largely two 'on-call' members of staff at any one time, this was reduced on occasion to one.
- The need to return the 'on-call' telephone to a central venue each Monday morning and to hand-over was difficult for some of the community staff based some distance from the hospital.
- A reliance on mobile telephone network coverage created some headaches for staff and some delays in returning calls.

Lessons Learned

- The preparation time for a group is considerably longer than anticipated.
- The demand for 'out of hours' services need to be evaluated on a local basis and a cost/benefit analysis conducted.
- Parents and Carers value the opportunity to learn about their child's difficulties and strategies to cope.
- The power of peer group support for parents in some cases outweighs that of professional advice. One parent/carer group decided to remain in touch following the end of the formal group. This prompted a discussion of consent, confidentiality and service support for such 'self-help' groups.
- Children and young people learn better in the company of peers in learning a wide range of emotional, social and psychological self-management skills.

Stakeholder Analysis

The project was largely focused on satisfying central government demands and the clinical needs identified by professionals. Going forward, a commitment to elicit young peoples and community views must be made.

Risk Analysis

The provision of an extended hours service model highlights several additional risk factors. The provision of clinical contact sessions, both in NHS buildings and the community outside of "traditional" hours required the development of a "safe visiting policy". On each of the two evenings a manager is present, who provides a monitoring and security function. All staff have to "check-in" with the manager at the end of sessions to ensure their safety. In addition, staff have been trained in safe visiting and risk evaluation. All members of staff have been issued with mobile telephones and panic alarms to enhance safety.

The increasing use of community venues will require a revision of these policies to ensure safety.

Technical Development

The increasing use of community venues and distributed staff groups in our rural area provides technical challenges in terms of mobile telephone use, computer support and transportation of staff and clinical/teaching materials in safe and secure ways.

Project Management

The project was run specifically through the intensive support team based in a local hospital and providing a service across East Lancashire. The outcomes from this evaluation will be cascaded to the community teams and CAMHS partnership board in order to maximise the project and develop the outcomes into standard service operating procedures.

During the project both service leads have had significant changes in their work assignment. Similarly, the Intensive Support team has undergone changes in management and in-centre roles and responsibilities. This has resulted in some loss of focus on the project.

Programme Support

- Support has been provided by the workforce lead and has been appreciated in its sensitivity and timeliness.
- Service and work constraints have precluded visits to any other services, which would have been valued.

Budget

There are no known issues around budgets. All developmental costs in terms of delivering the groups has been met through main funding. The cost of the 24hr cover and associated mobile phones has not been evaluated.

Evaluation

“New ways of working promotes flexible working with other professions, and there are potential benefits to job satisfaction and career development. In the end, though, you will be judged by how well it improves care for patients and their families” (Louis Appleby, National Clinical Director of Mental Health, 2007)

Each of these two main themes must be addressed in the evaluation:

Each group has been evaluated using an evaluation form and qualitative information derived from participants responses. The overall results reflect a positive response. In addition to the two groups that have been successfully run, there have been additional clinical appointments and family therapy sessions that have been conducted under the "safety" umbrella of the system.

Professionals report enhanced flexibility in their time management and in addition report having been able to offer appointments at the time that suits the service user. They also report a bonus of flexible working practices, for example, by working in the evenings. Time can then be taken back during the day to allow the childcare and other social and personal matters to be attended to. Within the new ways of working paradigm there must be a degree of reciprocity with benefit to both service users and staff, this appears to be the case in our study.

There are initial findings into the adoption of new ways of working on skills and staff attitudes. However, it must be stressed that these are only preliminary as are the reflections around them.

The key component of the agenda for change process is the adoption of the knowledge and skills framework, to make explicit as key skills and competencies require for effective clinical practise.

As previously stated in the new ways of working the move towards competency based practice rather than professional based practise requires that such focus on skills and knowledge be made central for the developing workforce.

However, competent clinical practise is directly affected by the attitude of the practitioner. The attitude of individual clinicians has been shown in many studies, in mental health settings, to have a direct impact on the attributions made towards clients with subsequent care they receive (Carse, 1989). Whilst the knowledge and skills framework has focused on just that, modifying attitude is far more difficult than transmitting information or developing technical skills (Chapel & Schott, 1977 reported in Tober & Raitrick, 1990). Harre & Secord (1993) referred to attitudes as “pseudo entities”, existing as a social construct only within the complex context on the discourse. A part of the cultural context, which must then be considered, is the professional imagination, or the way in which individual professions view themselves in their relationships to the clients (Flemming, 1997).

These professional imaginations are social systems with their own logic, perceptions and limitations. Each individual health care professional group will perceive their role in facilitating clinical change in ways influenced by their own professional imagination and organisational context. Qualitative feedback from Extended Scope Practitioners has illustrated several points that need to be taken into consideration in our overall evaluation of this project. Developing new ways of working as has been shown in the literature review requires a change in the attitudes of individual practitioners. Attitudes have been shown to consist of three elements, cognitive, affective and a tendency to act (i.e. behaviour). It is this latter tendency to act that is most directly influenced by the negative impact of resource limitations and organisational constraints.

A developmental project such as this must be able to address these factors, in order to bring about long term changes in the performance of the health care professionals.

Unfortunately, there are many negative attitudes presented by the participants in this initiative.

“We have been asked to think outside of the box, and then it's not been allowed to happen”.

Professional, organisation and cultural norms must reflect a positive approach to clinical change. However, the following quotes are indicative of the feelings within this organisation:

“We have just done it to keep the Doctors quiet”.

Some Staff did not feel valued, not adequately resourced, and of there being very little concern and contribution to staff well-being. Many staff reported working beyond the 37.5hour contracted week and that they struggled to get their 'time back'. The value of the clinical change was also questioned in terms of its longevity,

“It will fizzle out in 12 months anyway when “X” service comes online”.

A related area of concern is the longevity of clinical change. Initially, behaviour may change as a result of its novelty, the so called Hawthorne Effect (Mays, 1994).

However, after time, limitations of time and poor resources result in a drift back to older more “comfortable” working practices.

Turning to the “Professional Imagination” many practitioners reported finding their new title of Extended Scope Practitioner to be very “wishy washy”. They further articulated that “no one knows what it means”. Further analysis suggested that whilst practitioners were initially eager and happy to adopt these new found ways of working, they felt their professional roles were not supported.

The transparency of spine points was also raised as an issue. Several practitioners reported that despite their new ways of working and commensurate re-banding under agenda for change, that there had been no actual salary increase as a result. Probably due to the complexities of the agenda for change transitional process many practitioners reported that whilst they now had additional responsibilities they were receiving no concrete benefits by way of financial remuneration as a result.

The adoption of the Extended Scope Practitioners title and the subsequent merging of role identities has created tension between professional groups over diverse training, knowledge, attitude and supposed competency. There has been a reported failure to develop a corporate vision or value structure to which these practitioners could “sign up”.

In terms of the impact of family life, none of the staff interviewed reported there being any significant disruption. However, this is difficult to generalise as the majority of the staff interviewed are not known to have dependants.

Systemic factors

Spiegel, Murphy, Kinmonth Ross & Coates (1992) report that the commonest organisational constraints are those of resources. They propose that change is only possible in organisations that have slack resources.

Emotional impact

Dowie (1994) has illustrated the need for a consideration of emotional factors, in addition to the cognitive processes for clinicians adopting new working practises. The ability to deal with uncertainty and to maintain confidence in clinical judgement, in the face of uncertainty or a potentially life threatening event. However, the length between cognition and action is blurred, and emotional effect must be considered.

The National Service Framework for Mental Health (1999) identifies the need to increase staff moral, intention, recruitment and performance and thereby improve service user engagement and outcomes.

The transactional nature of attitude within environment requires a cultural shift within the NHS. The national context is moving towards evidence practice and clinical audit. At an individual level, Heard (1998) asserts that, “reflective space and time must be provided to enable health care professionals to think about what they are doing”.

The institute of Health and Care Development (1998) in a qualitative piece of research “Core Competencies for Mental health workers” reported that users of services most highly valued and “positive approach and optimism” in professionals. Clearly considerable work must be undertaken in order to bring this about within the current service.

The need for clear role distinctions has been brought in by Community Health care Workers and the study of required competencies “The Institute of Health Care and Development, 1998). The challenge for the education and training provided in the next millennium is to provide education that reflects and respects individual clinical roles and responsibilities, whilst at the same time capitalising on the synergistic capabilities as a multidisciplinary team.

In this project we have illustrated how different professional groups can learn common clinical skills in partnership with other professional groups, and develop integrated novel ways of working. However, it may be that in order to fine-tune these skills individuals need role models that reflect their own working experience, and their own professional peer group.

In addition to the political will and service resources there are profound implications for the provision of training in the National Health Service. The complexity influx of current clinical practise requires a paradigm shift in the approach to personal and professional development:

“To be prepared against surprise is to be trained. To be prepared for surprise is to be educated” (Carse; 1986)

The new ways of working initiative in the National Health Service has a potential of making it increasingly difficult for the clinician to maintain their internal sense of a coherent and integrated self.

“When work starts on the first change, you begin to see that a very different and more profound change is needed. In training terms, the first may be a skill based course but the real is not to require a skill but to learn how to learn”.

“Second order change penetrates so deeply that the change will remain constant in all future shapes of the practise first order change, the change which you thought might easily be accomplished, may lead to much more difficult and painful second order change” (Block, 1991)

Therefore, a longer term longitudinal study into staff retention and morale is suggested. Whilst nursing personnel have been socialised into shift patterns of working and unsocial hours, it may be anticipated that other professions allied to medicine may not have such expectations. Therefore, it would be useful to further investigate different staff perceptions around flexible working and whether differences exist between professional groups.

Dissemination Plan

All major outcomes have been achieved. Feedback and evaluation meetings have been conducted with community team co-ordinators and individually with team members. A strong platform for the further provision of out of hours and locally based services has been made. A report has been made to the National CAMHS Workforce Programme Board, CAMHS Commissioning Board and other stakeholders.

Impact and Sustainability

The 24hr telephone consultation service is highly sustainable and will continue in its present format in the foreseeable future.

At present an out of hours group is underway at the central venue. Intensive Support Team members are actively seeking out more community venues in association with community teams and are planning to deliver group interventions in the next quarter.

CAMHS out of hours model

Objective: Offer a 24-hour specialist CAMHS response within the context of multidisciplinary/multi-agency team working.

Aim

The aim of this paper is to outline the model to which the Tier 3-4 CAMHS team across East Lancashire will work to meet the Department of Health Proxy Targets and improved access to services. These proposals are part of the review of CAMHS Services in line with the NSF recommendations. The model will outline how specialist CAMHS will manage the following groups of children and young people who are traditionally managed on paediatric wards for a period of time, alongside colleagues from other disciplines/agencies.

- Children and young people who self harm.
- Children and young people with health needs requiring need significant input from paediatricians, child psychology services and CAMHS.
- Children in crisis known to the CAMHS Service.
- Children and young people with an episode of major mental illness.

The model is currently applicable to children and young people up to their 16th birthday, although this will be subject to review given the changes to CAMHS commissioned arrangements.

As part of the development of comprehensive CAMHS for Lancashire and Cumbria the need to develop a co-ordinated approach to the management of “out of hours” is essential. The NSF outlines this as follows:

“Access to CAMHS is improved through the location of services in a range of settings, high quality multi-disciplinary CAMHS Teams providing direct care and increase support for Primary Care Services and referral information being widely available. Services are flexible and understanding of the needs of children, young people and their families who may be reluctant to seek help. Local services have arrangements for 24 hour cover and mental health assessments are undertaken within 24 hours, or during the next working day where the child's needs are urgent”.

The purpose therefore is to improve inter-agency working/links, consolidate liaison between CAMHS, Adult Mental Health Services and Child Health Services and established robust crisis services.

The Key principles on which the model is based are:

- Continuity of care for the child/young person and their family/carer.
- Child/young person centred care.
- Promotion of holistic approach to working with acute paediatric services.
- Developing the capacity of all services to manage this group of children and young people.

Regional developments

There is limited provision of Tier 4 beds within Cumbria and Lancashire. Seven beds are available from 2008 with the re development of a children's inpatient unit to allow access for adolescents. This development is not yet able to provide out of hours services, although when fully developed staff at the new Unit will be available throughout a 24 hour basis to provide telephone clinical advice, and it is envisaged that there will be some Consultant cover available, again for advice on a rotational basis.

The lack of Tier 4 provision in Lancashire and Cumbria reflects 'the national picture' of inadequate access and appropriate provision for those young people who have significant mental health needs both on a voluntary and detained basis. The North West as a whole has proportionally the least number of beds per head of population in the country. This model will improve local communication, advice and support, but will not be able to overcome the hurdle of significant under provision.

In the meantime there is the need to streamline and develop services to provide for those young people with mental health issues who present in crisis outside of standard working hours. This proposal will not look at the needs of children and young people who present with self-harming behaviour in great detail, as there is a separate care pathway already established.

Children and young people who self harm/self injure

Currently children and young people who self-harm, including those taking overdoses of medication are admitted via A&E to Paediatric Wards under the care of the Consultant Paediatrician. Self harm covers a range of presentations.

These young people are usually seen by the CAMHS team the next working day and seen on the ward. The numbers fluctuate and there can be periods with no significant self-harm or overdoses presenting, whilst at other periods there may be large numbers occurring in one week. The planned response is for teams to share the responsibility for assessing these cases under the guidance/protocol agreed, where risk is assessed, and there are systems that guide the practitioner's decision making. The Paediatric Liaison Practitioner for CAMHS co-ordinates the self-harm rota and the current admission and existing care pathways of those young people would not be affected by extending the out of hours provision.

- All children and young people who present with self harm should to be admitted to Paediatric ward with acute paediatric inpatient beds.
- When physically fit the child/young person will have a specialist CAMHS assessment.
- These specialist CAMHS assessments will be carried out by CAMHS clinicians from a dedicated team of CAMHS practitioners who will work across the paediatric wards and the child/young person's locality CAMHS. These practitioners will be available five days a week and will be managed by their local CAMHS Service.
- Following the specialist CAMHS assessment, the small number of children/young people who continue to need to be managed on a paediatric ward to resolve psychological issues will receive CAMHS input but the child/young person will remain under the care of a named paediatrician.
- When discharged the child/young person will be offered an outpatient CAMHS appointment in their local district within seven days by CAMHS practitioners from the dedicated team. This will ensure both continuity of treatment and integration within local services.

Following the specialist CAMHS assessment, the small number of children/young people who continue to need to be managed on a paediatric ward to resolve psychological issues will receive ongoing CAMHS input but the child/young person will remain under the care of a named paediatrician, unless otherwise negotiated between CAMHS and Paediatric Consultant Medical Staff.

Whatever the form of self harm, an initial assessment of intent is needed both in A&E and by paediatric medical staff. Consideration needs to be given as to whether assessment under the terms of the Mental Health Act (1983 E&W) is required.

Children and young people with health needs which need significant input from Paediatrics and CAMHS

There are a wide range of symptoms which could fall into this category, with the overarching characteristic of impairment of physical and psychological health and functioning, sometimes very severe. Some examples are:

- Children and young people where psychological issues are a factor in poor diabetic control.
- Medically unexplained symptoms, e.g. severe recurrent abdominal pain, pseudo seizures.
- Young people with anorexia nervosa.

This group of children and young people are challenging and will require an integrated team working across CAMHS and Paediatrics in order that a holistic and flexible approach can be developed to meet their needs. The model of care, which will be developed will be dependent upon the model of care which Paediatric Services follow.

In principle, CAMHS will follow the model that paediatrics adopt but for certain conditions (e.g. paediatric admissions for re-feeding the cases of anorexia nervosa) it is likely that a clear protocol agreed before the admission will best be managed by the paediatric team with local CAMHS clinicians with relevant expertise providing support during the admission. A series of care pathways will be developed to meet differing needs of this group and may also require the further development of CAMHS Paediatric Liaison Services at a secondary level, thus enhancing CAMHS support for acute paediatrics. Colleagues within the Clinical Psychology Department (Lancashire Care NHS Trust) have established links with paediatric wards and these should be nurtured and developed as many of the young people with physical and psychological health needs can be dealt with psychological services at Tier 2. Strategically this is been developed differently across differing regions on East Lancashire.

Children in Crisis – known to the Service

These young people usually have increased social need; the majority of needs can be met by short-term intervention within the Intensive Support Team Daytime Services, particularly if good multi-agency services network together during the day where some of the non-clinical support could be offered to Specialist Services by other staff (Children's Social Care Out-Reach Team).

Wherever possible, provision is made for these young people within working hours so they don't present in crisis to services out of hours. Should these young people present out of hours, they should be admitted to paediatric provision as outlined above, and a referral faxed through to the CAMHS Service to be picked up the next working day.

Presentation of major disturbance of mental state

Major mental health symptoms can present in numerous ways and can generate a number of risks. There will be some incidences when this will arise from a paediatric state, e.g. poisoning, burns, toxic confusional state, but largely these will be due to mental health disturbance or mental illness. This group of children and young people may need to be admitted to or will be already on a unit with acute paediatric inpatient beds.

Following the appropriate paediatric and specialist mental health assessments, the agreement of nursing requirements, assessment of risks and the identification of appropriate and necessary treatment, there will be agreement as to the timely transfer of the child or young person to the most appropriate setting e.g. home, continuing placement on a paediatric ward or an inpatient psychiatry setting.

There is a commitment from providers and commissioners to ensure that the transfer to the appropriate setting is as timely as is possible, although the timings are compounded by lack of Tier 4 provision, and are often excessive.

These young people need rapid access to beds, and would normally be covered by the Tier 4 risk share agreement in relation to long term funding for Tier 4 provision. With this in place it would still be the aim to minimise time spent in hospital, therefore there would need to be multi-agency working and a team response during daytime hours to support recovery and discharge home. This would need to be followed up by work through the Intensive Support Team, which would fit with the rehabilitation of educational needs, needing careful planning and support. Following the immediate crisis the comprehensive Intensive Support Team Service will minimise relapse and need for out of hours crisis service.

Children who are out of control or in difficult social predicaments

This is the largest and most complex group. These children may present with anti-social behaviours, maybe intoxicated with drugs or alcohol, may have been abused, assaulted or badly treated. These children may need a psychiatric assessment, but if so it may not be needed immediately. This group do not necessarily need specialist therapeutic resources or placement, but may have long term emotional needs requiring a co-ordinated multi-agency approach and normally will not be suitable for admission as this is not a direct mental health crisis.

A&E is sometimes misused as a place of safety for those children who are out of control or in difficult social predicaments. Whilst it is acknowledged that A&E is classed as a "place of safety", other options need to be considered such as Social Services Emergency Duty Team, if there are no medical or psychiatric indicators for admission. Admission for these young people will be seen only as a last resort, but must be at the discretion of the A&E and Paediatric staff. A record of these young people who present but are not admitted should be faxed through to the CAMHS team so these details can be checked against existing records, and alerts raised to other agencies if indicated. This process is not a line of referral, but merely a risk management system to see if these young people are known to CAMHS. If this case is open to a CAMHS practitioner, this gives an opportunity for this case to be followed up.

Operational Service Development

Principles

- Prevention: Whilst it is important that young people receive an appropriate service in a crisis situation, it is also important that wherever possible, young people are given appropriate treatment and support so that a crisis situation is prevented.
- The service model is aiming to provide a footprint across East Lancashire to ensure that the response is predictable, appropriate and is not dependent on individual determination and goodwill but on agreed systems of practice across organisations.
- The responses have to concentrate on the welfare of the child, young person and family, and mobilise resources in a sensitive, proactive way that minimises distress.
- Resources identified through the CAMHS development grant to provide the out of hours advice service have to be managed effectively and efficiently.
- Cost effectiveness has to be considered as part of the equation; but has to also accept the limits of the current resources available. This takes into account 3 PCT locations and 2 local authorities.
- The model will have to consider simultaneously several factors developing across agencies and that there will often be conflicting and competing priorities.

Pathways

The pathway for the young person will be different for a crisis occurring in hours to that occurring out of hours.

Filter One All agencies will aim to provide young people with emotional support where and when they need it in order to try to prevent a crisis occurring. This is of particular importance to Connexions, Schools, Primary Care Health workers and Children's Social Care.

Filter Two Health professionals who are likely to come across young people with mental health difficulties will be given training/support in managing these young people. This will include Accident and Emergency Departments, Paediatric Wards, Out of Hours Social Care Services. A Training packages to be devised in conjunction with Paediatric Liaison Practitioner.

Filter Three During working hours, the response will be provided from the Tier 3 CAMHS teams. Out of hours, Tier 4 services will provide advice, guidance and consultation for agencies where a young person presents with severe mental health problems that the professional is unable to manage. The contact number will be available across the Network to allow agencies to access the service, based on an algorithm indicating what they should expect from the service. Similarly Tier 4 would have an algorithm indicating how to respond to emergency calls and how to operate between the filters. This service will not be available in Lancashire and Cumbria until at least 2009 (predicted), so in the interim clinical advice will be available from a CAMHS practitioner within the East Lancashire Network. This does not include medical staff.

The development of medical staff provision is linked to Tier 4 developments and is currently not available in Lancashire and Cumbria. As an interim measure, Consultant Child Psychiatrists will work closely with Paediatric colleagues in providing some availability for those young people who are resident on paediatric wards, where a negotiated care package is in place.

Filter Four Young people who present with mental health difficulties out of hours, in A&E, will be assessed by the Adult Mental Health Team out of hours and advice on mental state given to paediatricians/A&E staff. Consultation will be available from the CAMHS clinical on-call.

Where additional input is being provided by the Intensive support Team, the lines of medical responsibility will remain with the Consultant Paediatrician.

Out of Hours Structure

Telephone advice will be available through a clinical led service (Mental Health Practitioner) in providing an out of hours advice service. Out of hours will be classed as Monday to Friday 5.00pm to 8.00am, all day Saturday, Sunday and Bank Holidays. It is envisaged that the Intensive Support Team will be piloting extended day access by August 2006, although again medical staff will not be contracted to cover this

The Intensive Support Team will be re-structured to provide clinical out of hours advice by telephone to colleagues within East Lancashire Hospitals NHS Trust and Lancashire Care Trust. The role of these staff will be to provide telephone advice and support for those clinicians dealing directly with the young person. There will be a second on-call management cover from CAMHS who will support these clinicians through the out of hours processes. The model does not make provision for CAMHS staff to attend to undertake assessments, although this may be considered in the future and will depend on the strategic planning of the CAMHS Partnership Board.

The role of the clinical on-call will be:

- To provide specialist mental health advice.
- To offer support to clinical A&E, paediatric and other staff.
- To liaise with Bed Manager where appropriate.
- To liaise with ward staff to suggest strategies and advice until assessment the next working day.
- To record all dialogue in a CAMHS on-call book and follow up all contacts during the course of the next working day to ensure positive outcomes.
- To contribute to psychiatric assessments the following working day with CAMHS Medical Staff (SPR, Staff Grade or Consultant). These are likely to be picked up routinely by the IST medical staff.
- Based on the identified needs formulate a plan of care according to the child's individual needs, in conjunction with ward staff where indicated.

Operational detail

- Clinical on-call will be provided by one practitioner on a 7 day rolling rota, running from 5.00pm Monday to 8.00am the following Monday, out of hours only.
- This will be mirrored by a CAMHS managerial on-call rota, provided on staff with managerial responsibilities on Band 7 or above.
- On-call rates to be paid at Agenda for Change rate in line with Agenda for Change Terms and Conditions.
- On-Call cover to be telephone contact only.
- During the on-call week staff members will be encouraged to keep a minimal and fluid diary to allow any clinical follow up the next working day.
- One member of CAMHS staff will be on-call at all times out of hours, alongside a CAMHS Manager.
- Both staff members on-call will be provided with mobile phone by CAMHS and mobile phone numbers will be given to Switchboard, Senior Managers on-call and the Bed Manager.
- It is the responsibility of the person coming off the rota to ensure that the mobile phone is handed over to the person coming on the rota. Any changes to the on-call rota must be negotiated with either the CAMHS Service Manager or the Team Leader of the Intensive Support Team, and switchboard informed.
- At the current time there is no medical out of hours cover locally, although it is envisaged that this will become available when the Cumbria and Lancashire Tier 4 Service is operational.

Roles and responsibilities of agencies

East Lancashire Hospitals NHS Trust A&E Department

- Triage
- First line assessment
- Request Lancashire Care NHS Trust clinical out of hours opinion
- Consider CAMHS component against CAMHS assessment tool available via A&E
- Make recommendations to paediatric staff to either discharge or to admit to acute paediatric provision.
- Liaise with Bed Manager in relation to achieving 4 hour A&E target

East Lancashire Hospitals NHS Trust Acute Paediatric Service

- Negotiate with Bed Manager admitting those cases that have been defined by A&E and/or LCT staff as having a mental health risk or evidence of mental illness/disorder.
- Ward to complete admission documentation.
- Ward to fax through referral to either MBU or the Mount, depending on locality.

East Lancashire NHS Trust CAMHS

- Provide clinical advice out of hours to any of the above elements of services required.
- Authorise funding for additional cover where indicated (this will not be ELHT CAMHS staff).
- Advise ward staff around initial care planning and keeping safe when required.
- Ensure IST team is aware of admission by 9.00am the following working day.
- For Intensive Support Team to attend admitting ward and assess during the next working day and formulate a plan.
- Provide managerial support for the clinical on-call staff.
- CAMHS managerial on-call to liaise with SMOC for East Lancashire Hospitals Trust where indicated.

Lancashire Care NHS Trust

- Provide a 1st line mental health assessment in A&E for those young people who present in a mental health crisis, following the CAMHS documentation and guidance available in A&E.
- Ensure this is documented and communicated to A&E staff
- It is **not** the responsibility of LCT to either admit or take over the care of the young person; simply to provide that specialist information to the acute Trust to enable more informed decision making.

Children's Social Care

- Work with and support the above systems in relation to young people who present in crisis.
- Work with both the CAMHS and paediatric teams in instances where young people present in crisis but who do not have a mental or physical illness requiring either admission or prolonged stay in hospital.

Regional Provision

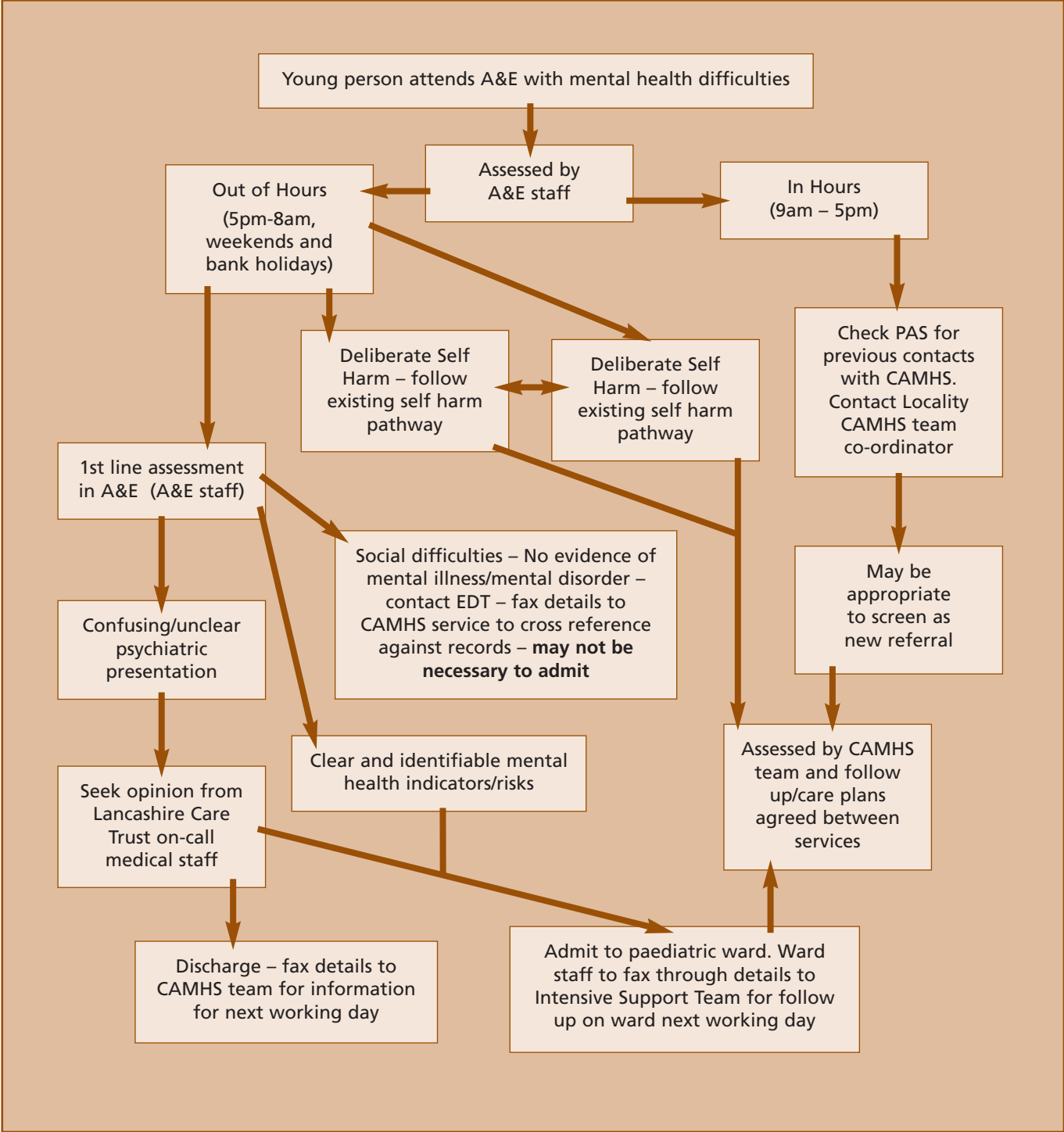
- Provide 1st line out of hours advice to agencies outside of health provision, such as police, social services, EDTs.
- Provide availability to Consultant Psychiatrist advice (timescale yet to be decided).

Structure for Evaluation

- The evaluation of this service will be locally carried by the CAMHS Administration and Evaluation Officer which will look at cost and use of service.
- The revenue allocation from the CAMHS Partnership Board will support the East Lancashire CAMHS as it seeks to implement the design of the service, and will meet out of hours costs against the CAMHS Development Grant allocation.
- The inherent difficulties of the geography and the interpretation of policy in the local CAMHS Services and Adult Mental Health will be knitted together to reflect a comprehensive response across East Lancashire.
- Children's Social Care Out of Hours Teams, will in partnership with the agencies described, be engaged in development of a pathway to ensure in the event of crisis all agencies across East Lancashire have a clearly defined system to work within. The system will provide a safe, transparent, agreed route through the crisis for the staff involved at the point of dealing with the emergency.
- Adult Mental Health will also be engaged through the Early Intervention in Psychosis Implementation Plan. There is a need to develop additional pathways which will be agreed on the same footprint and will dovetail with CAMHS developments around provision of liaison services for 16 and 17 year olds.
- Responses to all 'crisis' referrals will be monitored for evaluation purposes.

This current model of service is seen as an interim measure until the regional provision is fully functional. It is anticipated that any developments will be in addition to the described operational model and that local and regional services will complement each other in achieving more co-ordinated out of hours care.

Pathway for Young People Aged 15 and Under who present to Accident & Emergency



Contact Details

Lead Contact:	Jo Weller
Name or organisation:	East Lancashire Hospitals NHS Trust CAMHS
Contact details:	East Lancashire CAMHS The Mount, Whalley Road Accrington BB5 5DF email: <i>Joanne.weller@elht.nhs.uk</i> tel: 07739295298
CAMHS Regional Development Worker:	Julie Moss email: <i>Julie.Moss@csip.org.uk</i>
Geographical area covered by project:	East Lancashire

If you require further copies of this report please contact:

Barry Nixon, *National Workforce Lead for CAMHS*

e: *Barry.Nixon@wwl.nhs.uk*

This can also be downloaded from *www.newwaysofworking.org.uk*

