<table>
<thead>
<tr>
<th>Agenda Item No.</th>
<th>09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference No.</td>
<td>IESCCG 20-03</td>
</tr>
<tr>
<td>Date.</td>
<td>28 January 2020</td>
</tr>
<tr>
<td>Title</td>
<td>Business case for Child and Young Person (CYP) (0-18) Crisis Outreach Team for Mental Health</td>
</tr>
<tr>
<td>Lead Director</td>
<td>Lisa Nobes, Director of Nursing</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Lianne Nunn, Associate Director of Nursing, CYP, MH and LD</td>
</tr>
<tr>
<td>Purpose</td>
<td>To consider approval of the business case to fund the development of a CYP (0-18) Mental Health Crisis Outreach Team.</td>
</tr>
</tbody>
</table>

**Applicable CCG Clinical Priorities:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>To promote self-care</td>
</tr>
<tr>
<td>2.</td>
<td>To ensure high quality local services where possible</td>
</tr>
<tr>
<td>3.</td>
<td>To improve the health of those most in need</td>
</tr>
<tr>
<td>4.</td>
<td>To improve health and educational attainment for children and young people</td>
</tr>
<tr>
<td>5.</td>
<td>To improve access to mental health services</td>
</tr>
<tr>
<td>6.</td>
<td>To improve outcomes for patients with diabetes to above national averages</td>
</tr>
<tr>
<td>7.</td>
<td>To improve care for frail elderly individuals</td>
</tr>
<tr>
<td>8.</td>
<td>To allow patients to die with dignity and compassion and to choose their place of death where appropriate</td>
</tr>
<tr>
<td>9.</td>
<td>To ensure that the CCG operates within agreed budgets</td>
</tr>
</tbody>
</table>

**Action required by Governing Body:**

To consider approval of option two within the business case to fund the development of a CYP (0-18) Mental Health Crisis Outreach Team.
1.0 Executive Summary

1.1 This business case will examine the background to the proposal to commission a children and young people’s Mental Health crisis outreach model across Ipswich and East Suffolk and West Suffolk CCGs.

1.2 The rationale for change lies within a national and local context; current service delivery and the impact this has on children, young people (CYP) and their families including Tier 4 admissions; and the proposed model that has been developed from children and young people’s feedback.

1.3 Finally, the options with financial costings are available for the Governing Body to consider.

The authors recommend Option 2.

2.0 Background

2.1 Suffolk’s current model and KPIs

The current model in Suffolk for children and young people is an all age assessment offer. If a child or young person is in crisis the options, following this assessment is limited and not equitable with adult services (over 18 years old). The options consist of a community offer or a tier 4 admission out of county.

The current community offer is a clinic based community offer with limited flexibility for appointments outside of the clinics. Home visits are the exception due to demand and capacity and the general service specification of a Children and Adolescent Mental Health Service (CAMHS) community offer.

The current service offer in Suffolk has identified gaps in the offer available, this would be described as the tier 3.5 offer that sits between community and inpatient services. This offer can be described as a home treatment/ intensive support or outreach type of service offer.

3.0 Key issues

3.1 The current gap in demand for a tier 3.5 service for children and young people within community mental health settings within Suffolk has overwhelmed the community teams’ ability to respond. This has led to high CYP tier 4 admissions, out of area. The impact of a tier 4 admission on a child, young person and their family is felt through isolation from social and family settings, educational outcome impact and the potential of pathologising their condition and affecting their long-term recovery ability, which ultimately impacts on their life chances and success of achieving their potential.

3.2 Children and young people are also increasingly presenting within acute hospital emergency departments and these children and young people are often frequently already under a community team which signals that CYP mental health issues are escalating without appropriate intervention to prevent crisis and potential hospital admission.

3.3 These children are often admitted to acute paediatric or adult wards during a period of crisis, this delays the child’s mental health response and places additional demand on our acute services. These environments are often inappropriate for a child, young person and their family with the types of presenting problems they are experiencing.
This has become the default position due to our lack of service provision in Suffolk during these times of highest need.

3.4 There is also an increased risk currently of unavailable Tier 4 beds due to suspended and terminated services following CQC concerns, i.e. Ellingham hospital in Norfolk. Children and young people are placed out of area. The oversight of OOA Tier 4 CAMHS admissions remains with Norfolk and Suffolk NHS Foundation Trust (NSFT) who have to travel to review the child, this has cost implications as well as resource.

3.5 Primary care and local authority colleagues have also reported concerns related to accessing timely mental health support to prevent a child or young person’s mental health condition deteriorating and the unmet need that is experienced. This relates to some of our most vulnerable children and young people in Suffolk.

3.6 To support a reduction in self-harm and suicide, there is a need to develop new approaches to responding to self-harm as part of wider approaches to suicide prevention given that around half of young people aged under 25 who died by suicide had previously self-harmed and self-harm in young people was often accompanied with excessive alcohol and illicit drug use.

3.7 In 2017, the National Confidential Inquiry into Suicide and Safety in Mental Health services concluded that the following four focuses were needed in effective suicide prevention approaches with Children and Young People:

1. Support for young people who are bereaved, especially by suicide
2. Greater priority for mental health in colleges and universities
3. Housing and mental health care for looked after children
4. Mental health support for LGBT young people.

3.8 When reviewing PHE fingertips data Norfolk & Suffolk sit above the England and East of England averages for hospital admissions from self-harm. Additionally, Norfolk & Waveney and Suffolk & North East Essex Sustainability and Transformation Partnerships (STPs) are both in receipt of suicide prevention transformation funding (wave 1 and 2 respectively) given suicide prevalence rates are above the national average. Whilst these programmes do not have a core focus on children and young people they do focus on self-harm and therefore provide an opportunity to strengthen the development of new programmes of work specific to CYP.

3.9 The following table provides an overview of this data from 2017/18 hospital admissions data (most recent reported dataset) as rates per 100,000 population.

<table>
<thead>
<tr>
<th>Location</th>
<th>0-17 years</th>
<th>15-17 years</th>
<th>15-19 years</th>
<th>20-24 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>180.8</td>
<td>700.2</td>
<td>648.6</td>
<td>406</td>
</tr>
<tr>
<td>East of England</td>
<td>148</td>
<td>576.7</td>
<td>587.6</td>
<td>403.2</td>
</tr>
<tr>
<td>Norfolk</td>
<td>194.4</td>
<td>739.7</td>
<td>686.1</td>
<td>329.5</td>
</tr>
<tr>
<td>Suffolk</td>
<td>189.3</td>
<td>740.5</td>
<td>645.3</td>
<td>485.7</td>
</tr>
</tbody>
</table>

(NHS England)
Suffolk Tier 4 admission rates for the last two years: (admissions to out of area hospitals)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Number of tier 4 admissions 0-18 years</th>
<th>Number of transforming care CYP within tier 4 admission numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/18-01/01/19</td>
<td>75</td>
<td>12</td>
</tr>
<tr>
<td>01/01/19-01/01/20</td>
<td>74</td>
<td>19</td>
</tr>
</tbody>
</table>

3.10 Given the rates of Tier 4 out of area admissions (nationally and regionally) for CYP, and the risks this poses to suicide in the year following presentations, it is felt there is a need to provide a clear pathway for rapid access to specialist interventions for crisis presentations when needed. This is currently not in place within Suffolk.

4.0 **Patient and public Engagement**

4.1 **CYP feedback:**

Children and young people, who have experienced mental health crisis in Suffolk, have told us that they want a service to have four key components:

- Staff who answer the phone
- Staff who do something following the assessment
- Staff who work together, and
- Staff who have confidence in working with children and young people.

4.2 Further feedback from CYP on children’s crisis service in general is…

- “Don’t be afraid to seek help” is the current mental health message, but when you seek help for crisis care, you have to go to A&E. There needs to be mental health nurses, or professionals trained in mental health manned at A&E 24/7. If you go to A&E when you have overdosed or self-harmed you are meant to see a psychiatrist, by law, but this does not always happen. There is also no privacy in A&E- you have to sit in the main waiting room, and then are put onto a corridor with the curtain open when you are being seen.
- “It’s like you have to time your crises”. Mental health crisis care is open 9-5 Monday-Friday. Young people have said that if you have a crisis on a Saturday evening, or during out of hours, you have to wait a long time to be seen.
- There needs to be a replica of A&E specifically for mental health. A&E does not know how to respond to mental health problems, and young people tend to find the triage process takes around 4 hours. Professionals have told some young people that it is ‘just their hormones’, ‘here we go again’, ‘oh I guess you’ve broken up with your partner or whatever’, ‘were you bored?’ etc.
- Crisis support needs to be stronger, especially for under 14’s as there currently is not crisis care for them.

Refer to Appendix 1 for further feedback from children and young people on the service they want.
4.3 What engagement took place?

This proposed model has undergone extensive co-production. This has included:

- A full engagement day with all stakeholders including good representation from parents and carers. This day took place in December 2019. This was to sense check our proposals and the work has undergone numerous iterations following continued feedback.
- The work has been shared and feedback sought through our Suffolk CYP co-production group to ensure the child and young person voice is heard.
- Working groups have taken place over the last six months to progress this piece of work using an integrated system approach. This has proven extremely valuable when looking at the CYP journey across the system and utilising all skills and experiences to influence this work.
- Case studies of real life experience have been tested during our engagement sessions and working meetings to ensure we really learn from known experience currently.

5.0 NHS England/Improvement (NHSE/I) Key Performance Indicators (KPIs) and direction

5.1 The Long Term Plan (LTP) set a population-based target for Transforming Care Partnerships (TCP) of between 12-15 CYP in hospital per million U18 population. The table below indicates numbers at the end of August ‘19 as a rate per million. Viewed this way, the majority of East of England TCPs are in the highest rate group nationally and Suffolk has the second highest inpatient rate in the East of England.

### Under 18 Inpatient Rates (LTP)

<table>
<thead>
<tr>
<th>TCP</th>
<th>TCP Name</th>
<th>Rate Per million ONS U18 Pop.</th>
<th>Change Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGLAND</td>
<td></td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>East Of England</td>
<td></td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>TCP09</td>
<td>Norfolk</td>
<td>16</td>
<td>Below Average Rate Group</td>
</tr>
<tr>
<td>TCP13</td>
<td>Hertfordshire</td>
<td>26</td>
<td>Above Average Rate Group</td>
</tr>
<tr>
<td>TCP11</td>
<td>Essex</td>
<td>28</td>
<td>Highest Rate Group</td>
</tr>
<tr>
<td>TCP12</td>
<td>Bedford, Luton and Milton Keynes</td>
<td>35</td>
<td>Highest Rate Group</td>
</tr>
<tr>
<td>TCP08</td>
<td>Suffolk</td>
<td>46</td>
<td>Highest Rate Group</td>
</tr>
<tr>
<td>TCP10</td>
<td>Cambridge and Peterborough</td>
<td>47</td>
<td>Highest Rate Group</td>
</tr>
</tbody>
</table>

5.2 Improved support for children and young people during a mental health crisis, 24 hours a day, seven days a week is included within the NHS Long Term Plan- “These will include specialist care at A&E, alternatives to hospital admissions, such as crisis and liaison teams and crisis cafes and safe havens, a single point of access to support through NHS 111 and intensive home treatment”. This service will focus on the intensive home treatment function.

5.3 Evidence from children and young people mental health vanguard sites suggests that effective crisis services are delivered by staff with strong CYP mental health competencies who offer a continuous and flexible pathway. The financial modelling suggests that mature, dedicated CYP crisis and liaison services will show a promising
return on investment to the wider system - despite the non-inclusion in this study of the impact on in-patient mental health beds (NHS England 2016).

See appendix 4 for further information

5.4 Intensive services provided in the community can act as a bridge between inpatient services and community services, with the aim of preventing the need for an admission, or facilitating discharge back to the community when a child or young person presents in crisis. These services have previously been described as ‘Tier 3.5’, 'Tier 3+', 'assertive outreach' or 'intensive community' CAMHS services.

5.5 Out-of-hours and crisis services are also essential for responding to children and young people who need urgent assessment and treatment; paediatric liaison services, based within acute hospitals rather than CAMHS services, can also act as an important link, where they are available. The evidence we have received has described the important contribution these services can make, but has highlighted the fact that provision of such services is highly variable, and has suggested that this might be a more useful focus for investment than inpatient services.

(NHS England)

6.0 Proposed model

6.1 The philosophy that underpins the proposed model is the thrive framework, we want to ensure that risk support is available at any stage during a child or young persons journey, whenever a young person needs it as identified below in the getting risk support quadrant.

6.2 The outreach model of care, for 0-18 year olds, will transform local service provision by integrating the tier four and tier three pathways through an intensive outreach service ensuring that children and young people of East and West Suffolk can access the services that meet their needs at the right time. The intensive outreach team will form part of the crisis response pathway.
6.3 The intensive outreach service will deliver an intensive support package focusing on high-risk children and young people who are at risk of hospitalisation.

6.4 This will include oversight and ownership of a dynamic support register. This will provide a multi-disciplinary review function for all young people at risk of inpatient admission.

6.5 Each local area should have a dynamic register (as described in the national service model) which at a population level will inform the commissioning of support services and at an individual level will identify those who may go on to or are starting to display behaviour that challenges. The aim is to improve service design and enable early identification and intervention.


6.6 The CYP CAMHS outreach model service will provide Children and young people with an alternative to hospital admission supporting children and young people in their home, this means delivering evidence based clinical intervention close to their support networks, which is essential for good outcomes.

6.7 The service will support young people that do require Tier 4 inpatient treatment and work to facilitate early discharge ensuring positive links continue with local support systems including care and education services. The care coordination of those young people admitted will remain with secondary mental health teams but the outreach team will provide wrap around support to facilitate early discharge within the local area.

6.8 The team will provide targeted support to young people who are hard to reach and require a more assertive approach when most in need. These are some of Suffolk’s young people who currently struggle to engage with current commissioned services as we expect them to meet services needs rather than the other way around. This will target CYP who cannot leave their home, those who do not engage with traditional approaches of care delivery.

6.9 This service will work alongside local authority services and any other system partners that need to be involved. This service will wrap around any services that currently work with our CYP and complement existing provision.

6.10 If a young person is known to a community mental team, this offer will not stop and the community function still holds the coordination function under CPA (Care programme approach). The outreach function will be in addition to this and a short term intervention to focus specifically on the period of crisis need. This ensures we are not passing CYP from team to team. If a young person is not known to a community team, the outreach function will facilitate this at the beginning of their contact to ensure seamless transition.

**Personal health budget offer within the model:**

6.11 The personal health budget allocation is based on a Norfolk model that has seen great benefit to the young person and their families when given a personal health budget up to £500. With the implementation of the CYP outreach team, this would provide the clinical oversight and governance to provide this personalised offer alongside the outreach commissioned service. Examples of how this could be used include a young person buying a laptop to access self-help materials or a parent buying in short term support to help them get rest whilst managing a high level of risk at home.

6.12 Personal health budgets are a way of personalising care, based around what matters to people and their individual strengths and needs. They give people with long-term
health conditions and disabilities more choice, control and flexibility over their healthcare.

6.13 Personal health budgets are part of the NHS’s comprehensive model of personalised care, which will, as part of the NHS Long Term Plan, transform 2.5 million lives by 2023/24. (NHS England)

6.14 It is felt this offer of personalisation will respond to feedback from young people and families around how the experience has felt and what could improve their experience and outcome. This will also offer an additional offer of care that will work with children, young people and their families to reduce admissions and improve care outcomes. This is detailed further in option 2.

6.15 The CYP outreach team will form part of the wider all age mental health crisis pathway as detailed in process map below. The CYP outreach team is identified in yellow.
6.16 The outreach team will operate between the hours of 8-8pm Monday to Friday and 9-1pm Saturday and Sunday, however as part of the all age crisis model, 111 option 2, call centre, assessment, and brief intervention function will be operating 24 hours as part of the all age crisis offer. This will ensure an immediate response anytime of the day or night. The outreach service will ensure an equitable service provision for CYP up to age of 18-post assessment. The age range is 18 years as there is already a home treatment function team from 18 years and above.

6.17 As already identified earlier within the business case, we have researched other models of delivery across the country for this specific clinical offer and we have based the hours of operation on this alongside our own local data detailing demand.

6.18 Access points into the service are identified above in the process map. The blue ovals identify the three access points into the CYP outreach offer.

6.19 Whilst we have identified age ranges, these are for the purpose of operational delivery and all services will sit under the all age crisis umbrella. This will mean flexibility within service delivery based on a persons’ need. If someone over 18 has needs that would best be met by the child and young person outreach team, they would not be excluded purely on age.

6.20 Outcome and impact of proposed model

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people and their family / carers will experience mental health</td>
<td>Children, young people and their families will receive care within Suffolk in their homes</td>
</tr>
<tr>
<td>services that are accessible and responsive in times of crisis</td>
<td>Families feel listened to and included in their child or young person’s care planning</td>
</tr>
<tr>
<td></td>
<td>• Increased number of families /carers:</td>
</tr>
<tr>
<td></td>
<td>- feeling valued by staff</td>
</tr>
<tr>
<td></td>
<td>- feeling supported</td>
</tr>
<tr>
<td>Outcome</td>
<td>Impact</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Young People are well supported to achieve their individual Recovery Goals | • Achievement of individual Goals  
• Number of young people who rated the service as helpful to their recovery  
• Young people with a recovery plan  
• Young people with a Clear Crisis Plan |
| Young people, their family /carers are confident of their safety        | • Number of young people reporting they feel safe  
• Number of families /carers reporting they feel safe |
| Improvements in people’s mental health and wellbeing are sustained      | • Reduced referral rates to crisis services  
• Reduced number of admissions and length of stay |
| Care and treat young people in their own home when clinically appropriate| • Reduced number of admissions and length of stay  
• Reduced rates of Tier 4 admission for Suffolk  
• Improved outcomes for CYP through local support networks remaining in place |
| Evidence based clinical interventions delivered when needed with evidence based clinical outcomes | • Reduced rates of Number of serious incidents  
• Reduced Levels and frequency of self-harming behaviour  
• Reduced risk of suicide and this is realised through local statistics |
| Clinically competent staff, confident in working with CYP              | • Workforce development is continuous and meaningful for the CYP Suffolk population  
• Clinically appropriate supervision in place  
• Reflective practitioners that embrace learning and improvement  
• NICE compliant service delivery  
• CAMHS focussed workforce if invested in and valued |
| Young people’s mental health and wellbeing will improve as a result of the support and treatment they receive | • Improved scores across:  
➤ Honosca (health of nation children’s scale)  
➤ Sdq (strengths and difficulties questionnaire)  
➤ RCADS (revised child anxiety and depression scale)  
• Young people reporting services have helped them see a positive future |
6.21 This new care delivery model of care will:

Provide evidence based treatments to reduce crisis presentations and a need for admission

- Care and treat young people in their own home when clinically appropriate
- Care actively for young people through their full episode of care, from their crisis assessment through to supported transition. This service will complement and enhance the all age crisis offer that will be in place to support initial contact and presentation but also when and escalating presentation requires more intensive support to prevent a child or young person-reaching crisis.
- Care and treat young people who are difficult to engage and require a more intensive approach

6.22 The outcomes and impact we seek to achieve of implementing a new model of CYP outreach is to ensure that:

- All young people in East and West Suffolk who require admission to an adolescent inpatient unit are cared and managed for in Suffolk where possible
- All children and young people who require admission to a specialist unit are actively managed, have reduced length of stay and are stepped down to the least restrictive unit through to the outreach team and back into the community in line with clinical need
- All young people are treated in the least restrictive environment, with the ability to step up seamlessly if clinically necessary
- All young people have a choice of treatment options whenever possible
- Young people’s outcomes are significantly improved
- Young people’s and family experience is greatly improved

6.23 This new outreach model’s approach is to only use in-patient care when there is no better clinical alternative. There are many benefits to reducing the need for a tier 4 service and developing alternatives to admission, these include:

- preventing dependency
- preventing stigma
- increasing general stability and sustainability of therapeutic gains
- increasing young people’s choice
- minimising and reducing disruption to education, family and social life
- best use of funding

7.0 Options Appraisal

7.1 The following options have been developed looking at how the proposed model could be commissioned and provided.

**OPTION 1:** We do nothing.

<table>
<thead>
<tr>
<th>Pros</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>No cost</td>
<td>High levels of tier 4 admissions continue</td>
</tr>
<tr>
<td>No recruitment needed</td>
<td>Poor CYP and family carer experience</td>
</tr>
<tr>
<td></td>
<td>Poor psychosocial outcomes for CYP in Suffolk</td>
</tr>
<tr>
<td></td>
<td>Risk to patient safety</td>
</tr>
<tr>
<td></td>
<td>Continued over demand on community services leading to continued increasing crisis demand</td>
</tr>
</tbody>
</table>
OPTION 2:

This option will implement a CYP outreach model that will provide intensive crisis support for CYP up to the age of 18, this service will provide an offer for east and west Suffolk. The service will offer an intensive evidence based clinical offer to work with CYP in crisis to safely and effectively manage their needs when presenting in crisis for a period of up to eight weeks. This offer will work within the overall crisis all age model for Suffolk.

We have reviewed the current recorded face-to-face contacts from NSFT to try to understand the demand that is seen as 'additional need' within current community and crisis response teams. These contacts are recorded as urgent and emergency contacts so is defined as crisis need post assessment.

This below table details the number of contacts recorded within NSFT post assessment by the crisis and community defined as urgent and emergency contacts. This equates to approximately 15 contacts a week or two contacts a day across east and west Suffolk. Over the last 18 months, the following data was recorded:

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Number Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>165</td>
</tr>
<tr>
<td>Tuesday</td>
<td>156</td>
</tr>
<tr>
<td>Wednesday</td>
<td>170</td>
</tr>
<tr>
<td>Thursday</td>
<td>172</td>
</tr>
<tr>
<td>Friday</td>
<td>142</td>
</tr>
<tr>
<td>Saturday</td>
<td>126</td>
</tr>
<tr>
<td>Sunday</td>
<td>143</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1074</strong></td>
</tr>
</tbody>
</table>

We have also looked at the number of tier 4 admissions over the last two years to understand the likely demand for admission avoidance. The following table details that demand:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Number of tier 4 admissions 0-18 years</th>
<th>Number of transforming care CYP within tier 4 admission numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/18-01/01/19</td>
<td>75</td>
<td>12</td>
</tr>
<tr>
<td>01/01/19-01/01/20</td>
<td>74</td>
<td>19</td>
</tr>
</tbody>
</table>

We considered if all of these young people received an average of a four-week intervention, across a year with four appointments a week this would equate to 1200 hours of input. This is an average of what we think will be needed. We recognise some interventions will be longer and some will be shorter.
We then considered the demand detailed above that looks at 1074 urgent and emergency contacts from NSFT over 18 months and equated each contact to an hour of face-to-face contact time.

This enabled us to estimate a predicted need of 2274 hours of face-to-face time. We have then factored in the prevalence data to create a workforce we believe can meet needs based on this. In addition to this, we have had to factor in an average of an hour for every clinical contact in administration time and travel time as this will be a countywide service offer. We also recognise that demand is predicted on as much data and knowledge that is available but we have built in additional clinical time to cover additional demand that may present, as this is a new service. This demand has added an additional 25% of clinical hours on top of what has been predicted.

We have also considered the coverage needed based on what the data indicates are the times of highest need across a seven day week, we have then cross referenced this with other delivery models across the country with similar type populations sizes.

<table>
<thead>
<tr>
<th>Pros</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of young people reporting they:</td>
<td>• Level of unmet need is greater than predicted.</td>
</tr>
<tr>
<td>o Have a choice of appointment</td>
<td>We have factored in additional capacity to allow for additional</td>
</tr>
<tr>
<td>o Are able to get the right support and treatment when they needed</td>
<td>need in addition to what our data and prevalence predicts.</td>
</tr>
<tr>
<td>it, at a time and place that was convenient</td>
<td>To consider a period of start-up flexibility to allow additional</td>
</tr>
<tr>
<td>• Reduced complaints</td>
<td>resource should demand outweigh what is predicted. This may involve</td>
</tr>
<tr>
<td>• Improved clinical outcomes for CYP and families and carers</td>
<td>buddying with another service.</td>
</tr>
<tr>
<td>• Young people’s mental health and wellbeing will improve as a result</td>
<td>Discussion with NHS England to see if they can support our start up</td>
</tr>
<tr>
<td>of the support and treatment they receive</td>
<td>transition phase.</td>
</tr>
<tr>
<td>• Decreased Tier 4 admissions- leading to cost savings longer term</td>
<td>To consider a phased implementation of offer to reduce the possibility</td>
</tr>
<tr>
<td>• Provider clinical oversight of the Dynamic support register</td>
<td>of the service becoming overwhelmed as it embeds.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role</th>
<th>Establishment needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 6 practitioner</td>
<td>2.95 wte at B6</td>
</tr>
<tr>
<td>To include LD nursing, Social work, skill set for drug and alcohol</td>
<td></td>
</tr>
<tr>
<td>Band 8b Psychologist</td>
<td>0.74 wte</td>
</tr>
<tr>
<td>Psychiatrist (To consider Nurse consultants if unable to recruit psychiatrist)</td>
<td>0 (To utilise crisis consultant in all age pathway, session support to be agreed as this function will cover the all age crisis CYP pathway)</td>
</tr>
</tbody>
</table>
The total investment of £973,660 would deliver the following CYP outreach rota across East and west Suffolk. We would suggest an initial investment of £486,830 in year 1 (this would include a phasing cost with implementation planned for October 20), followed by £973,660 in year 2 an addition of £486,830 from 2020/2021.
<table>
<thead>
<tr>
<th>9-1 (sat- sun)</th>
<th>1xB6 1xB4 (to be clinically supported by all age crisis service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible working needed (Monday to Friday) with consideration of rotation cover over weekend if needed.</td>
<td>1x B7 (operational lead) 1x 0.6 wte B8b (Psychologist) 1x B8a (Family therapist) Access to CYP crisis Psychiatrist (agree session time)</td>
</tr>
</tbody>
</table>

This equates to shift hours of:

- 4680 hours of B6 time
- 4680 hours of B4 time
- 4160 hours of B7 time

Proposed staffing structure chart:
7.2 All other roles outside of the rota will work flexibly Monday to Friday dependant on need but will be based on 8-hour working days.

7.3 The personal health budget allocation is based on a Norfolk model that has seen great benefit to the young person and their families when given a personal health budget up to £500. With the implementation of the CYP outreach team, this would provide the clinical oversight and governance to provide this personalised offer alongside the outreach commissioned service.

7.4 Personal health budgets are a way of personalising care, based around what matters to people and their individual strengths and needs. They give people with long-term health conditions and disabilities more choice, control and flexibility over their healthcare.

7.5 Personal health budgets are part of the NHS’s comprehensive model of personalised care, which will, as part of the NHS Long Term Plan, transform 2.5 million lives by 2023/24. (NHS England)

7.6 It is felt this offer of personalisation will respond to feedback from young people and families around how the experience has felt and what could improve their experience and outcome. This will also offer an additional offer of care that will work with children, young people and their families to reduce admissions and improve care outcomes.

7.7 Option two is the recommended option. If agreed the next stage of work will be to work through how the model can be commissioned and who is best placed to deliver this. The team’s initial thoughts are that Suffolk County Council and NSFT should provide this in partnership as part of the wider developing CAMHS model.

8.0 Recommendation

8.1 To consider approval of option two within the business case to fund the development of a CYP (0-18) Mental Health Crisis Outreach Team.
Appendix 1.

Workforce development needs and costs:

The APT Diploma in working with Children and Adolescents provides 120 hours of training over 12 months. The diploma comprises 20 days of training made up from your eight chosen modules/courses below. You can select four 3-day modules and four 2-day modules. The whole group attends the same modules.

- The RAID® Course
- Motivational Interviewing, and how to use it effectively
- DBT Essentials (Dialectical Behaviour Therapy)
- The Assessment and Risk Assessment of Children and Adolescents in Crisis™
- Running Skills Development Groups
- CBT Essentials (Cognitive Behavioural Therapy)
- ADHD: Key Knowledge and Skills for Effective Biopsychosocial Intervention
- There Must Be A Better Way® (Treating Non-Suicidal Self-Injury)
- Teaching Mindfulness in Clinical Practice, Level 1
- Mindfulness-Based Cognitive Therapy
- The Effective Treatment of Anxiety in Children and Adolescents
- SFT Essentials (Solution-Focused Therapy)
- Attachment in Practice™
- Repairing the Damage™
- Providing Good Clinical Supervision
- Removing the Blocks to Good School Attendance

We would be recommending a one off cost to train all of the clinical team in the above areas at a cost of £30,490 plus VAT. This would train the entire team, it would then be expected that the organisation providing the service continue with professional development.
Appendix 2

Crisis care:

- “Don’t be afraid to seek help” is the current mental health message, but when you seek help for crisis care, you have to go to A&E. There needs to be mental health nurses, or professionals trained in mental health manned at A&E 24/7. There is also no privacy in A&E- you have to sit in the main waiting room, and then are put onto a corridor with the curtain open when you are being seen.
- “It’s like you have to time your crises”. Mental health crisis care is open 9-5 Monday-Friday. Young people have said that if you have a crisis on a Saturday evening, or during out of hours, you have to wait a long time to be seen.
- There needs to be a replica of A&E specifically for mental health. A&E doesn’t know how to respond to mental health problems, and young people tend to find the triage process takes around 4 hours. Some young people have been told by professionals that it is ‘just their hormones’, ‘here we go again’, ‘oh I guess you’ve broken up with your partner or whatever’, ‘were you bored?’ etc.
- Crisis support needs to be stronger, especially for under 14’s as there currently isn’t crisis care for them.
- The group also mentioned crisis care in relation to the transformation plan, as they all have experienced crisis services. Jo John has agreed to explore further options for the group to be involved in rethinking crisis services.

Views on original Draft crisis proposal

Question 1: should we have one model across East and West Suffolk? yes, one service across East and West. This needs to be consistent - for example; Wedgewood and Woodlands work differently, so if crisis team are based in each one they will work differently.

Question 2: how shall we align the age group? 0-25 would be best, as youth pathway is up to 25. Adult pathway starts at 18.

Question 3: what are the right hours of operation, and who will manage crisis referral in between? timings from 15:30 – 23:30 hours. It’s better later, plus you will have cross over with working hours. “You can’t time a crisis!” Adults get night time crisis support (how can we link with this?). Crisis referrals in-between 23:30-09:00 will have to be managed by 999 and A&E, or got to IDT for triage.
If people over 18-25 are using the youth service and not adult services, could that free up time/people to respond over night for young people too?

**Question 4: is it the right location?** Woodlands and Wedgewood are adult wards. Young people over 18 could be admitted to either hospital, but under 18’s would have to go elsewhere (in Suffolk – Lothingland or out of Suffolk). The team could easily talk to Wedgewood or Woodlands for an easy transfer for over 18’s. Therefore, there will be different services for under and over 18s. Why are they based at Woodlands or Wedgewood – what is the reasoning for this? Will the staff be used for other things? They are good locations, if the above concerns are taken into consideration.

We need to use case studies to map pathways.

**Question 5: is the team likely to deliver expectations?** someone who’s able to help – be comforting and reassuring. Have access to any records such as care plans (e.g. care plan may say ‘I don’t talk well on the phone’). Be able to assess the young person and the situation. They should follow up with you – they take ownership of the call. If they need to pass you on, they should keep you in the loop and stay with you until your issues are sorted. Respond to each person as an individual; ‘what has worked well for you before? What have you tried? Is there anything I can do for you right now?’. Be led by the person on the phone, don’t just go through a rigid ordered checklist. Response needed depends on situation. Some young people might just want to be heard and listened to; sometimes they just need to talk. Don’t put a time limit on calls. Times when seeing someone face to face is needed. Explain this, who, how, when etc.

How would it work? Who would answer the phone; the band 3 or the band 6? Is it a lucky dip? Would the band 3 triage and then pass to the band 6?

**Question 6: Is this enough staff?** not enough staff! Just going to end up passing you on.

**Question 7: given the other developments that are happening within Suffolk, such as the EWH and AAT review, what should the aims of the team be?** respond to all, not just NSFT clients. Aim to support you to get the right help as soon as possible. What does brief intervention mean? E.g. is it like Home Treatment team?

**Question 8: what should the primary functions and priorities of the team be?** At the very least telephone calls and onward referral. At the most, all things on the list under ‘Function of the Team’ heading should apply. How does it link with police duty of care?

**Question 9: does this team have an educative and training function to the rest of the workforce such as schools and colleges?** Yes, but how will they have time to educate others, due to short staff numbers and shift patterns?

**Weekends:** consistency on Saturdays and Sundays to have the service between 15:30-23:30, as when you’re in a crisis you may not know what day it is. Problem with a clinic in A&E is you have to turn up, but the phone is more accessible in a crisis. Follow up appointments are really important. How will it work with the new 111+1? It can’t be the same number as the hub because of this, and also the hub closes at 20:00.
Appendix 3

Coproduction – Young People have told us that the ideal worker...

Is able to give appropriate and sensitive responses
Is patient, kind & friendly
Respects your individuality
Praises achievement and gives positive feedback

Is able to remain calm
Has knowledge of conditions and services
Has good signposting skills
Is non-judgemental & takes you seriously

Doesn’t expect too much from you
Allows you to take your own time
Doesn’t cut you off or make assumptions
Gives you space when you need it

Is able to recognise signs of emotional and mental health problems
Understands that not one size fits all
Goes the extra mile or even cm!

Coproduction – What does ‘good’ look like?

Accessible
-I know where to go and getting help is clear & simple
-I received a prompt response
-I was kept informed of what was happening and how long I would need to wait
-The waiting time felt appropriate for the situation

Effective
-The service helped me move closer to achieving my goals
-My emotional wellbeing has improved
-My concerns or symptoms have reduced
-I can now do more of the things I want and need to do
-I was informed of the evidence for the approach offered

Kind
-I have confidence in the person helping me
-I feel listened to and treated with kindness
-I am offered an individualised approach and choices about my care
-My family and I are involved in decisions about our care
The Suffolk Practice Model

• Collaborative Assessment and Planning
  • Approaches which provide frameworks to think into and through casework

• Solution Focused Brief Therapy
  • Deepening practice around questions and scaling

• Finding Naturally Connected Networks
  • Building our capacity to develop sustainable and healing networks around people and families

• Relevant practice-based and academic research
  • Underpinning and deepening practice
Overall Conclusions - 2/4

- Most Vanguard sites offered a combined crisis and intensive home treatment pathway: Early indications suggest that fully resourced services were able to balance the demands of crisis response with those of scheduled follow-on and intensive care and that this contributes to reductions in re-attendance.

- Mature, dedicated CYP services also reported relatively stable rates of crisis presentation within a consistent range: circa 5.2 – 7.9 per 1000 CYP pa – ie equating to 624 - 948 presentations for a notional population of 120,000 CYP.

- Services increased the proportion of CYP responded to in community settings and reduced trends of increased CYP MH crisis presentations to emergency departments and admission to paediatric wards.

Overall Conclusions – 3/4

- Staffing rates for nurse-led teams varied above a minimum team size, reflecting local investment opportunities and service models, particularly the hours of operation and focus on intensive home treatment.

- Effective teams promoted strong professional and procedural relationships with local partner services to promote an integrated whole system response.

- Strong partnerships and integrated working with the wider community CAMH team was a critical success factor to ensure both access to specialist skills and a smooth flowing patient pathway.
Supported Discharge Service versus Inpatient Care Evaluation (SITE)

The first UK RCT of an intensive community treatment service for adolescents
Dr Dennis Ougrin, KCL and SLaM
Ms Mandy Sarhane

What is Intensive Community Treatment?

- **Intensive (Assertive) Community Treatment** is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to young people with serious and persistent mental illness.
Results: length of stay

- SDS mean 47.25 days
- Inpatient Care mean 84.32 days
- LOS difference 37.08 days

The ratio of the geometric mean total of inpatient hospital days from the TAU treatment group to the SDS treatment group was 1.67 (95% CI: 1.02 to 2.81), t (101) = 2.08, p=.04

Results: school reintegration

- Young people were significantly more likely to be re-integrated back to school with SDS (.81 SDS vs .51 TAU, χ² (1, 106) =10.768, p<.003, OR= 4.14, 95% CI 1.73 to 9.92)

- Days NEET SDS Median=49, TAU Median= 95.5, U= 665.00, p< .004
Background - Context

Ambition for crisis services set out in Future in Mind (2015) and The Five Year Forward View for Mental Health (2016)

By 2020/21, NHS England should expand Crisis Resolution and Home Treatment Teams (CRHTTs) across England to ensure that a 24/7 community-based mental health crisis response is available in all areas.

For children & young people, an equivalent model of care should be developed within this expansion programme

2. Service User Experience

Sites with high service user satisfaction demonstrated care that included

- Prompt access
- Choice of locations
- Individual flexible plans
- Continuity

Continuity of care – from a single practitioner where possible was highly valued particularly in brief intervention and IHT. Important components also included

- Involving families
- Co-produced agreed treatment options and,
- Goal orientated approaches (NB goal based outcomes)
6. Partnerships & Engagement

- **Participation** by CYP service users and carers played a powerful role in shaping service vision and in supporting implementation.
- **Strong leadership partnerships with stakeholders**, cross boundary working and a flexible approach to crisis management were success factors for a CYP crisis service.
- Services developing close working with ‘blue light’ agencies reported a reduction in CYP ambulance transportation. 
  
  30% reduction in ambulance transportation of CYP in crisis in Durham.
- **CYP receiving IHT follow-on support** used crisis services less often subsequently.
  
  Re-access rates:
  - Solihull = 12%
  - Teesside = 19%
  - Less integrated service = 41%

4. Referrals and Location

**Referrals sources and location of assessment**
- Majority of referrals from community sources.
- A&E remains largest single referral source.
- New services report initial increase in community referrals.
- Increased use of community locations for initial assessment.

![Graph of Source of Referral - All Sites](chart1)

![Graph of New Sites: Location of Assessment](chart2)