Richmond & Kingston Children and Young People's Mental Health Pathways

An Independent Review

March 2024

South West London Integrated Care System

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Review Aims, Approach & Recommendation Overview

Key Area of Focus	Contents of this pack
1. Current children and young people's landscape and service configuration	• Overview of key characteristics at place • Experiences of the pathway across young people, parents and families and teachers • Mapped pathway and journeys against these, including waiting times • Workforce and funding information • Identified gaps in service offers
2. Nature and efficacy of the interfaces between services	• Types of interface across the system and their challenges both in design and delivery • Specific findings on Mental Health Support Teams in schools (MHSTs) • Specifics on the utilisation of VCSE • Outline of issues with current governance framework
3. Merits and weakness of the multi-provider model in Kingston and Richmond	• Overall findings regarding the clinical pathway delivery as a multi-provider model • Challenges with neurodevelopmental across the two respective places, again delivered with multi-provider use • Resulting waitlists and how these are managed • Opportunities related to iThrive as a future model design

Methodology

- Qualitative data collection & analysis via:
  - in depth individual interviews & group sessions
  - joining operational and clinical staff meetings
  - attending stakeholder forums
  - documentation review of strategies, previous roundtables, action plans, service overviews and projects
- Quantitative data analysis via:
  - existing business as usual service data and performance reports including on activity and waiting times
  - bespoke data work responding to identified gaps, such as step up/downs and transfers
- Development of themes, hypotheses and resulting recommendations
- Closed stakeholder session to test draft recommendations
- Regular oversight from steering group with senior leaders from ICB and place, and CYPMH experts

Recommendations

Place-based strategic leadership, ownership and accountability

1. Agree new core delivery model, moving away from the current two-provider set up
2. Agree a place-based vision for iThrive framework
3. Take forward implementation of iThrive

Clinical Pathway Delivery

4. Ensure a trusted and flexible model of care
5. Realign the Neurodevelopmental (ND) pathway

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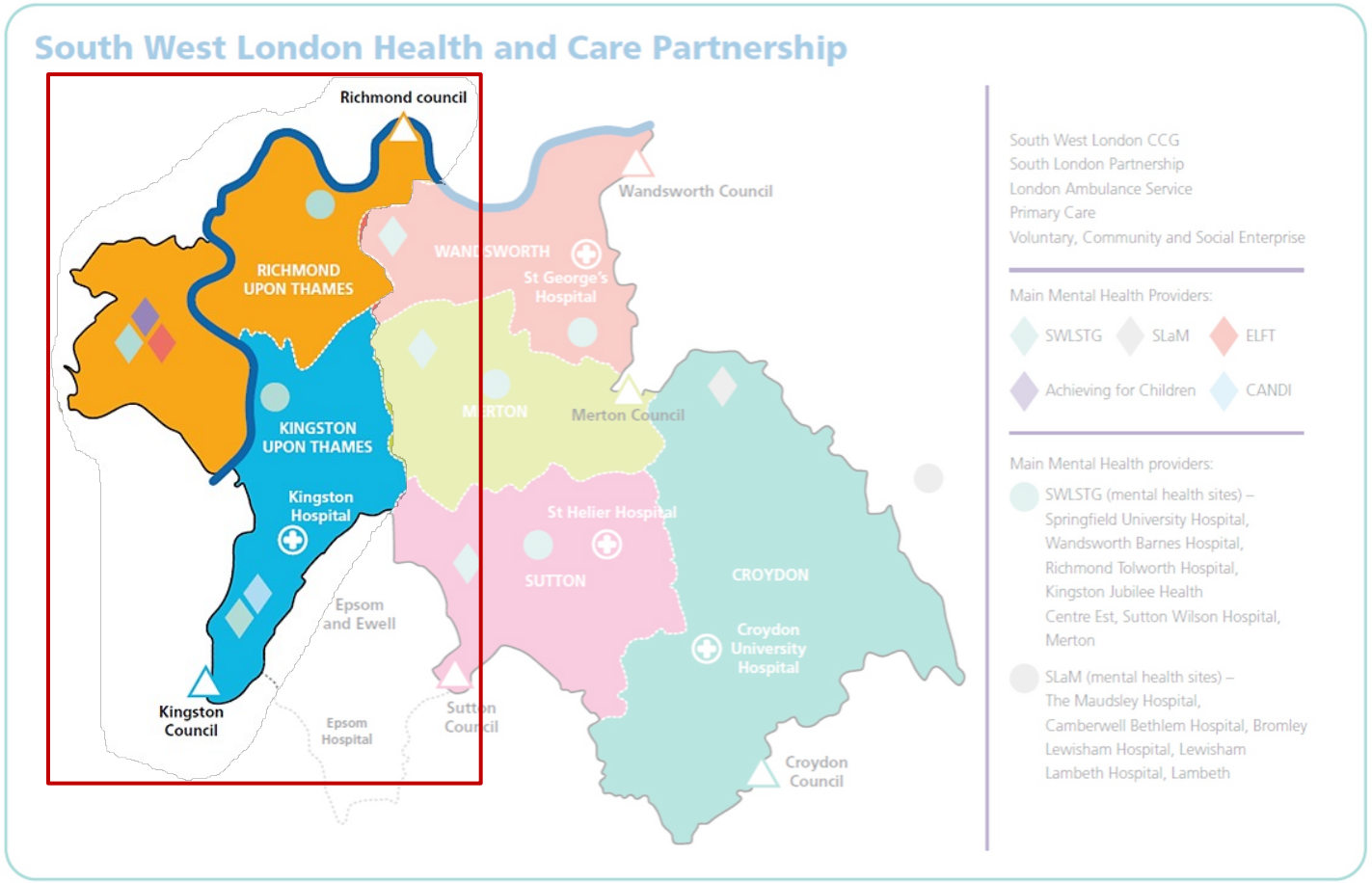
Introduction & Context

Introduction

South West London Integrated Care Board (SWL ICB) have agreed a five-year mental health strategy which offers the opportunity to consider service and pathway models across all six boroughs and work to ensure that both outcomes for children and young people (CYP) and their families currently utilising support, and future users, are optimised. The strategy also recognises the need to focus additional resources around CYP mental health as a population level prevention initiative recognising that 50% of all long-term mental disorders present by age 14 and 75% by age 24.

Within this, CYP mental health is a key priority for both Kingston and Richmond Places and is highlighted within each borough's health and care plan. Services in both boroughs, in common with the wider SWL, regional and national picture, have been experiencing increasing demand and complexity of presentations since the Covid pandemic. This has put pressure on service capacity, when SWL overall already benchmarks below average for London and England in terms of CYP mental health funding and workforce.



However, metrics - in particular, waiting times - suggest a level of unwarranted variation in Kingston and Richmond place which required work to determine cause, impact and actions to address. In recognition that significant work had already taken place from partners working *within* those boroughs and the system more broadly, SWL ICB commissioned **an independent rapid review**. This review took place between December 2023 and February 2024.

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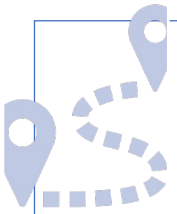
Aim of the Review

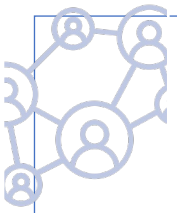
Data suggested adverse variation in Kingston & Richmond compared with neighbouring boroughs, delivered with a different provider set up.

The review will set out recommendations for further improvements to access, experience, and outcomes for CYP and their families and, where appropriate, recommend how existing resources could be put to better use.

Three main asks of the review:



Current CYP mental health landscape and service configuration



Nature and efficacy of the interfaces between services

Merits and weakness of the multi-provider model in Kingston and Richmond, including compared with others

Specified Outputs:

- *Mapped pathway of existing SWL ICB and local authority commissioned CYP mental health services across Kingston and Richmond*
- *Understanding of funding, workforce & operational performance metrics including waiting times and quality*
- *Challenges and areas of best practice and learning with existing pathways*
- *Provision including gaps, duplications and opportunities for improvement*
- *Consideration to wider SWL and South London work, including how around CYPMH plans can fit together at "place" and more broadly*
- *Consideration of the views of stakeholders, including education leaders & staff working in services*
- *Review of options to improve data reporting and data quality.*
- *Review of support offered for CYP awaiting assessment / treatment.*

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Methodology

The review used a mixed methodology of quantitative and qualitative data collection and analysis to enable the development of themes and hypotheses. Progress was tracked by an oversight group made up of senior leaders at SWL and place level, as well as CYPMH experts
To note, the reviewers, despite multiple attempts and approaches, had very little direct contact with young people currently using the service.

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1:1 interviews with stakeholders from across the pathway, categorised into core groups:

1) those in service delivery: clinical and operational leads, and frontline staff from the Emotional Health Service and other teams in Achieving for Children (AfC) and South West London and St George's (SWLstG); voluntary sector partners; analytical and performance leads
2) those experiencing or interfacing with the offer: young people, families, education leaders,
3) system partners: executive leaders, commissioners from health, local authority, public health; safeguarding; leads from a local Emergency Department

7

Further group sessions with parents & carers, staff working in primary and secondary schools, and frontline staff from teams in AfC and SWLstG

48

Documents reviewed and analysed, from South West London wide strategies, to outputs from previous deep dives into Kingston & Richmond, to commissioning specifications and performance reports

27

Data points reviewed, analysed and attributed to key aspects and themes emerging from stakeholder engagement and documentation review

5

Overall recommendations developed and tested with a group of core stakeholders before being finalised with detailed sub-points to address specifics in the clinical pathway as well as need for place-based strategic leadership, ownership and accountability

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Borough profile: Richmond

199,157 Population

29% Black, Asian, minority ethic

86.4 **82.2** Life expectancy

4% of residents live in the most deprived areas (C20) of Richmond — Deprivation

Children

11% of children are obese by year 6

Hospital admissions as a result of self-harm are the highest in London for ages 10-14. Hospital admissions as a result of self-harm are second highest in London for ages 15-19

Hospital admissions due to substance misuse are 4th highest for children and young people across London

Adults

51.9% of the population are obese. Obesity accounts for 80-85% of the risk of developing type 2 diabetes

Admissions for alcohol specific conditions have increased in the last 5 years

Cancer screening rates are low compared with the rest of London but in top 7 highest rates of cancer diagnosis rates in London

Older people

16.2% (32,403) of population are over 65 which is higher than London average. It will rise to 38,000 in 2029 with biggest rise in 75-84 years

4.7% of adults 65+ were living with dementia and this will increase by 29% by 2029 in 80yr+ group

Falls are the largest case of emergency hospital admissions for 65+ (2,567 per 100,000) which is the fifth highest in London

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Borough profile: Kingston

176,313 Population

32% born in countries outside UK

Sri Lanka, India, Korea

85.2 **81** Life expectancy

2% of residents live in the most deprived areas (C20) of Kingston – their lives are 6 years shorter

Deprivation

Children

18.6% of children are obese by year 6

Hospital admissions as a result of self-harm are the 3rd highest in London for ages 10-14. Hospital admissions as a result of self-harm are the highest in London for ages 15-19

3rd highest London borough where looked after children have emotional wellbeing as a cause for concern

Adults

65% of the population are over 16.64

Half the population are overweight and obese. 5.1% have a diagnosis of diabetes

10.3% have hypertension

Breast, bowel and cervical screening rates are low, but 5th highest rates of cancer diagnosis

Older people

23,494 of people are over 65. It will rise by 6,500 by 2026

1 in 14 have dementia

37% live alone

68.3% have high blood pressure

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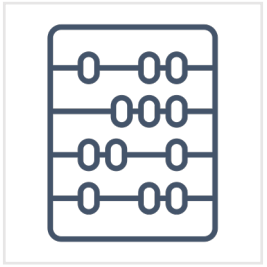
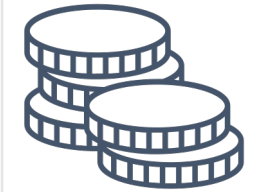
Context: Documentation Review snippets

Documentation at South West London level and place level to Kingston and Richmond was provided as part of the review. This included information on population, need, and previous work to address the challenges for CYPMH



CYP in school with social, emotional and/or mental health needs is 2.7% for London, 1.9% for Kingston and 2.8% for Richmond



SWL spend on CYPMH at 10% against a national average of 14%, with SWL as the lowest investor across London *(SWL Mental Health Strategy)*

Proportion of the population from Black, Asian and Minority Ethnic backgrounds is 52.6% on average for London, and below this average for Kingston (42%) and Richmond (31%)

Kingston, Richmond (& Sutton) have the highest rates of admission for deliberate self-harm in London, with Kingston rate twice the London *average (SWL Mental Health Strategy)*

Roundtable held in December 2021 resulting in 38 actions across 5 workstreams – from iThrive implementation to referral pathways to prevention. *(CYPMH roundtable packs & write up)*

Kingston note their need to Improve access to support for children and young people with neurodiverse conditions and their families, in particular access to support with their mental health (*Kingston JNSA)*

In 2021, 22.9% of the Richmond population was under 18, with the lowest child poverty in London, and lowest Looked After Children in London but with the highest percentage with mental health needs *(Richmond JNSA)*

Follow up CYP access deep dive at SWL level in July 2023 found success in MHST roll out, but variation in borough funding and commissioning and increased referrals *(CYPMH Access Deep Dive Packs)*

MHSTs highest reason for referral is anxiety and unrecorded, and source of referral 86% by school *(MHST Performance Report Q4 22-23)*

Kingston & Richmond SPA started in 2014 and enhanced in 2017 with a sub-team to offer triage and consultation on top of signposting, screen and risk assessment *(SPA service specification)*

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Context: Service Setup & Terminology

A fully mapped pathway is included in the detail of this review. However for context the service set up and terminology that will be used is set out here. It is also noted that although there is a commitment to move away from traditional "Tiers", this is still the predominant language used in these boroughs and will be used throughout the review.

Achieving for Children (AfC) is a community interest company (a not-for-profit social enterprise) created in 2014 by the Royal Borough of Kingston and the London Borough of Richmond to provide their children's services. For children and young people's mental health (CYPMH), AfC is the provider of:

- the **Emotional Health Service (EHS)** Richmond and Kingston - individual cluster teams. This is the overall "Tier 2" (mild to moderate) offer, and AfC is the provider and majority funder
- the **Mental Health Support Teams (MHSTs)** in schools (health funded – SWL ICB/NHS England)
- Non-complex single neurodevelopmental assessments (health funded – SWL ICB)
- AfC also provide an 'embedded clinicians' service in the wider children's social care teams (AfC is the provider and funder)

South West London and St George's (SWLstG) is a Mental Health Trust that serves 1.2 million people across the London boroughs of Kingston, Merton, Richmond, Sutton, and Wandsworth. This includes Child and Adolescent Mental Health Services (CAMHS):

- Kingston and Richmond "Tier 3" (moderate to severe) individual borough teams (health funded – SWL ICB)
- Kingston and Richmond joint Single Point of Access (SPA) which acts as the gateway to "Tier 2" and "Tier 3" for Kingston & Richmond (health funded – SWL ICB)
- Complex and dual neurodevelopmental assessments (health funded – SWL ICB)

In the remaining boroughs for SWL (except Croydon), SWLstG is also the provider of an (SWL health funded) "Tier 2" team

Voluntary, Community & Social Enterprises (VCSEs) provide offers in Kingston & Richmond, including:

- **Off the Record** for free counselling up to age 25
- **Richmond Mind** for parent and carer support, group work for children and young people and other short-term funded projects

When this review notes **"AfC"**, it is referring to the overall organisation who commission and provide children's services. This could be thought of as equivalent to the 'Local Authority' when referenced to other boroughs.

When this review notes "**EHS"** or "Tier 2", it is referring to the **Emotional Health Service** – EHS is provided by the AfC.

When this review notes "**Tier 3**" or "**CAMHS**", it is referring to the teams delivered by SWLstG.

Findings:

1. Current children and young people's landscape and service configuration

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Findings: Strengths & Areas of Good Practice

Significantly, and noted by multiple stakeholders and partners across the pathway, was **respect for the skills of clinicians as individuals**

Consultation model provided by **embedded clinicians to social care** is valued

The **quality of intervention** when someone is seen is often good - for example young person experience of counselling very positive, they **felt heard**

A number of **committed and stable stakeholders** (for example across health, social care, VCSE, public health and education) who are well informed on the issues, and keen to see and enable an improved future offer

Transitions hub is helpful to anticipate need - when early clinical input and advice is received it is really helpful and reduces the level of discharge package required

Significant work to **develop staff to help with retention,** for example a number of trainees choose to stay

Joint initiative between Education and Health: both EHS and Tier 3 staff outreaching to support early identification and advice for **alternative medical provision**

Praise for EHS **outreach support for ASD**

Pegasus project (play therapy in primary care) seen as positive

MHSTs valued, both in terms of **widespread implementation** and their in-school presence

Specialist school provision is good

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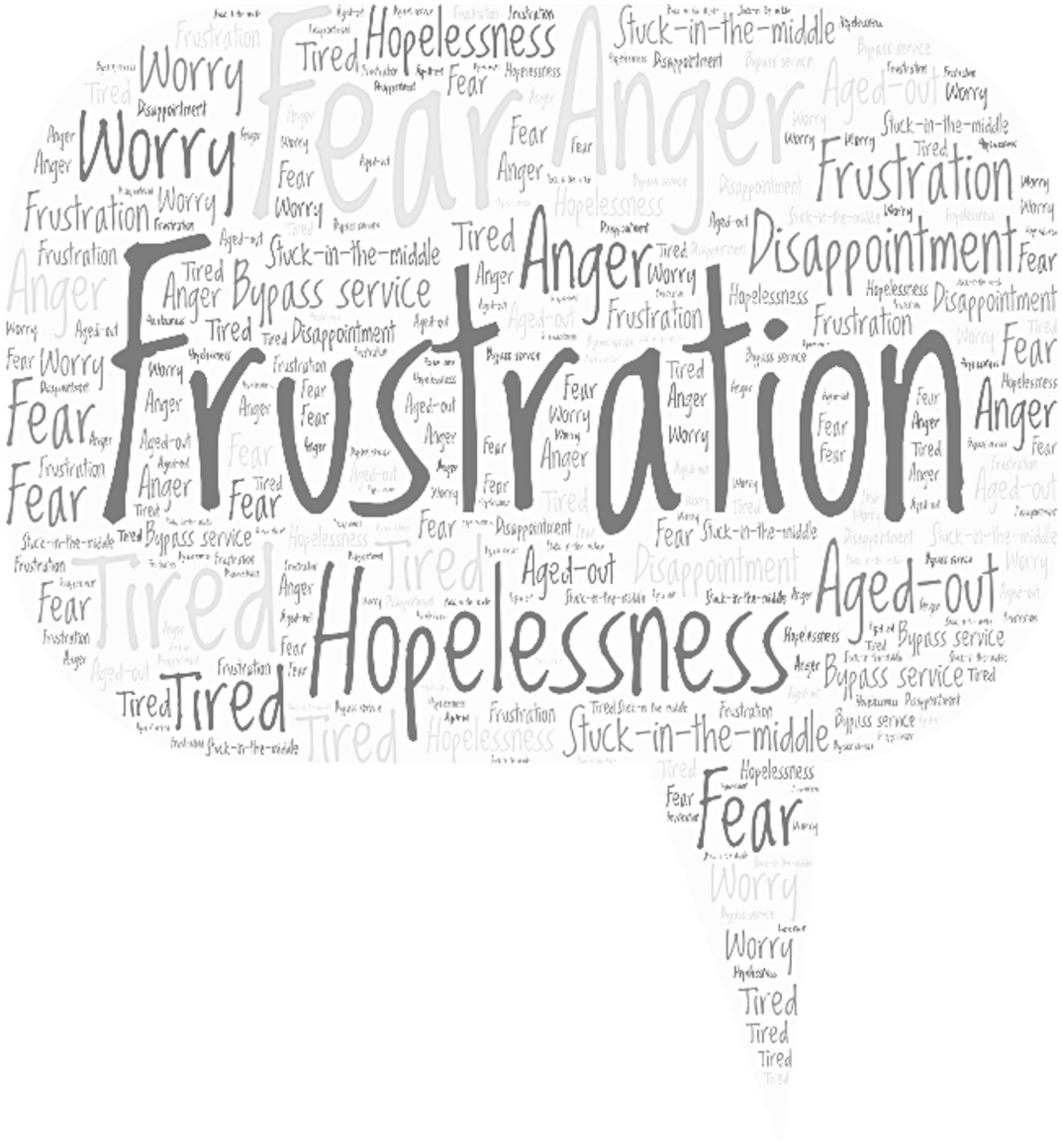
Findings: Experience of the current pathway



The review involved multiple stakeholder sessions and conversations, ranging from one-to-one interviews, to groups, to joining operational meetings or forum to understand the experiences of the current pathway.

During these conversations, stakeholders were given an overall introduction of the review and its aims, emphasising its independence and that feedback would not be directly attributable to individuals to enable open discussion. Broadly stakeholders were encouraged to provide free-flowing information, with prompts around what is positive about the current pathway, what are the challenges and their causes, and what ideas they have that might improve it.

The wordcloud on the right shows responses to "*describe three emotions to sum up your interaction with the service"* – taken from one of the questionnaires designed by the Parent Carer Forum for their members.

Further insights from all the stakeholder sessions are set out on the next page.

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Findings: Experience of the current pathway

No-one would set up a pathway like this with children and young people and their families in mind

It's tiring filing in endless forms and repeating your story.

Referral is a point of opportunity - this is missed due to waits and boundaries

We miss out on bringing other partners on board because there is such a lack of proper process and funding

Pathways are totally obscure to families; it is a nightmare to navigate

Language of a battle ground – having to argue your case and fight for everything

No real support whilst you are on the wait list other than a perfunctory "are you alive?"

Check in calls are counter-productive if there is no information about any next steps

We have been waiting one year with my child out of school and have never been seen

No phone numbers so there is no way to speak with a human

Bombarded with information – when really we need some hand-holding to process it

I feel like I'm a project manager of my own child

I don't want to be an expert in service delivery and service offer, I want to be an expert in my child

They have been "aged-out" of the service whilst waiting for it

A revolving door. Sent down lots of dead ends and long waiting lists.

Parents are bankrupting themselves to pay for help themselves

It's all a treasure hunt. I went through SPA initially and emailed past professionals to help

We [teachers] aren't specialists, yet we feel like we are gatekeeping services

Wait for assessment but then feel abandoned without support

What does "on the books" mean - to staff, to families and their children

Disruptive children at school get noticed more and access support over less visible

It's so hard to have to let families down who have been waiting so long

Only get seen in crisis and told to go to A&E. A waiting list is incredibly unhelpful in a crisis situation

I haven't even bothered to refer because I know the waits are so bad

Having to wait so long has meant we have had an inpatient admission

Hearing myself describe it out loud, it is such a mess of a pathway

The reality is there is very little whilst you wait

I struggle as a middle class parent with resources – imagine what it is like for those without such advantages

Quoted experiences and views from staff, parents, young people and teachers collected during the review

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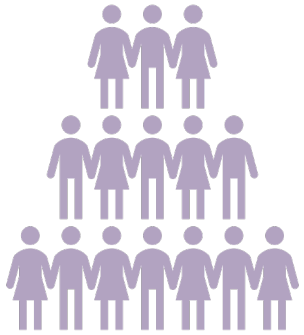
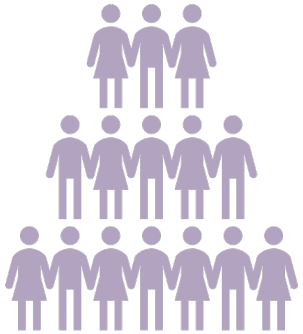
Findings: Workforce

Kingston



Total staffing across Tier 2 and Tier 3 is 24.1 WTE
75% of these are qualified staff with 3.9 WTE medical workforce

Richmond



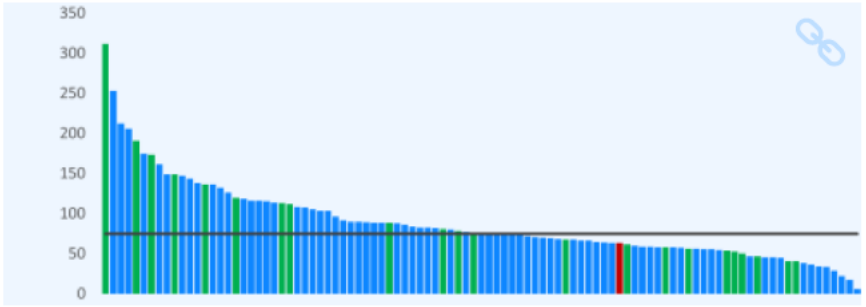
Total staffing across Tier 2 and Tier 3 is 27.8 WTE
76% of these are qualified staff with 4.4 WTE medical workforce

Workforce information provided by AfC & SWLstG service leads

NHS Benchmarking 22-23
Workforce in General CYPMH teams

Kingston

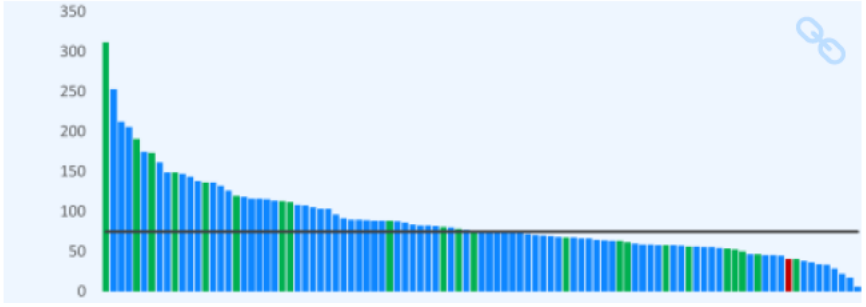
Community workforce per 100,000 population



CY456	63.2
Mean	88.5
Median	74.7
Upper quartile	111.7
Lower quartile	57.7
N	99

Richmond

Community workforce per 100,000 population



CY459	40.8
Mean	88.5
Median	74.7
Upper quartile	111.7
Lower quartile	57.7
N	99

Kingston & Richmond benchmarking is often used across the system to note a low level of WTE against population. However, critical to note **that NHSBN workforce data does not include EHS staffing**, employed by AfC therefore skews the workforce picture. This review found **the WTE total when including the Tier 2 offer is within equivalent range for other SWL boroughs** (see next page).

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Findings: Workforce against performance

	Kingston	Richmond	Merton
0-18 registered population *(SWL GP practice data, 2023)*	**42,219**	**47,919**	**50,840**
Emotional Health Service ("Tier 2") Qualified staff (WTE)	6.9	7.7	12.1
Emotional Health Service ("Tier 2") Unqualified staff (WTE)	3.0	3.0	0.0
CAMHS ("Tier 3") Consultant medical	1.7	1.6	2
CAMHS ("Tier 3") Other medical staff	2.2	2.8	3
CAMHS ("Tier 3") Qualified permanent staff (WTE)	6.7	7.9	8.5
CAMHS ("Tier 3") Qualified fixed term/honorary staff (WTE)		0.8	
CAMHS ("Tier 3") Unqualified permanent staff (WTE)	3.6	2.0	1
CAMHS ("Tier 3") Unqualified fixed term/honorary staff (WTE)		2.0	
Total Tier 2	***9.9***	***10.7***	***12.1***
Total Tier 3	***14.2***	***17.1***	***14.5***
Total all	***24.1***	***27.8***	***26.6***

Merton has been chosen as comparator borough as it is nearest in population size, with data completeness on waiting times, and is performing best across all wait time metrics

	Kingston	Richmond	Merton
"Tier 2" Staff per 50k registered 0-18 population	11.7	11.2	11.9
CAMHS ("Tier 3") Staff per 50k registered 0-18 population	16.8	17.8	14.3
Total CYPMH staff per 50k registered 0-18 population	28.6	29.0	26.16

The "Tier 2" WTE against a 50k population across all the boroughs is **very similar** (within a 0.7 WTE range). However, the proportion of SPA referrals that go on to "Tier 2" in Kingston is 37%, in Richmond is 33%, but in Merton is 25% (8-12% lower)

Total WTE staff in "Tier 2" and "Tier 3" for Kingston & Richmond is higher than in the comparator borough. However, the percentage of referrals that go on from SPA to Tier 2 and Tier 3 combined Kingston is 51%, in Richmond is 47%, but in Merton is 35% (12% -16% lower), despite similar referral rates. Overall, Kingston and Richmond have the highest referrals with neuro-related primary referral reason by 50k population

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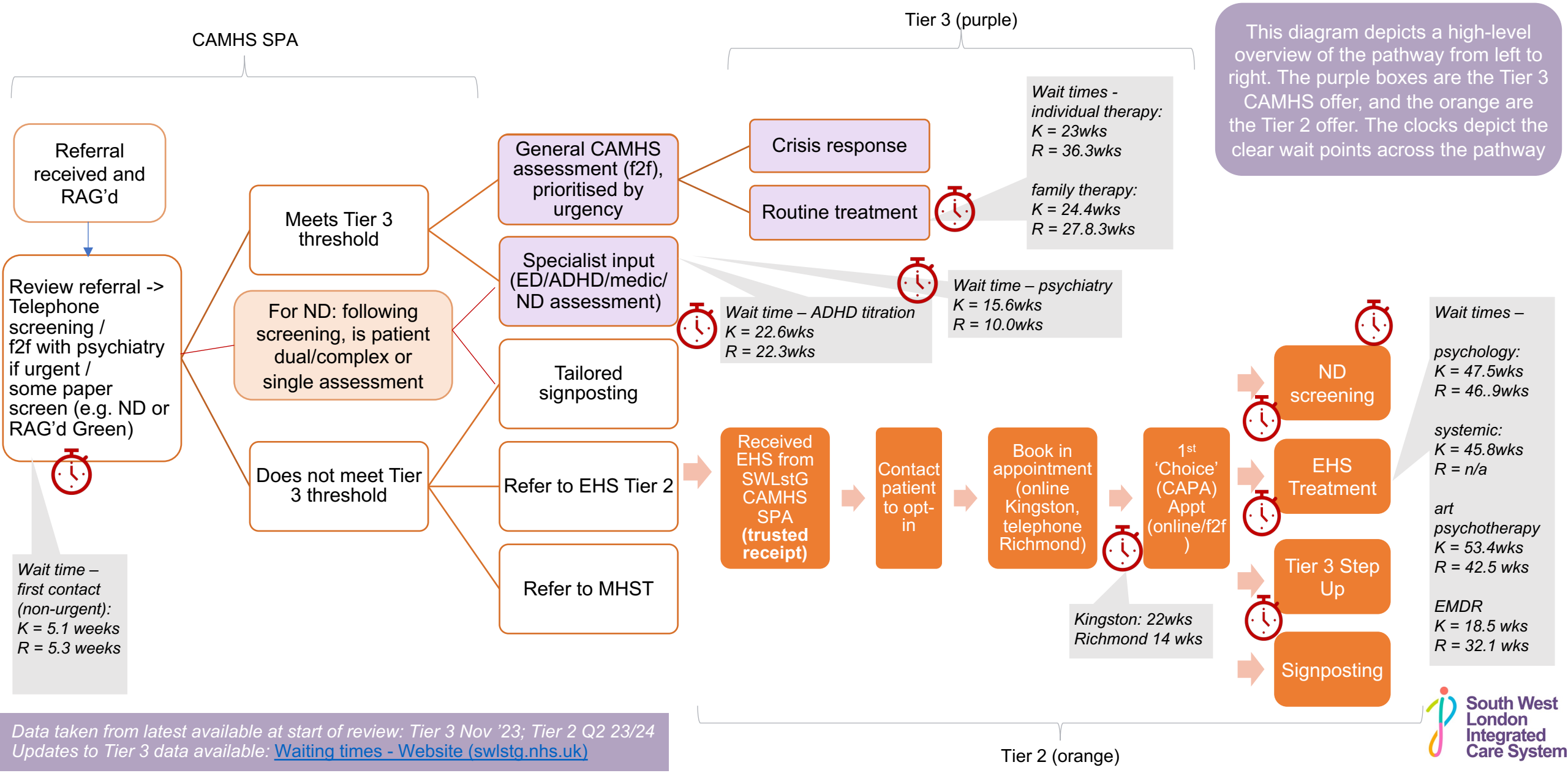
Findings: Performance and Delivery



Data taken from latest available at start of review: Tier 3 Nov '23; Tier 2 Q2 23/24
Updates to Tier 3 data available: [Waiting times - Website (swlstg.nhs.uk)]

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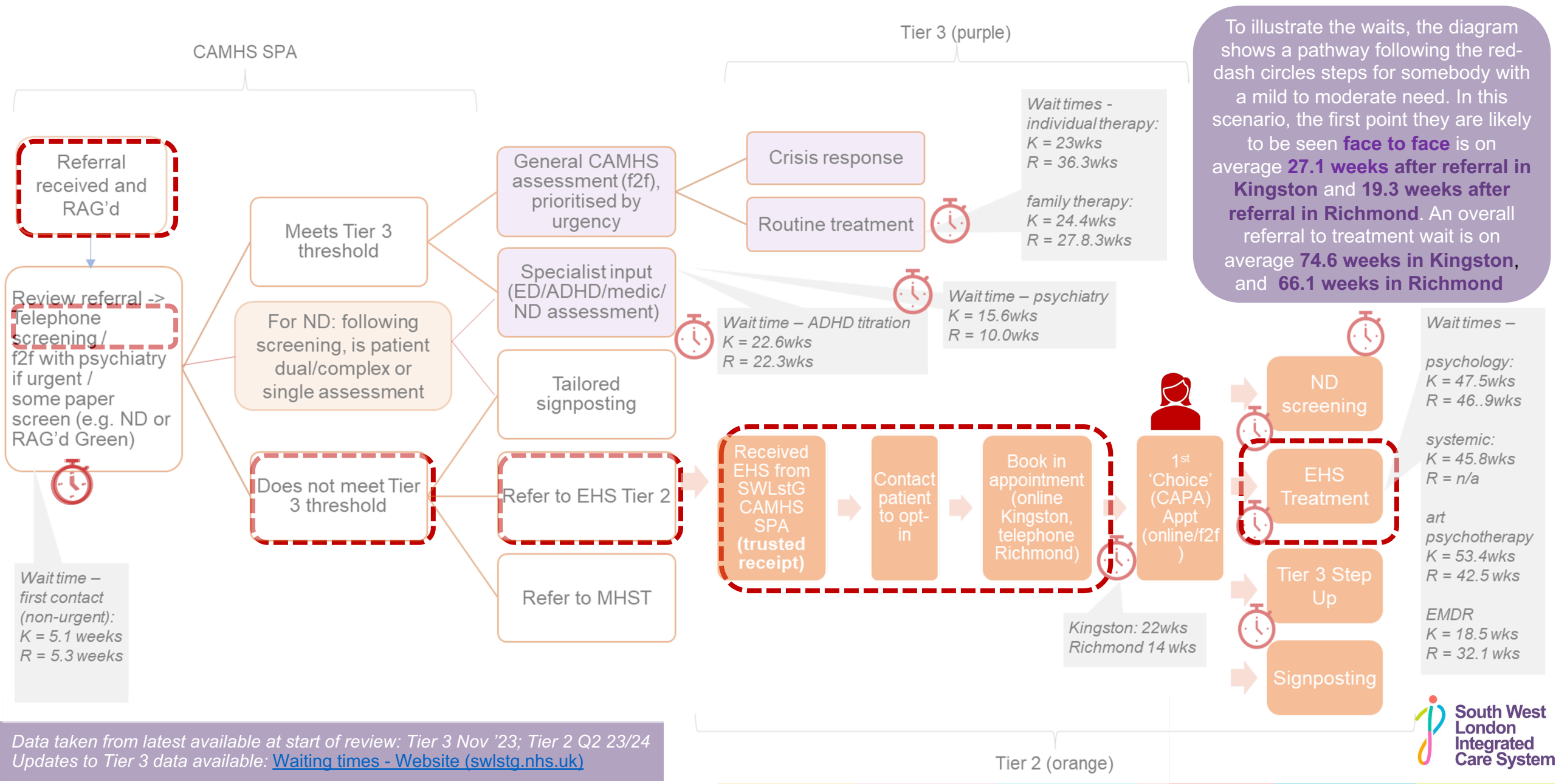
Findings: Performance and Delivery - Pathway mild/moderate



To illustrate the waits, the diagram shows a pathway following the red-dash circles steps for somebody with a mild to moderate need. In this scenario, the first point they are likely to be seen **face to face** is on average **27.1 weeks after referral in Kingston** and **19.3 weeks after referral in Richmond**. An overall referral to treatment wait is on average **74.6 weeks in Kingston**, and **66.1 weeks in Richmond**

Data taken from latest available at start of review: Tier 3 Nov '23; Tier 2 Q2 23/24
Updates to Tier 3 data available: [Waiting times - Website (swlstg.nhs.uk)]

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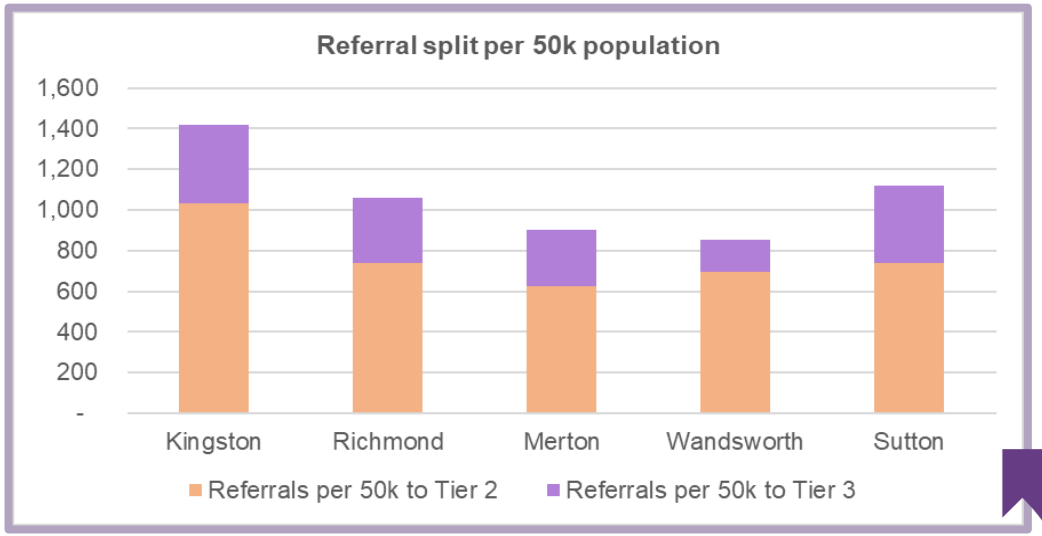
Findings: Performance and Delivery
Referrals and waits

	Tier 2 referrals & waits	Kingston	Richmond	Merton	Wandsworth	Sutton
	0-18 registered population	42,219	47,919	50,840	67,629	52,409
	SPA wait to first contact (weeks)	5.1	5.3	2.1	3.4	2.1
	SPA Referrals (p.a.)	2326	2166	2592	3432	2911
	SPA Referrals per 50k population	2755	2260	2549	2537	2777
	% overall referrals to T2	37%	33%	25%	27%	27%
"Tier 2" - AfC provided Emotional Health Service	Wait for first choice assessment	22.0	14.0			
	Individual psychology wait	47.5	46.8			
	Systemic psychotherapy wait	45.8				
	EMDR	18.5	32.1			
	Art therapy	53.4	32.1			
	Psychology group	0.0	20.5			
"Tier 2" - SWLstG provided Tier 2 CAMHS	CBT					16.3
	Referral self harm nurse					10.8
	YOT				7.5	22.5
	PRU				2.5	
	CAMHS at Social Care			5.4	6.4	
	Early years			2.5		
	Melrose school			2.5		
	Average wait across pathways	33.0	32.9	3.5	5.5	16.5

Tier 3 referrals & waits	Kingston	Richmond	Merton	Wandsworth	Sutton
0-18 registered population	42,219	47,919	50,840	67,629	52,409
SPA wait to first contact (weeks)	5.1	5.3	2.1	3.4	2.1
Tier 3 Referrals (p.a.)	327	307	280	213	397
Tier 3 Referrals per 50k population	387	320	275	157	379
% overall referrals to T3	14%	14%	11%	6%	14%
Individual therapy wait	23.2	36.3	8.3	24.2	3.9
Family therapy wait	24.4	27.8	4.6	30.0	10.2
ADHD meds/titration wait	22.6	22.3	11.6	21.7	0.0
Psychiatry wait	15.6	10	5.7	23.2	7.1
Average wait across pathways	21.5	24.1	7.6	24.8	5.3

Note data does not include Croydon as this is provided by South London & Maudsley. Data provided by performance leads in AfC and SWLstG for 22/23



The tables breakdown available data from AfC and SWLstG's on referral and wait times.

For Tier 2, (borough providers differ) note that the onward intervention pathways differ based on service offer for that population, however across all pathways Kingston & Richmond's waits are significantly longer.

For Tier 3 (five boroughs provided by SWLstG), the average wait across pathways is significantly longer in Kingston, Richmond & Wandsworth compared to other boroughs provided by SWLstG.

The graph shows split of referrals, by population, that go on to Tier 2 (orange) or Tier 3 (purple). These are highest in number and proportionate split in Kingston, followed by Sutton and then Richmond.

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Findings: Service Gaps in Pathway

Clear gaps in current service provision for specific groups have been identified through the review, most prominently:

- **Learning Disabilities**: there is no commissioned Tier 3 provision other than the Trust-wide LD service which has a different threshold for care. The funding for the provision that was provided within EHS has recently been withdrawn
- **Neurodevelopmental**: limited offer beyond diagnostics, and current diagnostic assessment pathway insufficient for demand
- **Youth Offending**: extremely minimal provision (funding for 0.4 WTE) yet over 50% of young offenders have mental health needs
- **Looked After Children** provision is entirely based within EHS (tier 2) and the current interface challenges between EHS and T3 makes joint input to these vulnerable cases difficult
- **Substance Use**:
  - specific support to respond to high level of use of substances in young people in the boroughs. Both boroughs are known to have particularly high levels of substance misuse yet there is no commissioned services at “Tier 3” level to support staff to respond to the increasing complexity this cohort is presenting with
  - The borough previously experienced the benefit of an excellent clinician within EHS but that post-holder has left leaving a further gap in provision
  - Substance misuse support can often be effectively provided in partnership with the VCSE but needs to be commissioned tailored to local need with explicit links to expertise including prescribing
- **Crisis response medic cover**: Tier 3 medical resource must respond to the high volume of emergency CYP A&E presentations, detracting from their core workload, despite a dedicated CAMHS resource (including medical) supporting three A&Es

Lack of these offers is not only poor for children and young people who have these specific needs, but also **has an impact on more general capacity** where these cohorts are presenting and/or waiting within the generic CAMHS pathways. It also illustrative of the need for a strategic vision and effective planning of the pathway

Findings: Service Gaps in Pathway

Lack of a true 'early intervention' offer
The extent and persistence of the long waits within both the SPA and the Emotional Health Service means that in essence there is **not** an early intervention offer within Kingston & Richmond, as it is not being delivered "early" enough.

Traditionally - in previous iterations of the national CAMHS model of care – "Tier 2" was envisioned as an offer of early intervention, delivered in a timely way, to prevent further deterioration and escalation. However, within Kingston & Richmond this "Tier 2" offer is predominantly (though not exclusively) provided by EHS and, given the extended waits (of many months) that those referred to EHS are experiencing, in effect this means that this concept of 'early intervention' is not being delivered in practice. This is compounded by the lack of a clear joined up vision with VCSE partners of where the VCSE offer can play a significant role in early intervention.

This is a significant and dominant finding in this review. It impacts negatively on the pathway, including reputationally, and the experience of those both using it and delivering it in multiple ways:

- There is an increased likelihood of escalation, whilst on the waiting list for EHS, to Tier 3
- This means that Tier 3 do more initial assessments than other boroughs
- There is an increased risk of CYP and their families presenting to A&E whilst waiting as "that's the only way to get into CAMHS"
- Clinicians find it hard to **not** offer a service, or advise they need a different intervention, because of asking long-suffering families to 'wait again' having finally been seen
- Many families feel they have to go privately, at significant financial impact, because they are desperate for support
- Tier 3 CAMHS is also experienced as hard to access quickly by EHS
- Reciprocally, Tier 3 report they cannot 'step down' to EHS due to the long access times

Findings: Linked core provision within the Pathway

Mental Health Support Teams in schools (MHSTs) have been successfully implemented at scale, provided by AfC, with only two schools in Kingston and Richmond not receiving this service. However, there are concerns regarding the next steps for these services:

- There is already an emerging narrative within their delivery of "*not being here to fill the waitlist gaps*" and there are interface challenges with the rest of the CYPMH pathway linked to this.
- The wider CAMHS teams (i.e. "Tier 3") were not involved in their design
- The MHSTs are relatively highly staffed, and there is a perception in some that this is at the expense of other areas of the pathway; there is a need for there to be compelling evidence of effective early intervention to prevent escalation to the rest of the (arguably less-resourced) pathway
- Schools report some frustration that skilled staff are now in their schools who could offer a much-needed intervention – and, critically, a timely one – yet the prescribed model of care limits this opportunity
- Neither borough's Parent and Carer Forums were aware of the MHSTs
- This initial delivery phase of MHSTs – which will require sustained local funding - constitutes an opportunity to test out, refine, evaluate and build on a model of care tailored to effective early intervention in schools including some crisis support, broader parental interventions and avoiding duplication

The **VCSE** is not fully embedded as an established and valued part of the offer, a significant missed opportunity:

- The VCSE approach is viewed as more 'accessible' – with self-referral, confidentiality, inclusive (if you live, work or study in the borough)
- Currently risks being perceived as an offer to 'fill the wait' rather than an effective intervention in its own right
- There needs to be a cultural acceptance of this by both families and clinicians
- VCSE partners aren't routinely involved at a strategic level which misses an opportunity to purposefully use their skills to broaden the offer to the whole pathway e.g. targeting specific hard to reach groups
- The level of funding from health to VCSE who run services which fill gaps in the overall pathway is at a very low level, and has remained the same for years

Findings:

2. Nature and efficacy of the interfaces between services

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Findings: Fragmented Pathway Interfaces

Throughout the stakeholder interviews a theme emerged of a lack of consistent **strategic vision** for the CYPMH pathway, which means offers can lack coherence and interfaces between provision are not "by design"

- Several partners spoke of a **'piecemeal'** approach to commissioning based on historical service models and opportunistic pockets of funding rather than a system-wide view of the whole pathway that includes a shared understanding of priorities
- This is exacerbated by there not being any established place-based partnership group for Kingston and Richmond respectively, and lack of clarity on who funds who to provide what
- Multiple stakeholders felt there was a lack of transparency about different parts of the service – what they are commissioned to provide, to who and with what evidence of outcome

This is further hampered by a lack of a governance and process to underpin commissioned services including:

- Tendering of services against agreed service priorities
- Clear service specifications with detailed expectations and KPIs
- Processes for contract monitoring and evaluation
- Oversight by a clear governance framework
- Recognition of turnover in key post-holders, particularly at the ICB
- Full and transparent understanding and monitoring of funding for different provision, including poorly understood s.75

For example pilot of Positive Behavioural Support – many spoke of its value, filling a clear gap, yet others spoke of it being expensive for what it was and not sustainable.

For example, lower initial investment into the K&R SPA (1 WTE initially to be a referral system) has had long-lasting impact. Although now equally funded compared to other boroughs, K&R SPA are not delivering the same face to face rates and struggling with a long ND backlog

For example when last minute funding becomes available, it is allocated with limited-to-no involvement or discussion with place-based partners on what is needed or how it will "fit" into the pathway structures

For example specialist consultation to the local authority SPA is separately funded by AfC, whereas elsewhere this is not a 'paid for' service, rather it is inherently part of joined up pathway working

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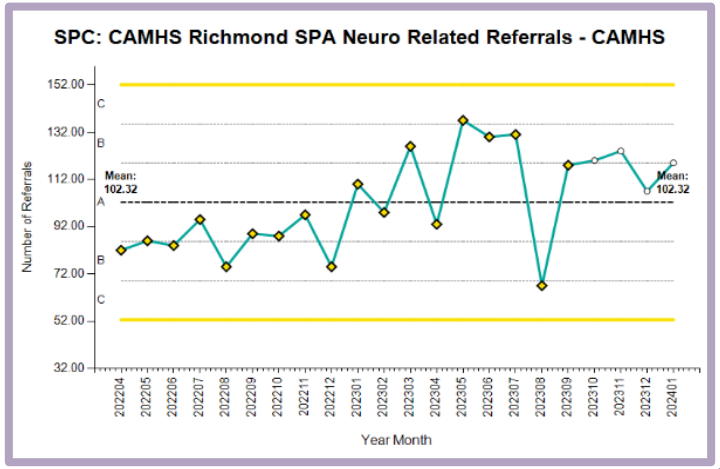
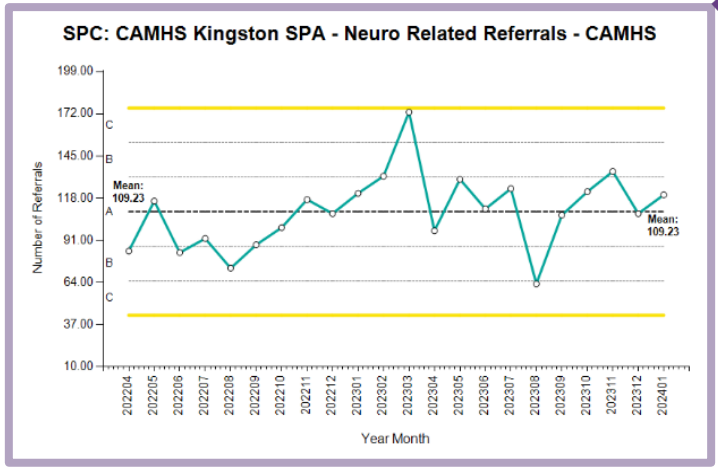
Findings: Disjointed Neurodevelopmental Pathway

The diagram shows a basic outline of the neurodevelopmental pathway, which splits referrals to different provider depending on how complex the referral is, determined during a screening process in the Kingston & Richmond SPA. Referrals are sent on and often re-screened before being allocated to assessment, at which point they may be returned to SPA or directly passed to the other provider if they are deemed inappropriate. Proportionate to 50k population, Kingston and Richmond have the highest referral levels for ND into their SPA compared to other boroughs, and have a 6 month backlog in screening within SPA

22/23	Kingston	Richmond	Merton	Wandsworth	Sutton
Referral to SPA per 50k for ND	**1542**	**1183**	1000	745	813





Demand significant however SPC shows it is not increasing

CAMHS SPA

Referral received by SPA and undergoes paper review, identified as ND related

Undertake screening process to identify complexity

If complex (multiple ND assessment and/or wider MH need), referral to SWLstG ND team

If 'single' assessment, referral to EHS for ND assessment

Re-screened ahead of assessment

assessment

Re-screened ahead of assessment

assessment

Referral may be returned (e.g. to SPA) for reallocation if below threshold

Referral may be returned (e.g. to SPA) for reallocation if found to be too complex

Neurodevelopmental pathway suffers from poor interfaces, duplication of screening processes and referrals moving back and forth to teams if not accepted at level of complexity

EHS April 23 – Jan 24	Referrals for 'Single' ADHD	Referrals for 'Single' ASD
Kingston	176	113
Richmond	179	86
Total	554	
Commissioned	240	

Findings: Clinical Interfaces

	Insight	Finding
Fragmentation	• Outcome of the December 2021 roundtable had an agreed workstream focussing on referral pathways, with actions related to areas such as interface meetings and auditing of referrals – all of which are 'workarounds' which will not resolve core issue • Different views regarding the benefit and/or need for interface meetings. Some feel “we have to fight for it”, others feel “we cannot spend yet more time discussing referrals – we need to get on and see people”. • Relationship management across “Tier 2” and “Tier 3” is "time-consuming and arguably inefficient" • Nursing leadership say rapid reviews have often cited challenge in step or step down as a contributing factor • GPs experience families seeking their help to 'find out what is happening' - yet GPs describe feeling similarly in the dark re whether a YP is being seen or awaiting care. A simple alert system – similar to that used to flag all safeguarding cases – would help them be aware when CYP are under school MHST support. • Several stakeholders spoke of at best a lack of clarity, at worst an avoidance, of where responsibility for the young person's care at any one time actually sits, with too many hand-offs between teams in the face of demand. • Lack of whole pathway visibility on operational delivery data means pathway cannot be managed as one “whole” and narratives regarding the impact of fragmentation cannot be fully validated. Gathering data for the purpose of this review involved a bespoke analytical request as it is not routinely reviewed, and following this a robust insight could not be drawn from data systems. This includes full understanding of step up and step down between tiers within both Kingston & Richmond where providers are separate, but also in the other SWL boroughs.	Address interfaces and handoffs within the core delivery model, and underpin this with whole pathway data visibility on delivery

In practice	• Whilst access to a psychiatrist in SPA is highly valued by EHS staff, sometimes “Tier 3” may still 'decline’ the recommended onward referral
	• There is a perception that accessing 'informal advice in other boroughs is easier even though different teams
	• A significant amount of time is spent 'negotiating' step up or step downs of referrals – seen as “doing favours”:
	  ○ Staff spoke of "dreading" making 'step up' referrals (MHST → T2 or T2 → T3): time-consuming to "argue the case with no guarantee of acceptance"
	  ○ In a similar manner MHSTs spoke of needing to 'quality assure' step down referrals into their services
	• There are providers within the wider pathway delivering statutory responsibilities which require time-sensitive clinical input at key points to prevent escalation through tailored early provision e.g. Dynamic Support Register Tribunals / SEND reports / Individual HCPs. This input from T2 and T3 staff is highly valued but the burden of competing demands on these clinical services means it is often not forthcoming in time, if at all.
		No joint allocation – thresholds strongly defended and protected across partners

Findings:

3. Merits and weaknesses of the multi-provider model in Kingston and Richmond

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Findings: Strengths & Areas of Good Practice

2. Nature and efficacy of the interfaces between services

3. Merits and weakness of the multi-provider model in Kingston and Richmond

Positive steps forward working together for **interoperability for IAPTus** between EHS and SWLstG

Despite limited availability due to number of organisations and level of commissioning, the **VCSE offers which exist are well regarded and respond to some pathway gaps** – for example counselling or support for those self-harming

Involvement of **SWLstG psychiatry** (individual case consultation) to AfC is seen **as really valuable**

MHSTs being delivered under AfC **enables closer links with EHS as well as education**

Services have responded to the pathway challenges with low-cost, rapidly-mobilised **initiatives to support those on the waitlist.** For example virtual waiting room, online workshops and pre-recorded sessions, ERSA project, rapid review of readiness/multiple lists

Separating CAMHS SPA from social care SPA is regarded as an improvement

Good relationships with Single Point of Access and Emotional Health Service and a 'trusted' approach to referrals

The **working relationship** between the two main providers AfC and SWLstG was commented on as **the best it has been for sometime**

EHS being based in social care allows for **join up and access** with other areas, for **example education**

Everyone from all organisations **committed to delivering good care and improving the experience** for children, young people and their families

Leaders of local services **working hard on relationships**

Jointly agreed criteria for neurodevelopmental assessment team to support better navigation

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Findings: Leadership, ownership and accountability

	Insight	Finding
Implementation & Focus	• Various sessions held in recent years (roundtable, deep dive, hosted workshops) led to agreement to implement a new model of care under the iThrive framework. This review found these were helpful at the time, but then faltered to progress to action or any “so what” and are now looked back on as talking shops. • Continued discrepancies on funding (including who funds what, “piecemeal” projects & low funds to VCSE) as well as the current two-provider model structure prevents being able to form a shared vision • Acute partners feel bed flow and adult MH need dominates the agenda, leaving no time for CYPMH	Consensus from other stakeholder views & from this review to take forward a revised model of care guided by the iThrive framework
VCSE & Early Intervention	• Ensure pathways not overly medicalised – Emotional Well Being is the remit of a wider group of providers • VCSE could do more, particularly to bridge known gaps. However, they need to be seen as equal partners with an underpinning vision and support to make this happen • Young people often engage well with VCSE, for example peer support to de-escalate deliberate self-harm • Yet for VCSE in Richmond & Kingston, the CYPMH offers are predominantly funded by non-statutory streams, with health funding to the CYPMH extremely low (approximate £30k) which has not increased since 2016. Continuity of funding for these well-regarded and well-used offers is a constant uncertainty	Clarity needed what the new model looks like for K&R place specifically, and the “how” to get there
Flexibility	• The impact of teams feeling they need to defend thresholds to survive the overwhelming demand (Slide 28) impacts across the whole pathway: ▪ Teams struggle to offer a flexible response to CYP with an over-reliance on (arguably fluid) thresholds ▪ Families can believe they "need CAMHS" and any other offer risks leading to a perception that they are not getting the right intervention, regardless of whether in reality it is the right intervention for the presenting need. • Embracing the Ithrive model needs to include this core principle of flexibility of offer in response to need. • This is more likely to be achievable if there is a diverse offer by range of providers (not only health), early intervention at its heart, and which includes a shift from the embedded language of step up-step down to one that enables movement according to need and where the appropriate offer is provided.	Flexibility required for iThrive – which cannot be achieved whilst services are ‘protecting’ boundaries/thresholds
Oversight & Accountability	• The overall governance framework for vision, design and delivery is unclear, and not jointly understood or bought in to • Plans are often taken forward are based on a specific individual, rather than as part of a jointly owned plan reporting into governance. This means work is disjointed, and stops or falters when there is staff turnover – there is no governance to provide continuity and ensure action plans are overseen and partners held to account for delivery. • There is a clear need for a locally-based vision, rather than just the overall SWL ICB MH strategy	Place-based oversight group with engaged and stable stakeholders is not in place – unlike other boroughs

Findings: Clinical delivery – Neurodevelopmental (ND) Pathway

	Insight	Finding
Fragmentation	• Current setup of 'dual pathway' (i.e. EHS as the provider for single/non-complex assessment and SWLstG as a separate provider for complex assessment, all channelled through the SPA) means there is multiple back and forth between SPA / EHS / SWLSG about where a referral "belongs" • This is made more difficult if the referral is for two needs – for example ND assessment and trauma, often the trauma element will be left to "wait" whilst the assessment is taken forward. • Although lots of work done to agree joint criteria to improve navigation is in place, in practice there is not a consistent trusted collaborative relationship and the "Tier 3"/Complex ND team "hold the power to say no" • Comparison has been made to another borough Merton where the non-complex is provided by a different VCSE provider, without so many issues	Review opportunities to realign ND assessment pathway. The split of providers for single vs. dual/complex not offering best care or value for patients, (despite a split approach working in neighbouring boroughs)
Capacity	• Historically K&R SPA was funded only for paper triage, and despite funding now being rectified, it has a higher backlog for ND assessments than others, which may be due to the split pathway consuming resource because of dispute • AfC is commissioned to deliver total 240 assessments a year, but in January 2024 had already assessed 270. Their referral rate dramatically outstrips the commissioned capacity, at over 500 referrals up to January 2024 • There is a need for more training to enhance competency in ND, for example for counsellors and wider group as well as working with GPs, which might help sense of exclusion. • New initiative to digitalise ND forms may help but needs to be supported to be fully embraced	SPA capacity used heavily for ND screening despite the ND pathway itself not being optimal, and commissioned capacity is outstripping demand

Responding to full need	• Limited offer beyond assessment and a sense that those with ND need do not 'qualify' for other sources of support. For example, any additional MH needs are viewed within the lens of neurodiversity adding to a sense of exclusion beyond the already challenging waits
	• Many stakeholders believe a totally different approach is needed to shift the balance away from the current diagnostic only service (with a confirmation of >90% diagnosis at assessment and meeting the ongoing needs of very few) to a pathway with:
	  ○ A normative approach with early input, open to all and a needs-based approach for ongoing input
	  ○ Broadening skill: iCOPE training could be given to adult IAPT staff to help them deliver intervention to ND cohort
	  ○ Offer post-diagnostic support for ASD in partnership with others eg families
	• Prescribing for ADHD is an issue, with families waiting so long that sometimes GPs 'feel obliged' to fill in the gap through a sense of desperation despite not being responsible for initiating ADHD medication.
		Complex pathway for those in need of diagnostic assessment – multiple screenings and bouncing - but limited beyond that assessment

Findings: Clinical delivery – impact of waitlists

	Insight	Finding

Narrative	• The narrative about waitlists dominates all aspects of the pathway which is hugely detrimental, not just to CYP and their families, but also to all staff working in children-facing services across all public sector domains.
	• School teachers feel burdened by the gap in service delivery:
	  ○ "not uncommonly by the time children reach T3 CAMHS they have been out of school for years"
	  ○ "we are bombarded by desperate families asking for support and how to access help more quickly – at times we've advised them simply to go directly to A&E"
	  ○ "families are waiting for an elusive 'gold standard of care' - but how can it ever be gold standard after that long a wait?
	  ○ Several schools fund their own MH provision from school funds or charities to fill the gap
	  ○ Some argued that the waits should be allowed to accumulate to make the case for more support
	• Families' experience is inevitably heavily impacted by the waits and the language frequently used to describe their experience conveyed an overwhelming sense of helplessness and frustration about a perceived lack of communication.
	• Currently full pathway data is not routinely reviewed as one “whole” – the lack of visibility means there is limited understanding of the true impact of where waits are and their interdependencies. The pathway is therefore, by default, managed in separate parts and is not supported to improve as a whole.
		Need to challenge the entrenched, and unhelpful to all, 'branding' of waits within the CYP pathway.

Current delivery	• Referral is seen as a 'moment of opportunity' that is not being harnessed within the current systemic barriers
	  ○ The opportunity for earlier face to face assessment, ie enhancing triage, would address this
	  ○ However, there is a concern that for this initial critical assessment to be an effective intervention in its own right it needs to have the right level of seniority and support
	• SPA in K&R do less F2F assessment than other boroughs so there is a higher reliance on telephone and paper screening. Whilst considerable effort has been made to implement 'waiting well' actions there remains:
	  ○ high risk of 'wrong' allocation - evidenced by a high number discharged from CAPA appointment
	  ○ concerns voiced about the RAG-rating system - if a referral is rated green on paper triage, they will wait longer which relies heavily on the accuracy of the referral information and how it is interpreted.
	  ○ The risk is further compounded by the lack of prioritisation and the absence of a duty service within EHS which again places risk for those waiting for a service post referral
	• Single view of full delivery and where waits sit in complete pathway is not routinely reviewed (and was a bespoke piece of work by this review).
		Improved waitlist management actions underpinned by whole pathway data visibility

Findings: Unsustainable current model & opportunity with iThrive

Lack of capacity and increased pressure → boundary and threshold protection → lack of flexibility → impacts on implementing iThrive

There are significant challenges with the current **two-provider model** where both are separately commissioned and funded, without any unified service specification or pathway management**.** Although there are mutual professional and good working relationships on the ground, these aren't enough to compensate for:

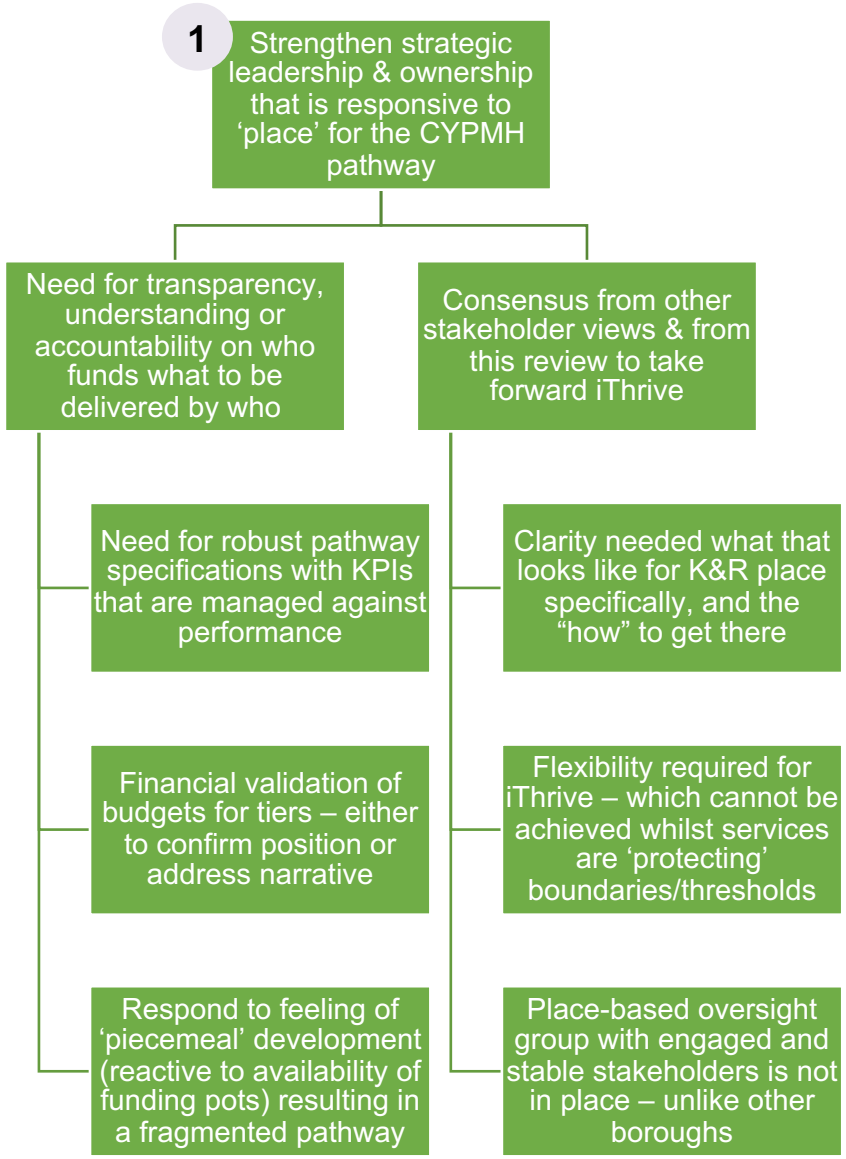
- Lack of shared understanding across the services regarding what their core offer is, how it is funded and with what expectation of outcome.
- There is confusion, and associated scepticism, throughout the system including parents, teachers and partners regarding "what CAMHS is".
- This confusion and lack of clarity internally and externally leads to a negative narrative used to fill the gap in comprehensive understanding. This is held both ways, for example "EHS providing non-evidenced based care" and "Tier 3 hold the power to say no"
- Perceived lack of access to prompt psychiatry in EHS impacts on that team's ability to hold risk:
    - They value highly the SPA consultation service but there is a risk of overuse (8 week wait) and it is heavily formalised process
    - Lack of flexibility in responding to clinical need contrasted to other boroughs able to operate a more joined up approach - for example by offering some bespoke additional intervention from Tier 3 the case could still be held in Tier 2 with less disruption to relationships for the young person.
    - There is a strong belief that there is a lower threshold and smoother process for step up and/or step down in boroughs where both Tier 2 and Tier 3 are delivered by the same provider. However, robust visibility on data both within Kingston and Richmond, and in wider SWL boroughs, is not available to validate this

The iThrive framework, with an underpinning of agreed funding and provider model, presents an opportunity to deliver a more coherent, flexible model of care around need. It has the support of stakeholders and would enable optimising precious resource by diverting it from managing interfaces towards delivering services against a shared vision, supported by a clear governance framework and transparency regarding expectations.

Recommendations

South West London Integrated Care System

Hypothesis to recommendations (1): Place-based strategic leadership, ownership and accountability



Recommendations

1. **New core delivery model:**
   The current two-provider model is not sustainable:
   a) Clarify and agree funding split ICB/AfC
   b) Agree lead / joint provider model
   c) One strategic partner to lead, holding *whole pathway* to account

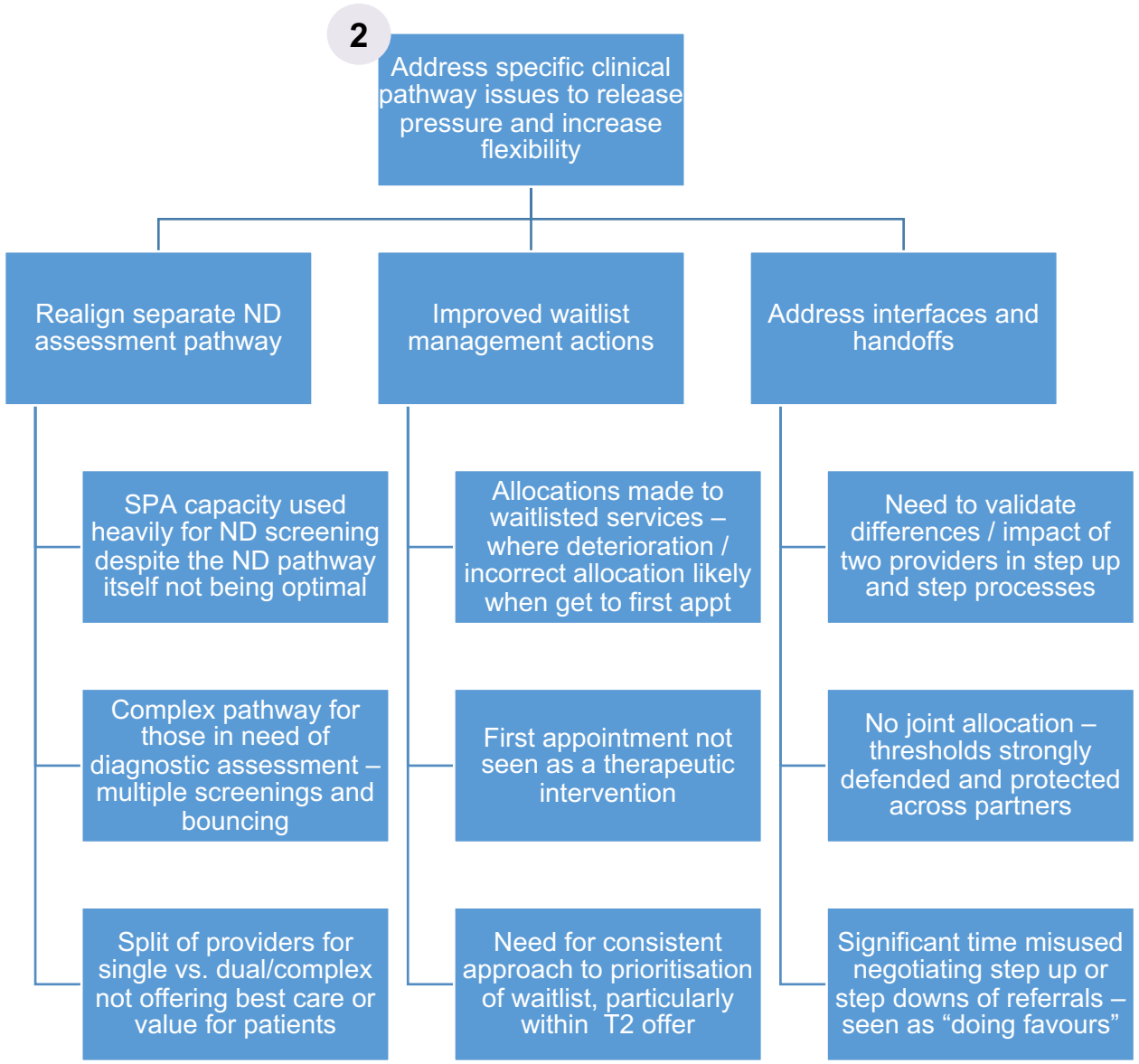
2. **Agree a place-based vision for the model of care informed by the iThrive framework:**
   iThrive presents an opportunity to design and deliver a coherent strategic vision for the care of CYP across K&R:
   a) Requires resolution of (1) to be able to realise this
   b) Broad vision of whole pathway involving broad range of service providers – an opportunity to:
      - Embrace VCSE as an essential part of the pathway
      - Increase offer to parents
      - Explicit early intervention offer

3. **Implementation of revised model of care**
   Previous efforts to implement have lacked translation due to lack of (1) and (2) and also requires:
   a) Clear and unified governance structure and accountability framework with service specifications and KPIs
   b) Addressing of clear gaps in current service provision (e.g. LD, YOT, LAC, substance use)

Hypothesis to recommendations (2): Place-based strategic leadership, ownership and accountability

Recommendation	Detail
1. New core delivery model: *The current two-provider model is not sustainable:* a) Clarify and agree funding split ICB/AfC b) Agree lead / joint provider model c) One strategic partner to lead, holding *whole pathway* to account	The lack of a shared and transparent understanding regarding the current funding of the pathway needs urgently addressing to enable a **joint** approach to how resource is optimised against agreed priorities, aligned to a full understanding of the "place" populations The considerable and recognised effort put in by leaders on the ground is not enough to overcome the inherent challenges working across two providers, with its clinical, IT and organisational interfaces. As such it is recommended that either a **lead or joint provider model** is adopted to deliver these vital core services in an integrated way, underpinned by the appropriate documentation and governance to make that model a reality. Furthermore, services across the **whole pathway** need to be held to account against the agreed revised model of care by **one strategic partner**.
2. Agree a place-based vision for the model of care informed by the iThrive framework: *iThrive presents an opportunity to design and deliver a coherent strategic vision for the care of CYP across K&R:* a) Requires resolution of (1) to be able to realise this b) Broad vision of whole pathway involving broad range of service providers – an opportunity to: ▪ Embrace VCSE as an essential part of the pathway ▪ Increase offer to parents ▪ Explicit early intervention offer	IThrive is nationally-recognised a framework for the delviery of CYP servcies and has the additional advantage of being already socialised, and agreed to, by local stakeholders within Kingston & Richmond. The barrier to progressing to date fundamentally arises from the lack of clarity regarding commissioning of the existing services. Resolving this is a first essential step to then enable a **multi-stakeholder visioning**, including CYP, parents and carers, of a new pathway to deliver iThrive. Essential to this is: • addressing the current clear **gaps in core provision** for particular groups • considering the whole pathway and ensuring a **breadth of offer and of providers** including the VCSE • Ensuring a clear emphasis on true **early intervention**, non-medicalised approaches where appropriate, and **offer to parents** including mutual support parent-led approaches
3. Implementation of revised model of care: *Previous efforts to implement have lacked translation due to lack of (1) and (2) and also requires:* a) Clear and unified governance structure and accountability framework with service specifications and KPIs	Delivery of an agreed approach to implementing a new model of care within Kingston & Richmond, under the iThrive framework, must be underpinned by a robust and unified **governance structure at Place** which all partners commit to. All aspects of the service pathway need clear **service specifications**, with agreed **meaningful KPIs** which can be reported to, and monitored via, a clear **accountability framework.** This oversight will enable review of service **effectiveness**, forward planning for agreed **priorities** and

Hypothesis to recommendations (3): Clinical pathway review



Recommendations

4. **A trusted and flexible model of care**
   The dominance of a narrative re waitlists is damaging and leads to defending of thresholds.
   A change in culture and delivery model is needed to change this:
   a) Transparent and shared understanding of what the offer is, for what presentations, for how long, with what intended outcome, how evaluated
   b) Frontloading of face to face (F2F) triage which is seen as an opportunity for intervention, not signposting
   c) Movement between different services should be navigated through conversation not referral form
   d) Review approach regarding 'open cases'

5. **Realign the Neurodevelopmental pathway:**
   The current dual pathway is inefficient and confusing to navigate with an over-emphasis on diagnosis at the expense of wider support offer:
   a) Review dual assessment pathway
   b) Explore alternative assessment approaches harnessing new digital opportunity
   c) Offer earlier help regardless of diagnosis to reduce cliff-edge experience

Hypothesis to recommendations (4): Clinical pathway review

Recommendation	Detail
4. A trusted and flexible model of care *The dominance of a narrative re waitlists is damaging and leads to defending of thresholds.* *A change in culture and delivery model is needed to change this:* a) Transparent and shared understanding of what the offer is, for what presentations, for how long, with what intended outcome, how evaluated b) Frontloading of face to face (F2F) triage which is seen as an opportunity for intervention, not signposting c) Movement between different services should be navigated through conversation not referral form d) Review approach regarding 'open cases'	It is clear that there is **heightened demand** for CYP services at a national level, particularly since the pandemic, which compounds the **low level of funding** of CYP services within the South West London region when benchmarked nationally. There are opportunities to deliver more effectively, even within current funding levels, by fostering a shared understanding of what the **specific clinical offer** is. For example: what intervention should be offered, for what conditions, and how will its effectiveness be measured; what **'low-level' interventions** can be delivered at scale, using less 'traditional' approaches as part of the early intervention offer, building on the opportunity of the MHST model – whilst recognising that demand is not the same as need. Clarity regarding the offer would also support another key recommendation, namely 'front-loading' **triage** so it is utilised as an **active intervention**, not to only signpost to another part of the pathway. Staff need to be supported to make the necessary **shift in culture** to support these changes, including the principle of **flexibility** whereby CYP are supported by the service most able to respond to their **current need,** agreed by mutual understanding and discussion, not through referral forms and criteria of exclusion. This also applies to more specialised services – and it is recommended the current practice of 'holding cases open' within Tier 3 whilst under the care of specialised teams should be reviewed.
5. Realign the Neurodevelopmental Pathway: *The current dual pathway is inefficient and confusing to navigate with an over-emphasis on diagnosis at the expense of wider support offer:* a) Review dual assessment pathway delivery b) Explore alternative assessment approaches harnessing new digital opportunity c) Offer earlier help regardless of diagnosis to reduce cliff-edge experience	The current ND pathway is highly challenged by **demand,** whilst the present configuration does not optimise how to respond to this. Whilst the dual pathway is run in its current format, it diverts clinical time to navigating across the split of "where cases belong" and causes a poor experience for those trying to access it. There needs to be a **'whole pathway'** approach to address this split base on responding to need, not just diagnostic request: • considering how to offer **earlier help** not based on diagnosis • Optimise **assessment approaches** that build on the new digital offer and address the current frustration of repeated and lengthy form completion • Review other boroughs use of VCSE **non-complex assessment approaches** to guide an alternative way forward based on trust and joint ownership.

Appendices

South West London Integrated Care System

Appendices

- Review Scope
- Stakeholder Briefings
- Data and Documentation List
- Interview and Focus Group List

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Appendix: Terms of Reference and Scope

Scope and objectives

Context	Children and Young People (CYP) mental health is a key priority for both Kingston and Richmond Places highlighted within each borough's health and care plan. Services in both boroughs, in common with the wider SWL, regional and national picture, have been experiencing increasing demand and complexity of presentations since the Covid pandemic. This puts pressure on service capacity which already benchmarks below average for London and England in terms of CYP mental health funding. The ICB has recently agreed a new 5 year mental health strategy which offers the opportunity to consider service and pathway models across all six boroughs and work to ensure that both outcomes for CYP and their families currently utilising support, and future users, are optimised. The strategy also recognises the need to focus additional resources around CYP mental health as a population level prevention initiative recognising that 50% of all long-term mental disorders present by age 14 and 75% by age 24. The provider landscape in Kingston and Richmond is different to other boroughs in SW London and more complex due to the interfaces between tier 2 and tier 3 services. Services are provided by a number of providers including Achieving for Children (Tier 2 CAMHS) and South West London and St George's Mental Health NHS Trust (Tier 3 CAMHS). The data suggests that there is adverse variation in both service user experience and access (waiting times) to CAMHS Tier 2 services compared with other neighbouring boroughs and the have also been questions in relation the efficacy of the interface between the Tier 2 and Tier 3 services within the two boroughs. This review will establish the: • Current CYP mental health landscape and service configuration • Nature and efficacy of the interfaces between services • Relative merits and weakness of the multi provider model in Kingston and Richmond compared with those SWL and best practice models elsewhere The review will set out recommendations for further improvements to access, experience, and outcomes for CYP and their families and, where appropriate, recommend how existing resources could be put to better use. The scope covers all SWL ICB, Kingston Place, Richmond Place, London Borough of Richmond, and Royal Borough of Kingston commissioned CYP mental health services.
Objectives	The specific objectives of the review are to: • Identify and map SWL ICB and local authority commissioned CYP mental health services that currently exist across Kingston and Richmond • Using a consistent set of criteria and data, identify funding, workforce (establishment and in post), operational performance including waiting times and quality metrics • Identify challenges and areas of best practice and learning with existing pathways and provision including gaps and duplications and opportunities for improvement • Consider wider SWL and South London work around CYP MH and how plans developed at borough and SW London level can best fit together. • Consider the views of stakeholders, including education leaders about services available and opportunities for improvement. • Consider the views of staff within CYP MH services around what is working well, where the challenges lie and identify improvements. • Review options to improve data reporting and data quality. • Review support offered for CYP awaiting assessment / treatment.

Outputs	The specific outputs of the review are:
	
	• Produce a report for the Kingston and Richmond Partnership Committees that includes:
	  ○ Description of existing services, performance, issues and opportunities
	  ○ Recommendations for more effective and efficient use of existing resources
	  ○ Suggestions as to how the organisational and pathway structure for CYP MH services across K&R could be optimised
	
	• Produce an implementation framework to deliver the recommendations that are considered and taken forward by the Kingston and Richmond Partnership Committees.

Approach and methodology	The review will be carried out by an independent external lead to be appointed by the Kingston and Richmond Place Executive Officer. The lead will be supported by a collaborative steering group which will guide and input to the review work. Members of the steering group will include: • SWL ICB representatives • Kingston and Richmond Local Authority representatives • CAMHS subject matter lead The methodology will involve documentary analysis (for example - service specifications and performance reports), interviews with key stakeholders, including service leads and broader focus group discussions with front line staff, service users and carers. The methodology will be defined by the steering group. Starting inputs in the form of existing reports and governance structures will be provided by members of the steering group to the review lead prior to the work commencing.

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Appendix: Stakeholder briefing documents

Review of Children and Young People's Mental Health (CYPMH) pathways across Kingston and Richmond

We are writing to tell you about some work that we have been commissioned to do by the South West London Integrated Care Board (SWL ICB) that we hope you as critical system partners will be part of.

We are working together to review the CYPMH Pathways and wanted to introduce ourselves. Jo is a consultant adult psychiatrist by background, having previously worked for many years in Central and North West London NHS Foundation Trust and was Medical Director there. Faye is currently working as Managing Director in Derbyshire Healthcare NHS Foundation Trust, and is experienced in running services and in the transformation and development of pathways.

We have been asked to focus on understanding the effectiveness of the current service configuration at meeting the needs of CYPMH. We are **independent** of SWL ICB and believe this provides the opportunity to bring an external perspective to this piece of work, using our shared experience of both delivering and developing mental health services elsewhere. The focus is to review the services within the boroughs of Kingston and Richmond that support the mental health of children and young people across partners, including health and social care.

The task we have been given is to produce a report for the Kingston and Richmond Partnership Committees that describes how existing services work, including the strengths and challenges of the current model. We have also been asked to make some recommendations about how to ensure this is as effective, to users and staff across partners, as it can be. To do this, we will need to look at a range of data and information from across your organisations, however we are keen to fully understand from you what it is really telling us – or not telling us – about how the pathway works and feels within the system.

With that in mind, one vital aspect is to review the experience of those leading the services and organisations delivering care. Therefore, we are keen to meet with stakeholders through a series of conversations to understand the current landscape and service configuration, the nature and efficacy of all the pathway interfaces, and the opportunities and challenges these bring. We want to ensure that this review is meaningful and that your views inform any recommendations we make.

We look forward to meeting you and hearing of your experiences.

Jo Emmanuel and Faye Rice

Jo.Emmanuel@nhs.net
Faye.Rice1@nhs.net

Review of Children and Young People's Mental Health (CYPMH) pathways across Kingston and Richmond

We are writing to tell you about some work that we have been commissioned to do by the South West London Integrated Care Board (SWL ICB) that we hope you, as users, carers and staff within these services, will be part of.

We are working together to review the CYPMH Pathways and wanted to introduce ourselves. Jo is a consultant adult psychiatrist by background, having previously worked for many years in Central and North West London NHS Foundation Trust and was Medical Director there. Faye is currently working as Managing Director in Derbyshire Healthcare NHS Foundation Trust, and is experienced in running services and in the transformation and development of pathways.

We have been asked to focus on understanding the effectiveness of the current service configuration at meeting the needs of CYPMH. We are **independent** of SWL ICB and believe this provides the opportunity to bring an external perspective to this piece of work, using our shared experience of both delivering and developing mental health services elsewhere. The focus is to review the services within the boroughs of Kingston and Richmond that support the mental health of children and young people across partners, including health and social care.

The task we have been given is to produce a report for the Kingston and Richmond Partnership Committees that describes how existing services work, including the strengths and challenges of the current model. We have also been asked to make some recommendations about how to ensure this is as effective, to users and staff across partners, as it can be. To do this, we will need to look at the type of data you will all be familiar with, for example waiting times, however we are keen to fully understand from you what the data is really telling us – or not telling us – about how the pathway works and feels from those experiencing it and delivering it.

With that in mind, one vital aspect is to review the experience of those that use the services and of staff working within them. Therefore, we are keen to meet with children and young people, carers and families and frontline staff through a series of focus groups and conversations. We want to understand: What works well? What are the challenges? What could be better?

We want to ensure that this review is meaningful and that your views inform any recommendations we make.

If you have any questions, or are interested in taking part, our contact details are below.

We look forward to meeting you and hearing of your experiences.

Jo Emmanuel and Faye Rice

Jo.Emmanuel@nhs.net
Faye.Rice1@nhs.net

South West London Integrated Care System

Appendix: Documents and Data

Data and Documents

1. Population estimates, population health and generic demographics
    a. Health and Care Plan Richmond
    b. Health and Care Plan Kingston
    c. Borough Profiles
2. Core 20+5
3. SWL CYP Deep Dive
    a. Presentation
    b. K&R SPA data 23 24
    c. K&R Deep Dive Data non-trust
4. Benchmarking 2022/2023
    a. Kingston CAMHS
    b. Richmond CAMHS
5. AfC Real Talk Counselling Annual Report
6. AfC Relate Annual report 22-23
7. EHS Performance Reports
    a. Kingston
    b. Richmond
    c. MHST
8. K&R Roundtable 2021
    a. Data pack Includes benchmarking (2021)
    b. Presentation
    c. Summary
9. JSNAs 2022
    a. Kingston
    b. Richmond
10. SWL MH Strategy
11. SWL CYP MH Transformation Plan 2023
12. Mapping
    a. K&R Mapping raw data spreadsheet
    b. SWL Mapping ICB commissioned services
13. Service Specifications
    a. AfC
    b. SWLSTG
14. S75
15. Off the Record Q3 report 2022
16. SWL Joint Forward Plan
17. SWL ICS priorities
18. Headteacher forum
    a. CYP MH in schools task and finish group
    b. CAMHS info sharing schools event
19. K&R EWMH plan
20. Documentation sent by interviewees
    a. Achieving for Children A Plan Report
    b. Achieving for Children Relate Report Jul-Sept 23
    c. EHS Virtual Waiting List Resource Pack
    d. Brief Evaluation of Virtual Waiting Room
    e. EHS Service Overview
    f. Neurodevelopmental Project Kingston April 22 – March 23
    g. Neurodevelopmental Project Richmond April 22 – March 23
    h. Tier 2 and Tier 3 Neurodevelopmental Criteria Sept 2023
    i. Mental Health Needs Assessment Richmond
21. Further Data Sources
    a. CAMHS Waiting times SWLSTG website
    b. Bespoke data request pathway waiting times EHS – referral to first choice appointment
    c. Bespoke data request SWLSTG - referrals (tier 2, ND, tier 3), average LoS, step up/step down
    d. Bespoke workforce data SWLSTG – Tier 2 & Tier 3 team structures – Richmond, Kingston & Merton

Appendix: Interview list

Interview	Organisation	Role
Jo Steer	AfC	Associate Director EHS
Alison Twyman	AfC	Social Care Deputy Director
Ian Dodds	AfC	Director of Children's Services
Janet Grimes	SWLSTG	Head of Service for CAMHS & ED
Joel Khor	SWLSTG	Clinical Director for CAMHS & ED
Rachel Tucker	SWLSTG	Head of Psychology
Rachel Mahoney	SWLSTG	Clinical Lead for SPA
Nick Wilson	SWLSTG	Service Manager CAMHS
Siobhan Lough	Education	Headteachers forum
Claire Richmond	Richmond parent care group	Chair of parent carer group
Michael Conner	Local Authority	Youth Council lead
Tracey Moore	Kingston Hospital	Chief Operating Officer
Graeme Markwell	Richmond LA	Public Health lead for Richmond
Liz Trayhorn	Kingston LA	Public Health Lead for Kingston
Alison Stewart	SWL ICB	Head of SEND
Gavin Spiller	SWL ICB	Deputy head of Transformation
Sheldon Shashall	AfC	Associate Director for pupil support

Interview	Organisation	Role
Pasquale Brammer	LA	Head of commissioning
Brinda Paramothayan	Primary Care	ICB GP Clinical lead for CYP MH
Stafroula Lees	Primary Care	CB GP Clinical lead for Adult MH
Louise Doherty	SWL ICB	Designate Nurse for safeguarding children
Deborah Kerpner	Off the Record	Clinical Lead
Val Farmer	Richmond MIND	CEO
Heather Mathew	VCSE	CYP VCSE Strategic Lead
Jennifer Allan	SWLSTG	Chief Operating Officer
Jummy Dowodu	CLCH	Director of Operations
Sue Lear	ICB	Transformation Director for Kingston and Richmond
Sharron Nelson	ICB	CYP Transformation Manager
Sarah Head	AfC	MHST Head of psychology
Portia Kumalo	ICB	MHST external consultant
Alex Doig	SWLSTG	Consultant psychiatrist for Richmond T3 and SPA

Appendix: Focus Group List

Focus Group	Organisation
Richmond Tier 3 CAMHS	SWLSTG
Kingston Tier 3 CAMHS	SWLSTG
EHS Leadership Team	AfC
EHS Richmond Cluster Group	AfC
EHS Kingston Cluster Group	AfC
EHS Embedded Clinicians Team	AfC
EHS Participation Group	AfC
Richmond Parent carer group - online	Parent Carer Group
Kingston Parent carer group - online	Parent Carer Group
Richmond and Kingston parent carer group – in person	Parent Carer Group
Richmond primary school headteachers forum – in person	Education
Kingston Secondary school headteachers forum - online	Education