Background in NHS Lanarkshire CAMHS
NHSL CAMHS serves the 3rd largest population of the Scottish Health Boards, with some of the highest levels of deprivation. ISD figures for the period April to June 2016 include the following:

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<thead>
<tr>
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<th>NHSL</th>
<th>Scottish Average</th>
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<tbody>
<tr>
<td>Workforce WTE per 100,000 population</td>
<td>15.8</td>
<td>18.5</td>
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<tr>
<td>Waiting Times % RTT</td>
<td>88.9%</td>
<td>77.4%</td>
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NHSL CAMHS Performance against RTT:

In addition:

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<tr>
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<th>January – July 2015</th>
<th>January – July 2016</th>
<th>Rate of Increase</th>
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<tbody>
<tr>
<td>Referral Rate</td>
<td>2347</td>
<td>2661</td>
<td>13%</td>
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Since the implementation of the RTT for CAMHS, the NHSL service has consistently performed above the Scottish Average performance (for significant periods attained the 90% target) with a below average workforce WTE. NHS Lanarkshire CAMHS has consistently outperformed other Board services with much greater workforce resource.
Response to Parliamentary Questions

1. What are key factors that result in long waits for CAMHS Services?

We are unable to comment on the experiences of other Board services. However in Lanarkshire we have achieved a high level of success against the RTT (consistently above the Scottish Average performance) with a workforce smaller than most other boards (consistently below the Scottish Average). We have achieved this through a number of actions:

- **Workforce.** Our workforce investment has increased in recent years to be within a closer range to the Scottish Average. This has increased our capacity.

- **Management and Leadership.** We redesigned our management structures, moving to an integrated/generic line management structure away from a professional structure. In doing so we recruited effective and committed clinicians into these posts and provided them with clear personal and organisational objectives. We brought a focus around performance management and accountability from top to bottom.

- **Service Strategy.** We reviewed our service strategy incorporating our areas for improvement bringing a focus to those objectives and ensuring our resources and pathways were lined up to best meet these objectives. In addition, we identified our skill shortages and how these impacted on our local areas for improvement (admission of eating disorder patients, DSH High Risk presentations and local admissions) and ensured our training strategy was in-line with our areas for service improvement. We have delivered on our training strategy and where necessary supplement our own local training needs, whilst accessing the NES training opportunities.

- **Performance Management.** We reviewed and re-defined our approach to performance management, including the following actions;
  i. Regular review of demand analysis – aligning workforce accordingly
  ii. Capacity definition using CAPA principles and Royal College of Psychiatry Guidance.
  iii. Introduced individual capacity plans, with allowances for service responsibilities and clinical specialism’s.
  iv. Team Capacity Plans derived from above.
  v. Systems for management review of performance, using available resource from vacancy underspend to target additional waiting list initiatives, re-directing flow of patients at times to areas with available capacity, and re-deploying workforce, at times, where capacity issues are identified.

- **Supervision Structures/Requirements.** Setting out requirements for clinical, professional and line management supervision. Introducing line management
and performance management into our wider supervision arrangements. We also ensured the development of our clinical supervision arrangements to maintain a quality focus.

2. **What would you identify as the main reasons for the CAMHS waiting time target not being met?**

Again, we can only comment on our own experience. The starting point for NHS Lanarkshire CAMHS is that our workforce resource, whilst significantly improved, remains below the recommended levels and Scottish Average. Whilst we have maintained a good level of performance with smaller resource, we recognize the latent demand in Lanarkshire and that our demand and capacity remains at a tight margin. In effect, we do not have much wiggle room. Consequently when our performance has dipped it has been quite clearly associated with demand outstripping our clearly defined capacity. This has occurred for periods where demand has significantly increased, usually associated with local recognition that waiting times have reduced.

In addition our capacity can be periodically affected by:

   i. High rate of turnover in staff due to the wider growth in CAMHS workforce opportunities.

   ii. The rate of recruitment has a significant impact. Vacancy periods average between 6 to 9 months. This has a direct effect on new capacity through the loss of a clinician for a period. However, it has an indirect effect through reducing the new capacity of remaining team colleagues who need to absorb departing colleagues existing cases.

   iii. The CAMHS workforce is predominantly young female clinicians. Whilst the overall maternity rate has some impact on capacity, it is when a cluster of maternity leaves happen in one area that capacity is greatly affected. In addition there is no workforce market for locum or cover staff.

3. **Are there any other issues in CAMHS that you would identify as being priority for improvement?**

   i. Regional CAMHS Forensic Networks. There remains a lack of knowledge, skill, experience and confidence with forensic cases. The demand does not justify local service development but more is required on a regional basis.

   ii. Autism Spectrum Disorders. There remains a tension between CAMHS service provision and behavioural/parenting advice and guidance for ASD/Neuro-developmental disorders. A clearer emphasis in developing post-diagnostic and autism specific services is required as ASD is in essence, not a mental health disorder. Many children and young people who develop mental health problems may have been averted by earlier autism specific interventions.
iii. In recent years CAMH Services have noted an increase in deliberate self harm (at the minor end of behaviours as well as at the more severe end of behaviours) and presentation of emotional distress. Services and strategies need to maintain a focus on a tiered response, increasing capacity at universal service level, early intervention and Tier 3/4 community provision. A greater inter-agency response to high risk situations is required (a shared ownership responsibility) as often residential/inpatient resources are utilized (with little clear long term benefit) due to deficits in organisational risk management.

iv. As financial pressures increase it will be all too easy to focus on higher risk/higher tariff service provision at the expense of early intervention. The good work and progress in early intervention/culture change needs to be protected.

4. **Are there any particular factors/initiatives you can identify which have helped improve service locally or in other parts of Scotland?**

**Local Initiatives**

i. Development of CAMHS Intensive Home Treatment Service has improved the quality of clinical care and reduced need for admission/ability for earlier discharge for local urgent admissions.

ii. CAMHS LAAC Team which has improved quality of care and built capacity within residential staff and foster carers.

iii. West of Scotland Family Based Treatment (Training and Supervision to improve clinical skill/outcomes) for Eating Disorders programme. Increased local ability to treat more young people at home with better clinical outcomes.

iv. West of Scotland Inpatient Network. Has made significant improvements in local ability to access Skye House Inpatient Unit. Improving quality of care and reducing need for using private sector.

v. Our development and continued investment in building our clinical model for young people with high risk self harm, utilizing the Dialectical Behaviour Therapy (DBT) approach. Has improved outcomes and reduce repeat admissions to local DG Hospitals for short term admissions.

**National Initiatives**

Training strategy and workforce development undertaken by NES.

5. **What support is provided to children and young people while they are waiting for a stage 3 referral?**

It is important to remind ourselves that all referrals to CAMHS are screened and prioritized on the basis of clinical urgency. All cases of high clinical urgency continue to be seen within a short space of time (same day if required). Within NHS Lanarkshire CAMHS, for those cases having to wait we have utilized several resources.
We operate a clinical duty telephone system and families are notified of this if they receive a wait list letter. In addition, for some condition specific referrals such as ASD, Anxiety Problems we send families information on self-help material and Voluntary Sector organizations which may be of some help.

We are currently updating our website and increasing the range of self-help material/links.

It remains a gap though in an area where more could be achieved.

6. **Which parts of the previous mental health strategy have been most successful?**

   i. Workforce development
   ii. Locally, performance against RTT
   iii. Increase in clinical/therapeutic interventions linked to (i) above.
   iv. Reduction in inpatient admissions and establishment of Intensive Home Treatment.
   v. Development of early intervention services.

7. **Which parts of the previous mental health strategy have been least successful?**

   Overall, I would suggest that there has been significant development and improvement in CAMH Services and that this has been achieved in all areas of the previous strategy. What appears to be the main concern is that at times patchy nature of the improvements and that not all areas have been able to improve in a consistent manner across the board. Whilst it is likely that each area has local issues to deal with what has been a major gap in the improvement agenda has been to loss of the CAMH advisor post at Scottish Government. This post and the previous incumbents provided a major focus for service improvement.

8. **What would you identify as the key priorities for the next mental health strategy?**

   i. Maintain a focus on early intervention, increasing emotional literacy within schools, communities and families. Improving access to self-help materials and reversing the culture of reliance on statutory services for emotional responses to difficult life circumstances. This requires a strategic link at a national level with mental health strategy, Attainment in Education strategy and the Government’s approach to children and families living in poverty.
A focus on increasing universal and primary care services in areas of high and multiple deprivation.

ii. Maintain a focus on a compassionate service and community response to distress (including self harm). Through NES Training strategy maintain a focus on training and expansion of clinical interventions, whilst developing inter-agency arrangements for high risk young people in order to achieve proportionate responses to risk management and develop clinical/therapeutic services that offer improved outcomes for young people. This includes young people who have experienced abuse and trauma.