

Designing a New Model of CYP Early Intervention & Multi- Agency Care for Children and Young People in Hillingdon

Workshop 2 'How'

22nd May 2019 - 9.30am – 2.30pm



Aims of Today's Workshop

1. To share and agree the key outputs from workshop 1
2. To agree an approach to quantifying demand for the model
3. To review in detail the **individual components of the model** and to agree how the model of care will work operationally - the specification, workforce requirements and timescales for delivery
4. To agree the **inter-dependencies** between the components of the model
5. To provide an update on the planning for **CYP with complex needs** and to consider the interdependencies between the models (Transition planning etc.)

Agenda

| | |
|-----------------|---|
| 9.30am | Overview of plan for the day |
| 9.35am | Agreeing the scope and key outcomes |
| 9.55am | Population segmentation and demand modeling |
| 10.35am | Further development of the model components |
| 11.35 Tea Break | |
| 11.45am | Specifying the model – working together as one system |
| 12.35pm LUNCH | |
| 1.15pm | Complex Needs and Transition Planning |
| 2.20pm | Next Steps |

- **Scope and Outcomes**
- **Population segmentation and demand modelling**
- **Further development of the key components**
- **Working as one system**
- **Complex needs and transition planning**
- **Next Steps**

6 Key Principles Underpin the Model

Co-production

Co-producing the model with children, young people and their families/carers, to ensure that they are part of the commissioning, monitoring and reviews of services

Integration

Finding ways to work together to stop parents receiving overlapping and conflicting advice and support from different professionals. Developing a skilled, integrated workforce that works one team.

Placed Based

Services will be grounded in Neighbourhoods which will see integrated multi-disciplinary services, with Primary Care at its centre, working with people and communities

Telling their story once

Children and their families should only have to 'tell their story once' Facilitated by shared records, a single point of referral, and use of technology where appropriate

Building resilience

Focused on building the resilience of families and reducing their isolation. Resilience building at all levels of need and service provision, through prevention, early intervention and empowerment

Outcomes Focused

A consistent and integrated focus on a single set of shared outcomes

Key Service Outcomes

| | Key Outcome | Proposed Measures |
|---|---|--|
| 1 | Access to the right services and support at the right time. Care focuses on improving health and psychosocial status, and preventing exacerbations. | <ul style="list-style-type: none"> • 24 hour response time of service (F2F or NF2F) • Reduction in A&E Attendance • Reduction in re-attendance • Decrease in inappropriate referrals to CAMHS and other services • Decrease in touch points • Reduction in CAMHS waiting lists and times |
| 2 | CYP experience improved access to pro-active and co-ordinated care Multi-disciplinary care is co-ordinated and people experience a seamless service. | |
| 2 | The CYP is central to how professionals work together in the multi-disciplinary teams. The person's needs and preferences shape what care is delivered and how the MDT delivers this. | <ul style="list-style-type: none"> • The number of 'One Shared Plan' used ('My Support Plan') |
| 3 | CYP feel empowered, capable of and engage in self-management. People are actively involved in care planning and have access to support for self-management. | <ul style="list-style-type: none"> • Increased resilience through self reported survey |
| 4 | Professionals enjoy their work as together they ensure people get the care they need. They provide this care themselves or this is provided by a colleague of the multi-disciplinary team. | <ul style="list-style-type: none"> • Increase of self reported Practitioners satisfaction |
| 6 | CYP are effectively supported within schools | <ul style="list-style-type: none"> • Increased attendance of SEN & SEMH in schools • Decreased rate of schools exclusions |

Service Scope - New Model of CYP Early Intervention & Multi- Agency Care for Children and Young People

1. Triage / Front Door Team

This comprised of the core service team that will be co-located roles from different organisations and existing services.

2. Core Team

These are the core multi-disciplinary/ early intervention focused services that will become part of the new service specification

3. Supporting Functions

These are the services that are primarily health focused/ provide more complex care or are stand alone services that make more sense to have close links with the early intervention service rather than become part of it (the specification should specify how each service works with the new model)

Are these the right assumptions?

Service Scope - New Model of CYP Early Intervention & Multi- Agency Care for Children and Young People

1.Triage Team

- Key Worker
- P3
- Link
- Psychologist/ Therapist
- Support worker
- Family therapist
- Nurse
- SEND

2.Core Team

- CAMHS
- CAMHS LD
- Crisis Services
- Eating disorders
- CAMHS 0-5
- EIS (14-35)
- ARCH (Drug and Alcohol)
- CDC
- Integrated Therapies (0-19)
- SLT
- OT
- Physio
- School nursing
- School Counselor
- Peer Support
- SEND
- P3
- DASH
- KOOTH
- HACHS
- EPS
- 'Place to Be'
- Health Visiting
- AIMS Peer mentoring service
- LINK Youth Counseling service
- SORTED (Substance Misuse)
- Key workers
- Transition Nurse

3.Supporting Functions

- EIS (14-35)
- ARCH
- Lavender Walk
- CDC
- Community Health
- Paediatrics
- LAC
- Post natal Services
- Community Clinics
- Paediatric Psychology
- Maternity services
- Hillingdon Young Carers
- KISS (Sexual Health and Wellbeing)
- Youth Centers
- Employment services
- Youth Centers
- Children Centers
- Employment services
- Children's social services
- Parent support and development programmes
- MASH
- YOS / YOT
- Hillingdon Carers
- Aphelia (support around unaccompanied minors)
- Bereavement services
- Green corridor
- Bucket & Spades (LA Commissioned)
- Health watch
- Brilliant parents

Are these the right groupings?

- Scope and Outcomes
- Population segmentation and demand modelling
- Further development of the key components
- Working as one system
- Complex needs and transition planning
- Next Steps

We are developing a 4 prong approach to modelling the demand and understanding needs of the population...

1. **Using the WSIC Data** – to segment the population based on available NHS data (acute, care planning, community intervention and diagnosis)
2. **Cross referencing with other available data (Local Authority/ Public Health) to understand and to model unmet need** – what are the key data sources we should be considering?
3. **Demand modeling using the NHS digital approach** – to understand the prevalence of mental health and physical issues
4. **Current service demand** - We can understand this by baselining the demand of the current in scope services

A combination of these approaches should ensure that we have a comprehensive view of the needs and demand of the CYP population in Hillingdon

3 key levels of need in children and young people (aged 0-24) in Hillingdon

Good Mental & Physical Wellbeing (Universal Needs)

These CYP have no physical or emotional wellbeing/ mental health needs. They would benefit from support to build resilience and 'stay well'

Schools, GPs, Health Visitors, Children's Centres, Universal Services (prevention and resilience building)

X%

Low to Moderate Mental & Physical Needs (At Risk)

These CYP and their family are vulnerable to mental health and/or physical difficulties, they may be experiencing low-moderate level stress and anxiety and/or physical health problems

Targeted integrated services in education, social care and health (early intervention)

Y%

High Mental & Physical Needs (Complex Needs)

These CYP and their families have urgent, persistent, complex and severe mental health and/or physical health problems

Specialist services will provide a full range of mental health services via multi-disciplinary teams where universal or targeted intervention level is insufficient to meet an identified need

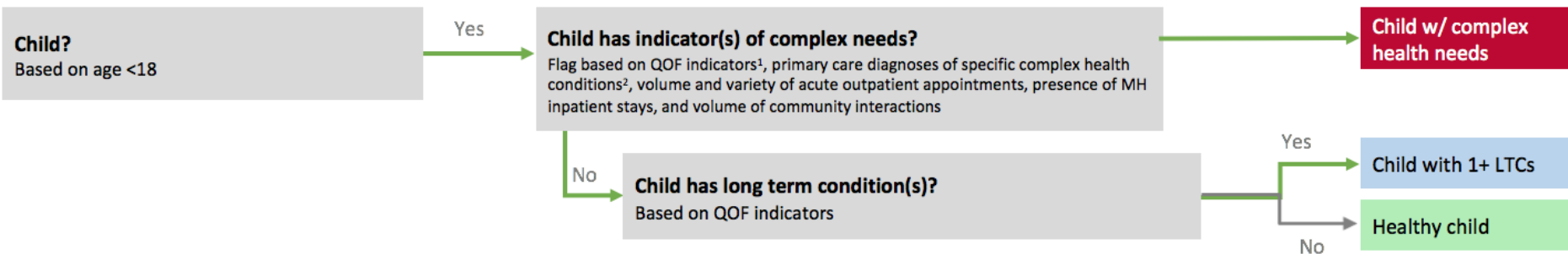
Z%

Total -0-24 population - 66, 921 (100%)

WSIC Approach

| | <u>Description of Group</u> | <u>Data Inclusion</u> |
|---|---|--|
| 1 Children with complex health needs | People aged under 18 diagnosed with complex health needs, significant community (not GP) involvement, a MH inpatient stay, or a variety of outpatient appointments. Includes a variety of defined diagnoses, LTCs. | Age under 18 Any of: 1+ defined LTCs ¹ , 1+ defined list of primary care diagnoses, 5+ paed's OP appts, 2+ OP specialties, 1+ MH IP stay, 7+ community |
| 8 Children with one or more long term conditions | People aged under 18 that have one or more long-term conditions ² , e.g. asthma, diabetes, and not in another group. Includes common mental illnesses, e.g. depression, anxiety, and long term neurological conditions | Age under 18 Have 1+ LTC Not a member of Group 1 |
| 11 Mostly healthy children | People aged under 18 that are mostly healthy and do not fit into any other group | Age under 18 Not a member of any other Group |

WSIC segmentation Flow Chart



What the WSIC data tells us -

Good Mental & Physical Wellbeing (Universal Needs)

CYP has 1 LTC OR has a
Community Intervention OR has a
Primary Care Plan

43903 67%

Low to Moderate Mental & Physical Needs (At Risk)

CYP has 1 LTC OR has a
Community Intervention OR
has a Primary Care Plan

11093 17%

High Mental & Physical Needs (Complex Needs)

CYP has More than 1 LTC OR
Inpatient Stay (Elective or NEL)
OR Outpatient Acute Procedure
OR has more than 4
Prescriptions

11058 16%

We need to combine this with other available data
to understand the size and needs of each
population segment, and the unmet need.

About the Mental Health of Children and Young People survey

This survey series provides England's best source of data on trends in child mental health.

Major surveys of the mental health of children and young people in England were carried out in 1999, 2004, and 2017.

While many surveys use brief tools to screen for nonspecific psychiatric distress or dissatisfaction, this series applied rigorous, detailed and consistent methods to assess for a range of different types of disorder according to International Classification of Disease (ICD-10) diagnostic criteria (WHO 1992). All cases were reviewed by clinically-trained raters.

The latest survey was funded by the Department of Health and Social Care and commissioned by NHS Digital. The survey was carried out by:

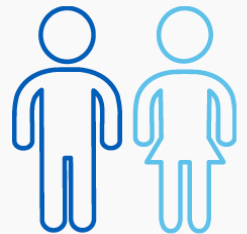
NatCen
Social Research

 Office for
National Statistics

youthinmind

The 2017 survey collected information about mental health and wellbeing from a stratified probability sample of children and young people living in England and registered with a GP. Information was collected on 9,117 children aged 2 to 19 between January and October 2017. The survey combines reports from children, their parents and teachers (depending on the age of the selected child).

This survey for the first time provides findings on the prevalence of mental disorder in 2 to 4 year olds, and spans the transition into adulthood by covering 17 to 19 year olds. Unless specified otherwise, 'children' is generally used here to refer to 5 to 19 year olds and 'young people' usually refers to those aged 11 to 19.



Disorders were grouped into four broad types

Emotional disorders

- Include anxiety disorders (characterised by fear and worry), depressive disorders (characterised by sadness, loss of interest and energy, and low self-esteem), and mania and bipolar affective disorder.
- One in twelve (8.1%) 5 to 19 year olds had an emotional disorder, with rates higher in girls (10.0%) than boys (6.2%). Anxiety disorders (7.2%) were more common than depressive disorders (2.1%).

Behavioural (or conduct) disorders

- A group of disorders characterised by repetitive and persistent patterns of disruptive and violent behaviour in which the rights of others, and social norms or rules, are violated.
- About one in twenty (4.6%) 5 to 19 year olds had a behavioural disorder, with rates higher in boys (5.8%) than girls (3.4%).

Hyperactivity disorders

- Include disorders characterised by inattention, impulsivity, and hyperactivity. The number of children with a hyperactivity disorder (as defined by ICD-10) is likely lower than the number of children with ADHD (as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)) as hyperactivity disorders have a more restrictive set of criteria
- About one in sixty (1.6%) 5 to 19 year olds had a hyperactivity disorder, with rates higher in boys (2.6%) than girls (0.6%).

Other less common disorders

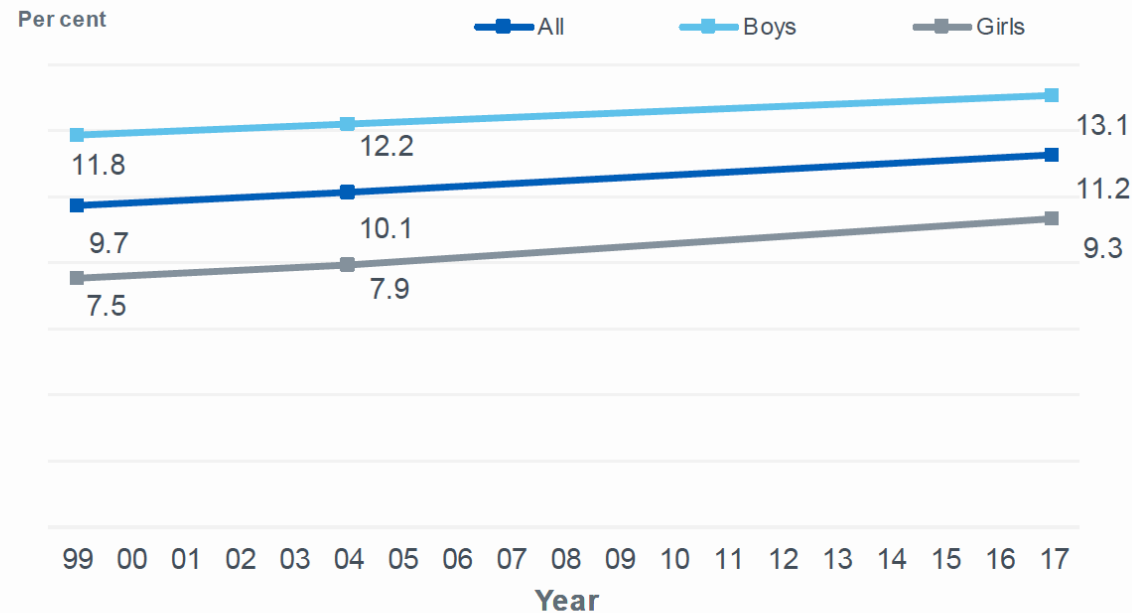
- Include autism spectrum disorders (ASD), eating disorders, tic disorders, and a number of very low prevalence conditions.
- About one in fifty (2.1%) 5 to 19 year olds were identified with one or more of these other types of disorder: 1.2% with ASD, 0.4% with an eating disorder, and 0.8% with tics or another less common disorder.

There has been a slight increase in overall rates of mental disorder

Background There is a widespread perception that children and young people today are more troubled than previous generations (Murphy and Fonagy, 2013). Treatment and referral data indicate increased demand for specialist mental health interventions over the past decade (e.g. Sarginson et al., 2017, Royal College of Emergency Medicine 2017). General surveys have found increased levels of low wellbeing in children in England. But it has not been possible before now to establish the trend in underlying rates of mental disorder in children.

Trends Data from this survey series reveal a slight increase over time in the prevalence of mental disorder in 5 to 15 year olds (the age-group covered on all surveys in this series). Rising from 9.7% in 1999 and 10.1% in 2004, to 11.2% in 2017.

Trends in any disorder in 5 to 15 year olds by sex, 1999 to 2017



Preschool children: one in eighteen 2 to 4 year olds had a disorder

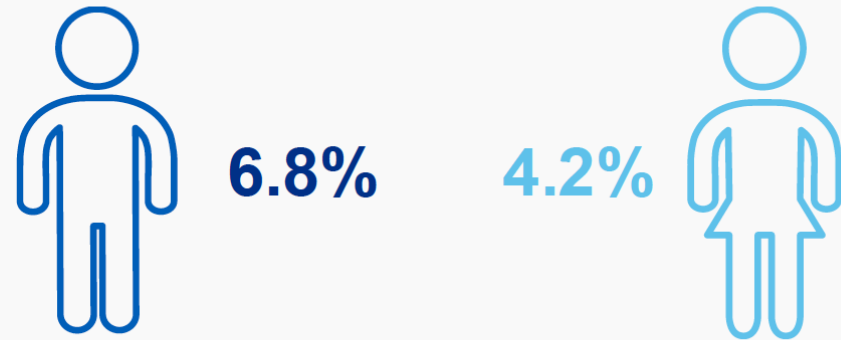
The early years are a critical time of rapid development.

These Experimental Statistics are England's first estimates of disorder prevalence in 2 to 4 year olds based on high quality assessments with a national, random sample.

One in eighteen (5.5%) preschool children were identified with at least one mental disorder around the time of the interview.

Behavioural disorders were evident in 2.5% of preschool children, consisting mostly of oppositional defiant disorder (1.9%). Autism spectrum disorder (ASD) was identified in 1.4% of 2 to 4 year olds. Other disorders of specific relevance to this age group were also assessed, of which sleeping (1.3%) and feeding (0.8%) disorders were the most common.

Among 2 to 4 year olds, boys were more likely than girls to have a disorder



Primary school years: one in ten 5 to 10 year olds had a disorder

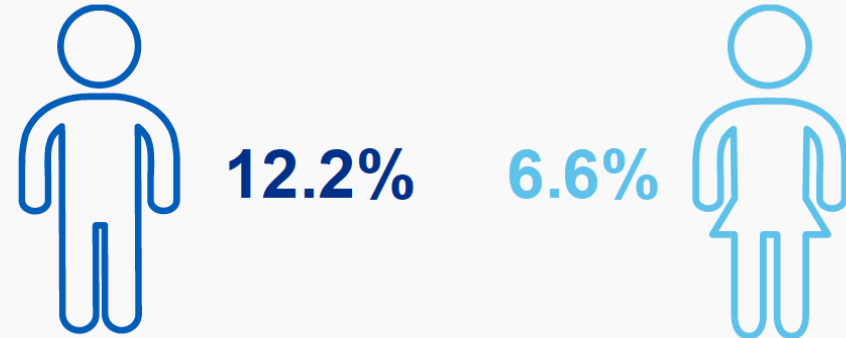
Primary school is a major stage in early childhood.

About one in ten (9.5%) 5 to 10 year olds had at least one disorder. And about one in thirty (3.4%) met the criteria for two or more mental disorders around the time of the interview.

Behavioural disorders (5.0%) and emotional disorders (4.1%) were the most common types in this age group.

At this age, rates of emotional disorder were similar in boys (4.6%) and girls (3.6%). However, other types of disorder were more than twice as likely in boys as girls. For example, 2.6% of 5 to 10 year old boys were identified with a hyperactivity disorder, compared with 0.8% of 5 to 10 year old girls.

Among 5 to 10 year olds, boys were about twice as likely as girls to have a disorder



Secondary school years: one in seven 11 to 16 year olds had a disorder

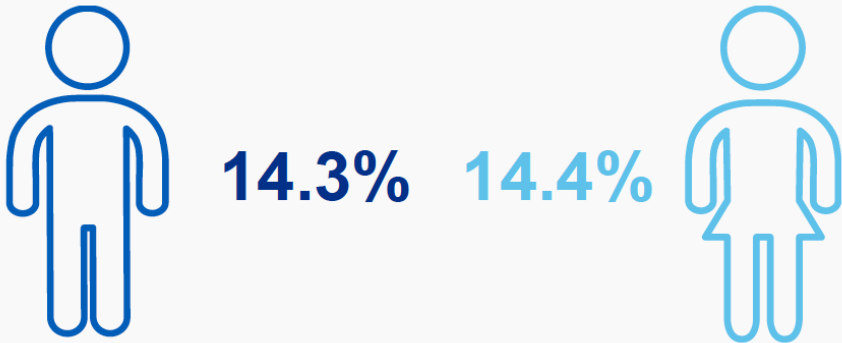
The move to secondary school coincides with the start of adolescence.

About one in seven (14.4%) 11 to 16 year olds were identified with a mental disorder. And one in sixteen (6.2%) met the criteria for two or more mental disorders at the time of the interview.

Emotional disorders were the most common type at this age, present in 9.0% of 11 to 16 year olds. This was followed by behavioural disorders (6.2%).

While at this age boys and girls were equally likely to have a disorder, they tended to have different types of disorder. Girls were more likely than boys to have an emotional disorder (10.9% compared to 7.1%), while boys were more likely than girls to have a behavioural disorder (7.4%, compared with 5.0%) or a hyperactivity disorder (3.2% compared with 0.7%).

Among 11 to 16 year olds, boys and girls were equally likely to have a disorder



Transitioning to adulthood: one in six 17 to 19 year olds had a disorder

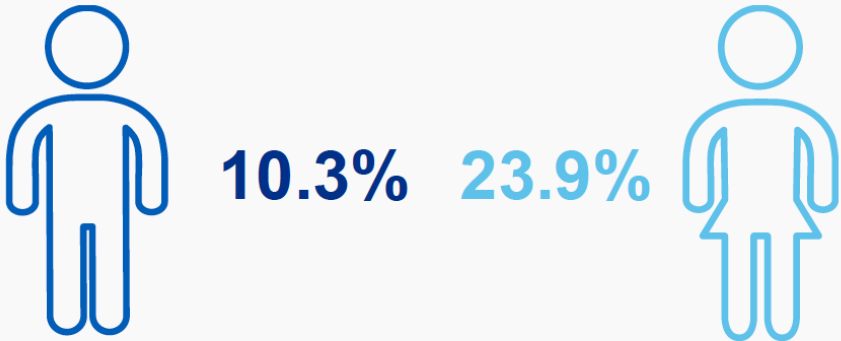
Adolescence is an extended period of change.

About one in six (16.9%) 17 to 19 year olds had a mental disorder. And one in sixteen (6.4%) met the criteria for more than one mental disorder at the time of the interview.

Emotional disorders were the most common type in this age group, present in 14.9% of 17 to 19 year olds. 13.1% were identified with an anxiety disorder and 4.8% with depression. The other disorder types (behavioural, hyperactivity, and other less common disorders) all had an overall prevalence of less than one in fifty at this stage.

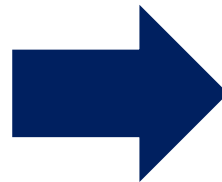
Among boys, the likelihood of having a disorder was highest at age 11 to 16. In girls, however, the disorder rate was highest in those aged 17 to 19. These differences in the pattern of association between age and presence of disorder were due in part to differences in the types of disorder boys and girls had.

Girls aged 17 to 19 were more than twice as likely as boys that age to have a disorder



What does this mean for the prevalence in Hillingdon?

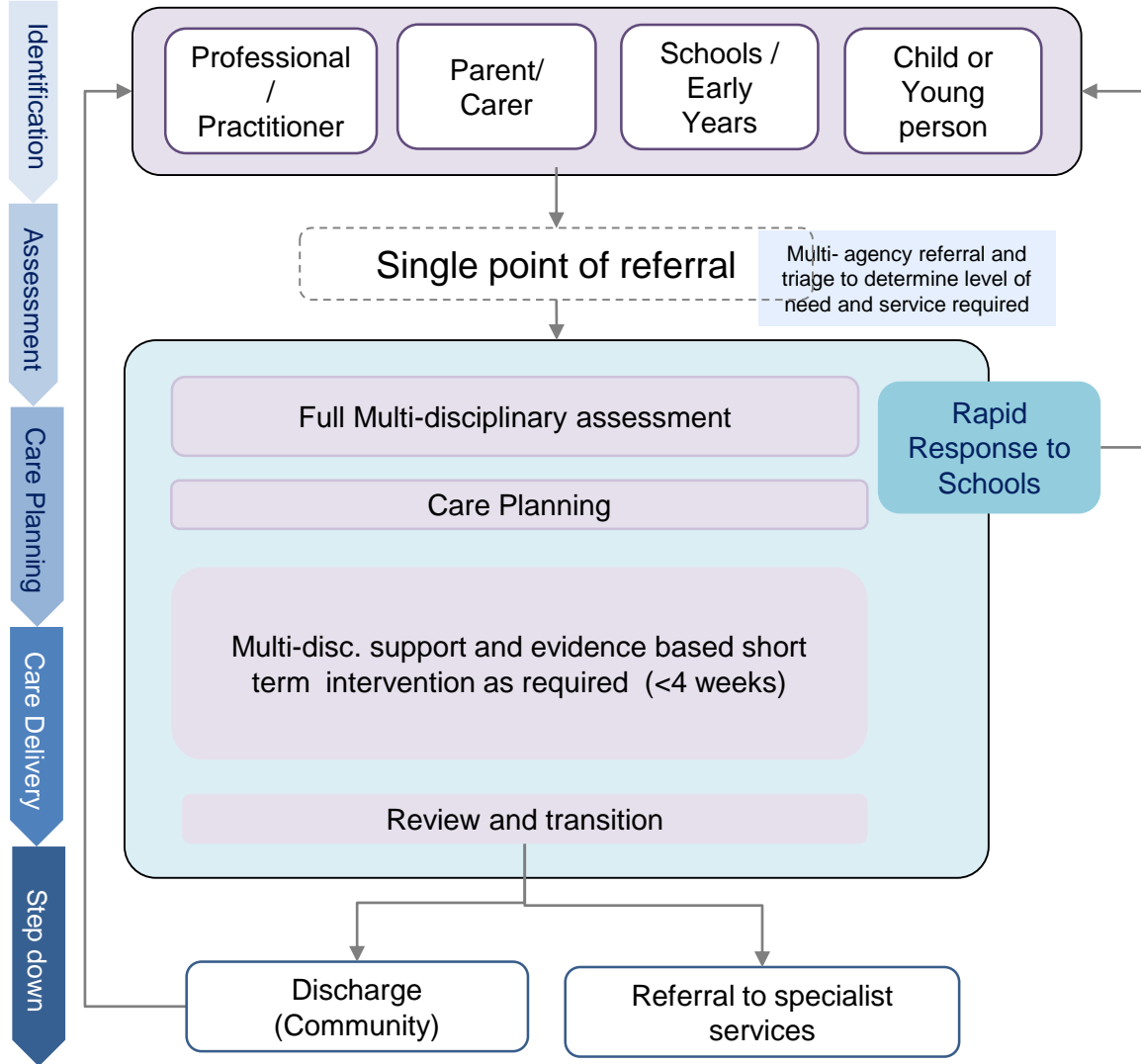
| Prevalent population | Old prevalence |
|---------------------------|----------------|
| Brent | 4572 |
| Ealing | 4692 |
| Hammersmith & Fulham | 1828 |
| Harrow | 3171 |
| Hillingdon | 4051 |
| Hounslow | 3468 |
| Kensington & Chelsea / WL | 1440 |
| Westminster / CL* | 2417 |



| Prevalent population | Jan'19 CCGs suggested updated prevalence |
|---------------------------|--|
| Brent | 6,507 |
| Ealing | 6,912 |
| Hammersmith & Fulham | 3,023 |
| Harrow | 4,897 |
| Hillingdon | 6,142 |
| Hounslow | 5,356 |
| Kensington & Chelsea / WL | 2,430 |
| Westminster / CL* | 2782 |

- **Scope and Outcomes**
- **Population segmentation and demand modelling**
- **Further development of the key components**
- **Working as one system**
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- **Next Steps**

Early Intervention Approach for Hillingdon



Key features

The Hillingdon Integrated Early Intervention approach will provide rapid multi-disciplinary assessment and time-bound multi-disciplinary follow-on support at home for up to 4 weeks for children and young people experiencing low to moderate level mental and physical health needs.

The aim is to prevent escalation of need and to provide the support needed to build resilience.

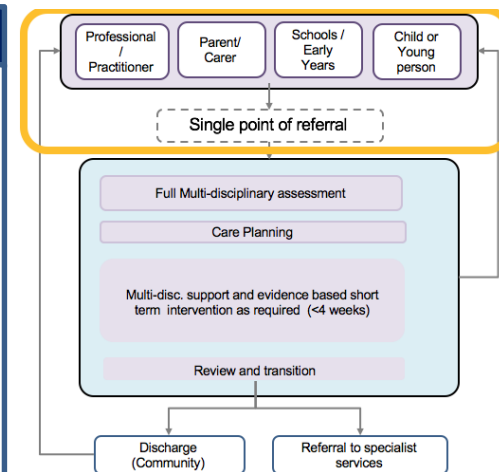
Key features include:

- **Multi-disciplinary team** consisting of Therapists, Paediatricians, and Social Care professionals with rapid access to psychologists from relevant specialties.
- **Single Point of Access and triage**
- **Multi-disciplinary assessment and short term intervention**
- **Referral to specialist services**
- **Training and development for schools, parents and other supporting services**
- **Rapid response out reach to schools**
- **A time bound period of support** followed by handover to services able to provide long-term support (school counsellor etc.)

Component 1 – Identification & Triage

Key features

- The Early Intervention service will also provide pro-active, multi-disciplinary support for CYP with low to moderate needs but who require care planning with multi-disciplinary input or sign-posting to early intervention services
- The focus of the new service is multi-disciplinary assessment and care co-ordination.
- The integrated triage team (pool of knowledge) are co-located (at the Early Intervention Hub) and are experienced (experience up front)
- There will be a **single point of access**/ 1 triage team/hub per locality
- **Anyone can refer into the service including the CYP (Self Referral)**
- F2F and NF2F triage options available based on need
- Referral and assessment processes are streamlined (SINGLE NEEDS ASSESSMENT - 1 form)
- Two types/definitions of assessment:
 - Triage (Pulling together all the information to establish priority, a plan and RTT)
 - Specialist assessment (MDT assessment of dependent on need)
- **24 hour single point of entry 7 days access or 24 Hours a day?**



Triage Team

- Key Worker
- P3
- Link
- Psychologist/ Therapist
- Support worker
- Family therapist
- Nurse
- SEND

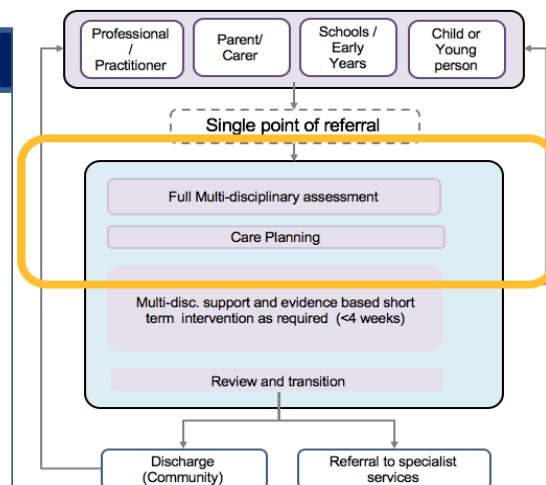


Are there any other considerations/ key features?

Component 2 – Assessment and Care Planning

Key features

- The triage form should feed into the holistic assessment (1 form)
- The team will have access to previous assessment by any agency and ability to build on and devise **1 meaningful Care Plan** that reflects the views of the CYP and is CYP friendly (**Use My Support Plan as a model**)
- Everyone involved in care will have access to the assessment and the meaningful care plan (E.g. A CAF electronic form used by 24 agencies in Hertfordshire)
- **Need to identify a vehicle to drive the information** across in a seamless and timely manner either in a paper form or electronic form
- **Key worker with co-ordinate assessment** once arrives and will be responsible for managing from beginning to end, however they are not the 'Case Manager' – need to ensure doesn't cause blockage at the front end
- Once referred into a specialist service 'Case management' will pass over to that agency, but the key support worker within the early intervention team will **still hold the CYP on their 'Case List' and will follow up** (1 Month?)
- They will also be responsible for **feedback** to the agency and the person regarding the outcome
- * Consider the **MASH team model** and building on with the review the skills mix



My Support Plan

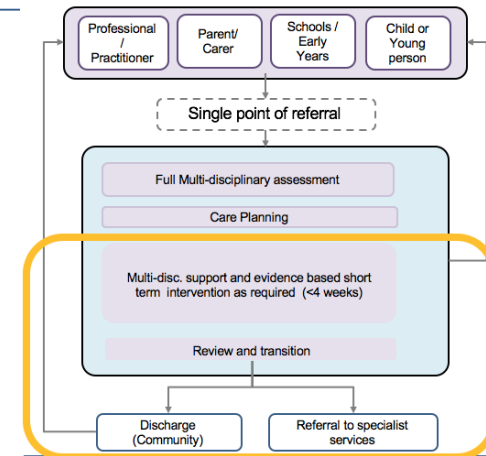
- 1 Plan that follows the child
- Simple
- Young person friendly
- Outcome Focused(SMART)
- Regular reviews
- 1 joint review with all agencies (currently piloted for LAC/YOT)
- Inclusive of CYP views

Are there any other considerations/ key features?

Component 3 – Delivery and Step Down

Key features

- The early intervention team will co-ordinate the 'Core' functions of the service or refer into the 'Supporting' services as required based on the needs of the CYP
- There will be same day follow up with crisis team as required
- The Early Intervention team will include a Lead professional from P3 hub who will co-ordinate low level support services
- All professionals and teams involved in the CYP will have access to their 'live' shared care plan
- Reference [support to schools model](#)
- The new delivery model will include low level psychology support in schools (high-level supervision support with sit within the core early intervention team)



Are there any other considerations/ key features?

Key Questions:

- **What are the key interventions we need to deliver with this component ?** E.g. screening, group therapy etc.
- **What are the necessary skills and technology thats required?** E.g. clinical, care co-ordination and administrative, online tools
- **What are the key roles involved in delivery?** E.g. management, clinical, practitioner
- **Do we need any new/revised roles?**
- **What should the service timings be?** E.g. X waiting time, X no. of session, 24hr referral?
- **How can we ensure that the workforce work as one team?** E.g. matrix working, electronic white board etc.
- **What are the other planning considerations of the model and what information do we need?** E.g. current demand and workforce
- **What should the key service thresholds be?** Do we need them?
- **How do we integrate with the schools and early years setting?** E.g. CAMHS rapid response to schools component look like ?
- **Who are the transformation leads for this component** (CCG, CNWL, LA, 3rd Sector)

Which best practice or current models and tools should we be building upon and where would you apply it?

Models:

- Integrated therapies model
- MASH hub
- Safe Spaces
- Oakwood school model - drop in and referral
- Wellbeing champion in school with access to P3 support. A similar model to the End of Life Care model with a key worker, triage upfront and escalation to specialists as and when required

Tools:

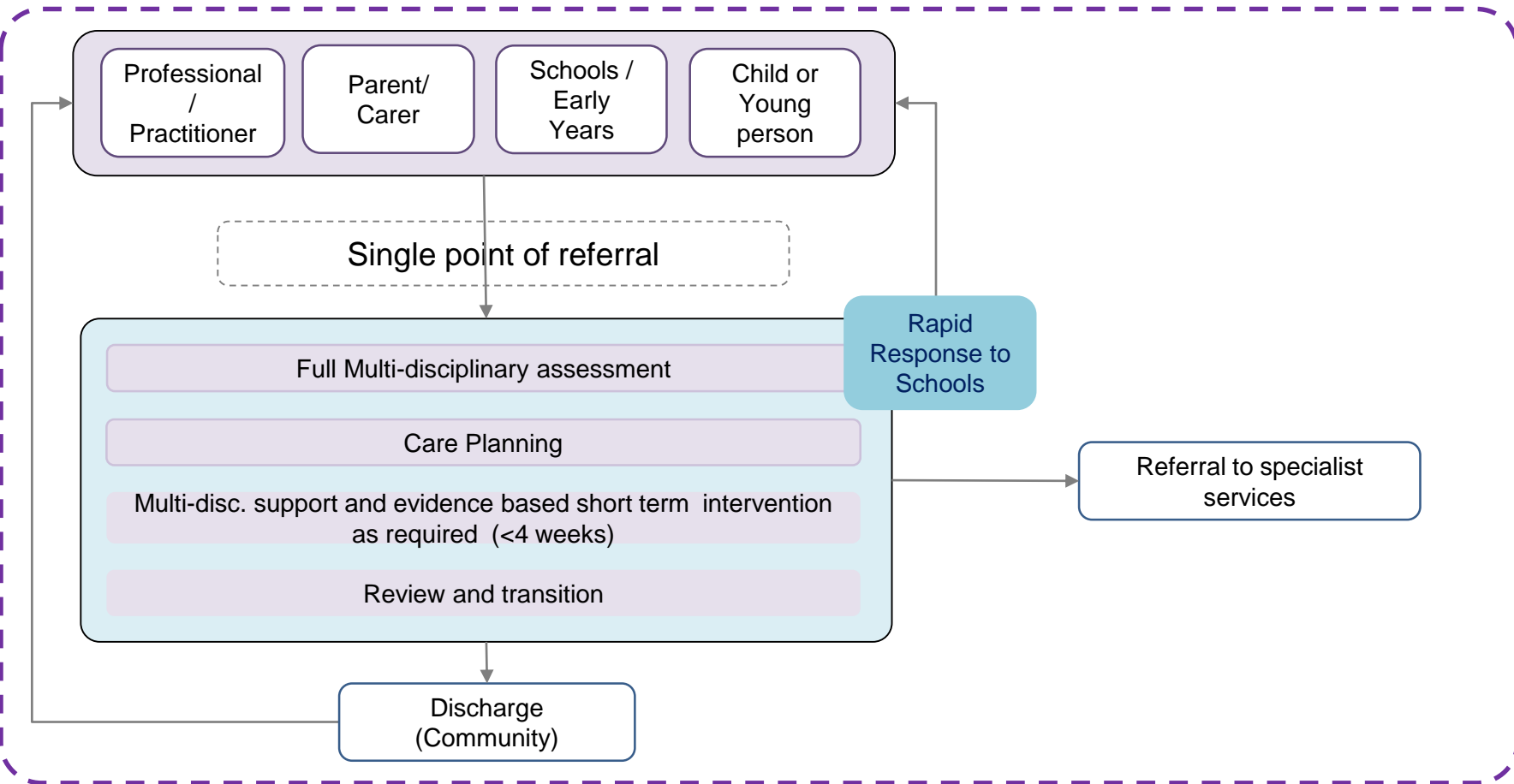
- My support plan
- CAF electronic form used by 24 agencies in Hertfordshire
- Infiniti (MD working tool – currently being trialled for adults)

Are there anymore models or tools that we should be referencing?

- **Scope and Outcomes**
- **Population segmentation and demand modelling**
- **Further development of the key components**
- **Working as one system**
- **Complex needs and transition planning**
- **Next Steps**

We need to understand how this will work as one system

Prevention, early intervention and resilience building focused to prevent escalation of issues



How will all service components fit together as a whole system?

- **How do we make efficiencies by reducing duplication and moving into an early intervention model** i.e. target of 15% reduction of current services to reinvest in early intervention?
- **How will professionals work across locations and how do we create a ‘one team ethos’?** i.e. people have different professional frameworks
- **How do we practically implement a functioning CYP holistic model (emotional, social, psychological and physical wellbeing) across the system?**
- **In the short – medium term how can we work effectively as one team across organisations?** E.g. how can we come together across different statutory responsibilities, IG etc.

- **Scope and Outcomes**
- **Population segmentation and demand modelling**
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- **Complex needs and transition planning**
- **Next Steps**

- **Scope and Outcomes**
- **Service baselining and demand modelling**
- **Further development of the key components**
- **Working as one system**
- **Complex needs and transition planning**
- **Next Steps**

Key Next Steps

1. Feed outputs of this workshop into Workshop 3 'Mobilise' – Tuesday 11th June
2. Further develop the population segmentation and baselining to model the demand of the new service model
3. Develop the financial and contractual plans to support the model
4. Develop the 1st draft of the Integrated Business Case and Service Specification
5. Agree the sign-off approach for the IBC and Service Specification

Timelines

