City and Hackney CAMHS Transformation Plan
Foreword

This Transformation Plan is the result of close engagement with local voluntary sector groups, young people, families, schools and local statutory sector services and we will endeavour to continue this engagement as we move forward with this plan.

City and Hackney is firmly committed to whole system joined up working between organisations and for this reason a multi-organisational CAMHS Alliance was created in April 2015 to develop more integrated care pathways that reach children and young people in families, schools and the wider community. This transformation plan builds on that vision and for this reason it will be delivered through the CAMHS Alliance, which has established governance structures and a track record in project delivery.

City and Hackney City and Hackney CAMHS services face high levels of deprivation and a young, growing and increasingly diverse population. Rates of inpatient admission remain relatively high. Our plan responds to this by setting out how we will build capacity, increase access and resilience in communities and intervene early before problems become more acute.

This plan also sets out a clear and achievable action plan for how we will deliver this vision. We look forward to working together to make this happen.

Signed of behalf of City and Hackney CCG

Dr Rhiannon England
CCG Mental Health Programme Board Chair

David Maher
CCG Mental Health Programme Board Director
# Contents

1 Executive Summary ........................................................................................................... 3  
2 Local Needs .................................................................................................................................. 6  
3 Current CAMHS Provision ........................................................................................................ 15  
4 Gap Analysis and Vision ......................................................................................................... 22  
5 Engagement ................................................................................................................................... 27  
6 How we will Deliver Our Vision ........................................................................................... 29  
7 Managing Risk .......................................................................................................................... 51  
8 Governance ............................................................................................................................... 22  
9 Investment Summary ............................................................................................................... 56  

Appendix 1: CAMHS Alliance Agreement  
Appendix 2: Five to Thrive Engagement Event Feedback
1 Executive Summary

Child and Adolescent services in City Hackney face the following challenges:

1. **Increased demand** as a result of a growing young population with increasing levels of diversity and migration and immigration.
2. **There is a prevalence of groups, which are challenging to reach** including BME communities, young offenders, substance misusers, young people in gangs, those struggling at school and deprived families.
3. **Inequality**: BME groups and deprived areas tend to have poor access to community services and are over represented at the acute end and in terms of looked after children and child protection plans.
4. **High admission rates**: there is a need to intervene earlier and improve community services and resilience to reduce admissions.
5. **Pressure on schools**: there are high levels of conduct disorder and a high proportion of statemented children and young people.
6. **Increased prevalence of eating disorders**.

A review of current service provision reveals the following gaps:

1. **Lack of integrated pathways**: there are a wide range of services but services need to work more closely together to create more integrated pathways, which support early intervention a stronger community services.
2. **Lack of services which build resilience**: services tend to be reactive responding to problems rather than helping people and communities pro-actively manage mental health and promote wellbeing. More work is needed with whole communities and families in order to develop greater resilience and reduce inpatient admission.
3. **Skills**: there are a number of third sector organisations which have access to children and young people in hard to reach communities. However, to function effectively, these organisations need to develop better skills in identifying mental health problems to support better access.
4. **CYP outcome standardisation and access**: Whilst, Children and Young People’s services routinely measure outcomes there is a lack of standardisation of recording and reporting. This makes is difficult to compare and benchmark recovery rates. There is also a need to make the patient rated outcome measures more user friendly and accessible to young people.
5. **ASD in mainstream schools**. There is a gap in provision for children and young people in mainstream schools at the higher functioning end.
6. **Lack of community eating disorder service**: There is currently no specialist community eating disorders service within the East London boroughs.

Based on the identified needs, gaps in provision listed above and the recommendations in Future in Mind, we have developed the following vision for the CAMHS Transformation Programme:

1. **Strengthen community resilience**, working with children, families and communities.
2. **Intervene early** – focus on early years and community based interventions that avoid acute admissions.

3. **Integrate care pathways** through partnership working to promote better, more equitable access, early intervention, community follow up and the integration of support in terms of physical health, mental health, social care and youth justice.

4. **Integrate information systems** to support integrated pathways

5. **Equitable access for groups that are challenging to reach**

6. **Promote recovery** through standardised user friendly outcome measures

To deliver this vision our investment priorities are as follows:

- **Building Reach and Resilience.** We will invest in delivering training and supervision to third sector organisations, which have access to hard to reach communities to develop their skills level to better identify mental health problems. We will support increased work with families to develop resilience.

- **Developing CYP Outcomes.** We will develop more user friendly methods of collecting patient reported outcome measures and develop standardised reporting systems, which allow benchmarking.

- **Early Years:** We will create more integrated pathways for the early years to support the early diagnosis and intervention of mental health problems and stronger community based services. This will involve improved liaison and links between the Mother and Baby service, the NICU the perinatal service and First Steps.

- **ASD mainstream schools:** we will invest in educational psychology capacity in mainstream schools for ASD and to increase ASD identification and the creation of SEND plans for each child diagnosed with ASD.

- **Crisis pathway:** greater integration between mental health and physical health including improved Paediatric Mental Health Liaison in A&E; increasing crisis drop in support; pathway integration for Young Offenders linking criminal justice to mental health.

- **Integrating Information Systems:** the investment will ensure that third sector organisations can share and access data and report on standardised KPIs.

- **Community Eating Disorders:** we will establish a single community eating disorder service across City and Hackney, Newham and Tower Hamlets. The service will conduct early assessment, diagnosis and treatment, and liaise and interface with other services as part of an integrated pathway.

Extensive multi-agency engagement was conducted to develop our vision involving a series of workshops from August to mid-November with the CAMHS Alliance and wider stakeholders including, service users, public health, the local authority, social care, youth justice, education and third sector organisations. Further engagement is planned for the remainder of Q3 in order to refine our planning in preparation for the investment start in Q4. Service user engagement will continue throughout the plan in the form of a service user reference group. The table below summarises the cost of each investment priority. It also demonstrates how our KPIs are linked to objectives aligned to our vision.

**Figure 1: Investment Priority Summary**
<table>
<thead>
<tr>
<th>Investment Priority</th>
<th>Investment (£)</th>
<th>KPI</th>
<th>KPI Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach and Resilience</td>
<td></td>
<td>1. % CAMHS access rates to reflect % BME group population sizes. 2. % of open cases with mental health involvement having a support worker who’s received accredited mental health training.</td>
<td>1. Equity of access 2. Increase in third sector skills</td>
</tr>
<tr>
<td>Developing CYP Outcomes</td>
<td>52,260</td>
<td>% of outcome measures being recorded at 2 points in time (i.e. change can be evidenced)</td>
<td>Timely meaningful standardised reporting of clinical effectiveness.</td>
</tr>
<tr>
<td>Early Years: Perinatal</td>
<td>36,472</td>
<td>% services receiving intervention reporting that they are fully supported in meeting the mental health needs of patients</td>
<td>Integrated pathways as perceived by staff and patients from agreed survey.</td>
</tr>
<tr>
<td>Early Years: NICU Trauma and Attachment Clinic</td>
<td>39,105</td>
<td>% of appropriate patients referred from NICU</td>
<td>Successful delivery of integrated pathway evidenced by cross referral.</td>
</tr>
<tr>
<td>ASD</td>
<td>77,090</td>
<td>% of children with ASD diagnosis having SEND plan</td>
<td>All children with ASD supported by effective planning.</td>
</tr>
<tr>
<td>Crisis: Psych and Paediatric Liaison</td>
<td>30,091</td>
<td>% patients reporting improved Patient well-being and clinical effectiveness outcomes (using ESQ and SDQ and CGAs and DAWBA measurement tools)</td>
<td>Improved clinical outcomes from better liaison services.</td>
</tr>
<tr>
<td>Crisis: Off-Centre YIAC</td>
<td>10,205</td>
<td>% of services users reporting that the service is accessible during hours suitable to them</td>
<td>Better access as evidenced by service users.</td>
</tr>
<tr>
<td>Crisis: Youth Offending Team</td>
<td>6,623</td>
<td>% increase in referrals to CAMHS from police services</td>
<td>More integrated pathway from police to mental health.</td>
</tr>
<tr>
<td>Integrated Information Systems</td>
<td>41,785</td>
<td>% of IT system implementation plan complete</td>
<td>Successful delivery of new IT system.</td>
</tr>
<tr>
<td>Eating Disorder Service</td>
<td>150,372</td>
<td>1. % of cases receiving NICE concordant treatment within the standard’s timeframes. 2. Decrease in inpatient admissions.</td>
<td>Evidenced based community treatments which reduce inpatient admissions.</td>
</tr>
<tr>
<td>Total</td>
<td>526,769</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2 Local Needs

2.1 Demographic Profile

The London borough of City and Hackney CCG covers a 0-17 population of 58,457 with most of the population in Hackney.

**Figure 2: Population size**

<table>
<thead>
<tr>
<th>Population</th>
<th>City of London</th>
<th>Hackney</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17 years</td>
<td>732</td>
<td>57,725</td>
<td>58,457</td>
</tr>
<tr>
<td>5-16 years</td>
<td>410</td>
<td>35,357</td>
<td>35,767</td>
</tr>
</tbody>
</table>

The population is relatively young - more than one in four (27%) residents are aged under 20 years and 39% are aged between 20 and 39 years. As the figure below shows this young population is set to grow by 5% over the next 5 years increasing the demand for CAMHS services.

**Figure 3: 0-17 Population Growth Across East London Boroughs**

![Population Growth Graph](image)

The population is also highly diverse with 70% of children and young people aged under 20 years in Hackney belonging to minority ethnic backgrounds. As the figure below shows, this diversity is forecast to increase across Greater London.
Within City and Hackney a significant growth sector is the Orthodox Jewish community, which predicted to reach 20% of the under 5 population. There is also growth from Eastern European countries due in part to increased EU access from 2004. Studies indicate that BME groups, migrants and immigrants are more likely to experience mental health problems including psychosis due, in part, to the effects of social marginalisation. Therefore the increasing diversity of the young population is also likely to increase demand for CAMHS services. More marginalised communities can also sometimes be more challenging for services to reach and hence services will need to focus on how best to ensure there is an equity of access.

### 2.2. Demand analysis

As a result of population growth and higher diversity demand is projected to increase. The figure below highlights the potential growing gap between projected demand increases for community services for East London and current capacity assuming current capacity remains at current levels and demand increases by 5%.

**Figure 5: The Demand Gap for CAMHS Community Services in East London**

*Source: North East London CSU (November 2015)*
The figure below highlights the growing potential gap for inpatient services based on the same set of assumptions.

**Figure 6: The Demand Gap for CAMHS Inpatient Services in East London**

*Source: North East London CSU (November 2015)*

2.3. Deprivation
Hackney is ranked as the second most deprived local authority (out of 326) in England in the Index of Multiple Deprivation (IMD) and all of the wards are in the top 10% most deprived in the country. Overall, 42% of Hackney’s Lower Super Output Areas (LSOAs) are in the top 10% most deprived areas nationally, and 13% of Hackney’s LSOAs are in the top 5% most deprived areas nationally. 31% of households in Hackney with children are workless; more than double the national rate of 14%. Child poverty where at least one parent is working is concentrated in the north of the borough whereas workless child poverty is more concentrated in eastern and southern wards.

City and Hackney’s Mental Health Needs Assessment found that clinicians reported increases in the number of self-harm cases presenting to services (not requiring admission), the number of eating disorders and the complexity of cases e.g. mental disorders further exacerbated by difficult social circumstances.

The figure below shows the estimated prevalence rates for the City and Hackney population for each tier of CAMHS service weighted by mental health need.

- Tier 1: mental health problems manageable by non-specialist community practitioners, teachers, GPs, social workers.
- Tier 2: problems requiring specialist primary care and community practitioners e.g. psychologists)
- Tier 3: problems requiring specialist team input
- Tier 4: severe problems requiring inpatient, outpatient and specialist day units.

As can be seen, due to the relatively high levels of deprivation, expected prevalence is 79% higher than the un-weighted estimate for a the same size population based on national average population needs.

**Figure 7: Expected prevalence by CAMHS tier compared to the national average**

**Tiers**

Estimates for the number of children requiring Tiers 1-4 services in City & Hackney are as follows:

<table>
<thead>
<tr>
<th>Tier</th>
<th>National estimate</th>
<th>MINI2K estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8,769</td>
<td>15,740</td>
</tr>
<tr>
<td>2</td>
<td>4,384</td>
<td>7,870</td>
</tr>
<tr>
<td>3</td>
<td>1,461</td>
<td>2,623</td>
</tr>
<tr>
<td>4</td>
<td>292</td>
<td>525</td>
</tr>
</tbody>
</table>

Kurtz Z. Treating Children Well, Mental Health Foundation, 1995
GLA population estimates

**2.4 Children and Young People in Schools**

In addition to having a higher mental health weighting, Hackney also has a far higher proportion of children in special schools or pupil referral units. Furthermore, this number has
been increasing and in 2013 represented 3.2% of the population compared to a national average of 2.8% and a London average of 2.75%.

**Figure 8: Children in special schools and Pupil Referral Units**

Children in special schools for behavioural, emotional and social difficulties (BESD schools) or Pupil Referral Units (PRU) are significantly more likely to experience mental health difficulties than the general population. In Hackney in 2012/13 259 children attend 4 special schools and 242 children attend Hackney’s 1 pupil referral unit.\(^{119}\)

Hackney also a high proportion (2.4%) of children and young people, who have a Special Educational Needs (SEN) as shown below. These children are much more likely to experience mental health problems.
Hackney also has a higher than London average proportion of young people aged 16 – 18 who are not in education, employment or Training (NEET) – 7% compared to a London average of 5% with a borough ranking of 8th out of 33 London boroughs.

Figure 10: Young people 16-18 years old not in education employment or training
Ofsted found that children and young people expressed a desire to learn about emotional wellbeing. NICE recommends comprehensive whole school approaches to promoting the social and emotional wellbeing of children and young people. When whole school approaches encompass all that goes on in the school (not just teaching) they have been found to achieve health benefits that are sustained. The Department for Education found whole school emotional wellbeing approaches to be a protective factor for child and adolescent mental health.

2.5 Looked after children

The figure below shows that BME groups are over represented in Hackney, relative to their population sizes in terms of the numbers of child protection plans and the number of looked after children. As children in these groups tend to have a high proportion of mental health problems it is vital that CAMHS services provide reach into BME communities.

Figure 11: Looked after children in Hackney by Ethnic Group

*Child protection plans and Looked After Children by ethnic group (data provided by Hackney Learning Trust, spring 2015)*

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Child protection plans</th>
<th>Looked after children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>77</td>
<td>147</td>
</tr>
<tr>
<td></td>
<td>34%</td>
<td>44%</td>
</tr>
<tr>
<td>White</td>
<td>65</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>29%</td>
<td>28%</td>
</tr>
<tr>
<td>Mixed</td>
<td>56</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Asian</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Other Ethnic group</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Not Stated/not recorded</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

2.6 Young Offenders and Conduct Disorder

City and Hackney has a history of gang rivalry and high prevalence of gang related crime. Hackney has over 20 established gangs with gang numbers ranging from 20 to 100. City and Hackney is above the London average for youth offending rates and crime rates with the 6th highest ranking for violence against the person. There are strong links between offending and mental health. One in 10 boys and one in five girls in Youth Offending Institutions (YOIs) have attention deficit hyperactivity disorder. Research commissioned by the Youth Justice Board has found that 19% of 13-18 year olds in custody have depression, 11% have anxiety and 11% post-traumatic stress disorder. A further study found that 85% of 16-20 year olds in custody showed signs of personality disorder compared with 10-13% in the general population. The figure below shows that there are over 2,000 children and young people in Hackney with a conduct disorder. There is a strong link between conduct disorder and offending and also mental health with 46% of boys and 36% of girls with conduct disorder having a least one mental health problem. However, often this is undiagnosed and untreated.
Figure 12: Conduct disorder in Hackney

46% of boys and 36% of girls with conduct disorder have at least 1 co-existing mental health problem, and more than 40% of children and young people with a diagnosis of conduct disorder also have a diagnosis of ADHD. Conduct disorders in childhood are also associated with a significantly increased rate of mental health problems in adult life and up to 50% of children and young people with a conduct disorder go on to develop antisocial personality disorder.  

2.7 Eating Issues

The figure below shows a 63% rise of in the number of young people with eating issues in the last year across all three boroughs. The rise was 97% in City and Hackney and is significant at all levels of severity.

Figure 13: Eating Issues in East London CCGs 2013-2015

<table>
<thead>
<tr>
<th></th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City &amp; Hackney</td>
<td>58</td>
<td>26</td>
<td>9</td>
<td>93</td>
</tr>
<tr>
<td>Newham</td>
<td>83</td>
<td>44</td>
<td>20</td>
<td>147</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>80</td>
<td>34</td>
<td>8</td>
<td>122</td>
</tr>
<tr>
<td>Total 2013/14</td>
<td>221</td>
<td>104</td>
<td>37</td>
<td>362</td>
</tr>
<tr>
<td>2014/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City &amp; Hackney</td>
<td>109</td>
<td>58</td>
<td>16</td>
<td>183</td>
</tr>
<tr>
<td>Newham</td>
<td>101</td>
<td>46</td>
<td>16</td>
<td>163</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>141</td>
<td>73</td>
<td>24</td>
<td>238</td>
</tr>
<tr>
<td>Total 2014/15</td>
<td>351</td>
<td>177</td>
<td>56</td>
<td>584</td>
</tr>
</tbody>
</table>
2.8 Inpatient admissions

The inpatient admission rate as a percentage of the CYP population is relatively high compared to neighbouring boroughs, London and England as a whole. There were 435 admissions of children and young people aged 0-19 years in 2013. There is a need to reduce the admission rate by building community resilience and through intervening earlier.

**Figure 14: Admission rates as a percentage of the population**

<table>
<thead>
<tr>
<th>Area</th>
<th>% acute admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>City &amp; Hackney</td>
<td>0.37%</td>
</tr>
<tr>
<td>Newham</td>
<td>0.35%</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>0.12%</td>
</tr>
<tr>
<td>London</td>
<td>0.11%</td>
</tr>
<tr>
<td>England</td>
<td>0.11%</td>
</tr>
</tbody>
</table>

2.9 Community Access

A recent study by the East London Mental Health Commissioning Consortium (November 2015) found that East London CAMHS services were seeing approximately 15-20% of the estimated total numbers of children and young people with mental health difficulties. The figure below shows activity rates for community CAMH services across East London CCGs. As can be seen, City and Hackney has relatively high access rates measured in referrals. In part this appears to be due to the work of the CAMHS alliance in developing a more integrated single point of access.

**Figure 15: Community CAMHS Activity across east London CCGs**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Measure</th>
<th>ELFT</th>
<th>NELFT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>City &amp; Hackney</td>
<td>Newham</td>
<td>Tower Hamlets</td>
</tr>
<tr>
<td>Community CAMHS</td>
<td>Referrals</td>
<td>1,928</td>
<td>1,634</td>
<td>1,441</td>
</tr>
<tr>
<td></td>
<td>Referrals Accepted</td>
<td>1,644</td>
<td>1,224</td>
<td>1,257</td>
</tr>
<tr>
<td></td>
<td>Contacts</td>
<td>14,207</td>
<td>10,578</td>
<td>10,863</td>
</tr>
<tr>
<td></td>
<td>Overall DNA Rate (latest value)</td>
<td>8.6%</td>
<td>12.1%</td>
<td>13.4%</td>
</tr>
<tr>
<td></td>
<td>Equivalent Missed Appointments (at latest DNA rate)</td>
<td>1,337</td>
<td>1,456</td>
<td>1,681</td>
</tr>
</tbody>
</table>
3. Current CAMHS Provision

3.1 Current CAMHS Investment

The table below provides a breakdown of the £23.7m currently invested in CAMHS services in City and Hackney.

Figure 16: 2015/16 Recurrent Funding Profile across agencies in City and Hackney

<table>
<thead>
<tr>
<th>City and Hackney CCG</th>
<th>2015-16 Recurrent Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELFT: Specialist CAMHS</td>
<td>£3,657,000</td>
</tr>
<tr>
<td>ELFT: Perinatal Services</td>
<td>£287,793</td>
</tr>
<tr>
<td>HUH: CAMHS Autistic Spectrum Disorder</td>
<td>£42,000</td>
</tr>
<tr>
<td>HUH: First Steps</td>
<td>£1,070,000</td>
</tr>
<tr>
<td>HUH/ELFT: CAMHS Disability</td>
<td>£451,000</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>£5,507,793</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHSE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother and Baby</td>
<td>£2,275,000</td>
</tr>
<tr>
<td>The Coburn Centre (inpatient and day places)</td>
<td>TBC</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>£2,275,000</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>London Borough of Hackney (Local Settlement OR DfE early intervention)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical services, Targeted youth support, exc. children's social care, and school specific support</td>
<td>£1,500,000</td>
</tr>
<tr>
<td>Educational psychologists; School specific support</td>
<td></td>
</tr>
<tr>
<td>Key Stage 2 - Place2Be offers 1 day a week for a year, which involves 40 weeks, at £10,000; School specific support</td>
<td>£400,000</td>
</tr>
<tr>
<td>Key Stage 4 – A Space offers 1 day a week for a year, which involves 40 weeks, at £12,000; School specific support</td>
<td>£480,000</td>
</tr>
<tr>
<td>Learning Trust - Emotional Success - promoting wellbeing (PHSA curriculum), character building, mindfulness, excluding training activities; Targeted youth support, exc. children's social care, and school specific support</td>
<td>£2,500,000</td>
</tr>
<tr>
<td>Learning Trust - Emotional Success - training activities only; Targeted youth support, exc. children's social care, and school specific support</td>
<td>£200,000</td>
</tr>
</tbody>
</table>
Young Hackney: Targeted youth support, exc. children’s social care, and school specific support

| Sub Total | £8,500,000 |

London Borough Hackney: Public Health

Healthier Hackney; Targeted youth support, exc. children’s social care, and school specific support

| School nurses | £1,000,000 |

| Sub Total | £1,126,000 |

| Grand Total | £22,488,793 |

The table below shows the non-recurrent investment for 2015-16. The vehicle for delivering this is alliances, which bring together statutory and third sector providers to deliver shared, shared projects and shared KPIs. The alliances are described in more detail in the next section and in the Governance section (Section 8) in this document.

Figure 17: Non-recurrent Investment

<table>
<thead>
<tr>
<th>City and Hackney</th>
<th>2015-16 Non-recurrent Alliance Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td></td>
</tr>
<tr>
<td>CAMHS Alliance: Off Centre</td>
<td>£66,338</td>
</tr>
<tr>
<td>CAMHS Alliance: HUH</td>
<td>£134,927</td>
</tr>
<tr>
<td>CAMHS Alliance: ELFT</td>
<td>£118,357</td>
</tr>
<tr>
<td>Primary Care Alliance: Family Action</td>
<td>£284,943</td>
</tr>
<tr>
<td>Sub Total</td>
<td>£604,565</td>
</tr>
</tbody>
</table>

3.2 Current CAMHS Provision

The paragraphs below describe the scope of the CAMHS services outlined in table 9 above.

3.2.1 CCG Funded Services

Community Child Psychology Services (First Steps)

Provided by Homerton University Hospital NHS Foundation Trust, First Steps Early Intervention Community Psychology Service operates between 9-5pm, Monday to Friday and provides a service for children and young people aged 0-18 and their families, who have mild to moderate mental health problems and who are likely to be helped by a brief psychological intervention. The service is provided by a team of child mental health professionals, locality leads and a parenting lead, all of whom are based in children’s centres and GP practices across the borough where interventions are also delivered. The service delivers a range of individual and group interventions, parenting support, mental health promotion, education and training, and topic based groups such as ‘Calm Connections’ and...
‘Transition’. Referrals onto specialist CAMHS is required. Referrals can be made by any professional working with a child. Families may also self-refer.

**Child and Adolescent Mental Health Service (CAMHS) Disability Team**

CAMHS disabilities is provided by the Hackney Ark Children & Young People’s Centre for Development & Disability by Homerton University Hospitals NHS Foundation Trust and East London NHS Foundation Trust. The service operates between 9-5pm, Monday to Friday.

- A specialist, tier 3 service for children and young people aged 0-19 who have dual difficulties; mental health or emotional needs, which occur alongside a disability.
- A joint multidisciplinary team provided by Homerton University Hospital NHS Foundation Trust and East London NHS Foundation Trust, which consists of clinical psychologists, consultant child and adolescent psychiatrist, play specialist, systemic family therapist, child psychotherapist and specialist autism clinicians.
- The service provides diagnosis e.g. ASD, ADHD, psycho-pharmacological intervention (medication), therapeutic/behavioural support and interventions and support with emotional response to diagnosis. It also delivers group work around parenting, siblings support groups, Next Steps intervention (MDT) for under 5s, Teen Troubles (ASD), ASD parent support group.
- Referrals can be made by any professional working with a child. Parents may self-refer provided they have been known to the service in the past.
- Delivered in partnership with ELFT

**Specialist Child and Adolescent Mental Health Services**

Core specialist CAMHS services are provided by East London NHS Foundation Trust from two bases in the borough.

- A specialist service for children and young people up to the age of 18 years, where there is likelihood that the child or young person has a severe mental health disorder; and children and young people whose symptoms, or distress, and degree of social and/or functional impairment are severe.
- The service will work with children, young people and their families where there is a high level of case complexity, that is, where there are significant mental health problems, and in addition, multiple risk factors (co-morbidity), including complex family problems, child protection concerns, significant risk of harm to self or others, risks of violence, terminal illness, parental substance misuse/mental illness, seeking asylum, refugee status, or being the victims of torture, placing self or others at risk, being at the threshold of corporate care or being looked after, or being subject to child safeguarding procedures.
- The service will assess and treat children and young people who are experiencing serious risks to their emotional and psychological wellbeing and development. The
threshold for referral to specialist CAMHS is that the suspected mental health difficulties are urgent, persistent, complex or severe.

- Teams are multidisciplinary and consist of consultant child and adolescent psychiatrists, clinical psychologists, child psychotherapists, systemic family therapists, clinical nurse specialists and junior doctors from the Great Ormond Street/Royal London CAMH training scheme.
- The service provides a range of therapeutic and psycho-pharmacological interventions, consultation and liaison with other services including the paediatric liaison, and out of hours service.
- Referrals can be made by any professional working with a child, young person or their family.

**Adolescent Mental Health Team (Specifically targeted work with Psychosis)**

The Trust also provides and Adolescent Mental Health Team which targets work with psychosis. The team provides the early intervention in psychosis service to offer quick identification of the first onset of a psychotic disorder and appropriate treatment including intensive support, crisis intervention, assertive outreach and home treatment in the early phase.

- The service also provides assessment and treatment of mental health problems of an acute and severe nature for young people including complex eating disorders, OCD, ASD, Anxiety and Depression.
- The service will implement appropriate discharge planning, liaison and community outreach in conjunction with the Coborn Centre for Adolescent Mental Health (Inpatient unit).
- The team is multidisciplinary and consists of consultant child and adolescent psychiatrists, clinical psychologist; systemic family therapists, and specialist mental health nurses and mental health clinicians.
- Referrals through core service and the Coborn Centre for Adolescent Mental Health (in-patient unit)

**The Perinatal Service**

The Perinatal Service, provided by ELFT, works with women, who have moderate to severe mental health difficulties in pregnancy or within the first year after child birth. These may be pre-existing illnesses or have their onset in the perinatal period. If there is a previous, current or a family history of mental health difficulties, a woman can consent to a referral to this service. Members of the team have many different professional backgrounds: nursing, psychology, and medicine.
3.3.2 NHSE Funded Services

The Mother and Baby Unit
East London NHS Foundation Trust provide a family centred mother and baby unit for mothers experiencing mental health problems before and after pregnancy.

The Coborn Centre

The Coborn Centre for Adolescent Mental Health is a service specially set up to look after young people between the ages of 12 and 18 years old who are experiencing significant emotional and/or mental distress. It is mixed gender and provides a service to young people from Hackney, Tower Hamlets and Newham. The unit has 15 beds and 9 day care places.

3.2.3 Services funded and delivered by the London Borough of Hackney

Integrated Clinicians in Young People’s Services

Hackney Children & Young People’s Service has a highly specialist and integrated clinical service that delivers high quality assessments and multi-modal interventions to children who are in need, at risk and looked after and who have a range of complex needs in relation to their emotional health and wellbeing. Clinical assessments are undertaken collaboratively alongside social work assessment and care planning by Specialist Clinical Practitioners working in clinical hubs across Children’s Social Care.

The hubs deliver brief, intensive and multi-modal interventions to address a range of complex needs including but not exclusive to:

- Early identification and screening of child mental health
- Children who have experienced abuse, neglect and are suffering from trauma
- Children in Need and/or subject to Child Protection Plans
- Children and families in crisis and experiencing family breakdown
- Children subject to care proceedings
- Attachment and trauma focused interventions with looked after children and children awaiting or being placed for adoption
- Looked after children and care leavers
- Children who are privately fostered
- Children awaiting adoption and post-adoption support

The model utilising clinical posts embedded in Young Hackney has recently been reviewed and restructured.
3.2.4. Voluntary Sector Provision

**Family Action**

Family Action provides Mental Health Workers in School as part of an early intervention pilot across 6 schools. The service aims to improve children and young people’s attendance and educational attainment, enjoyment of school life, self-esteem (essential for good mental health), safety in and outside of school and their ability to form positive, trusting relationships.

- Provides individual and group support for school aged children and young people experiencing emotional or mental health related difficulties, and their families, within the home environment and school setting
- Promotes the emotional wellbeing and mental health of children and young people.
- Provides early intervention, before difficulties escalate resulting in exclusion, offending, and more acute or clinical mental health difficulties.
- Delivers a family support model, which promotes joined up, holistic support for the whole family.
- Engages schools in a Borough-wide dialogue about the necessity to address young people’s mental health as a joint venture.

Family Action also provides the ‘Well Family Plus’ service, which is designed to support primary care by seeing cohorts of patients, who may experience unexplained symptoms and/or frequent attenders thus relieving some of these known pressures on primary care. By investigating root causes and signposting to services, which can address wider social determinants identified, the service will also be supporting secondary care services by ensuring referrals to secondary services are more appropriate. The service can also act as a suitable “holding” function as patients, who are referred to secondary care and waiting to be seen.

**Off-Centre**

Off Centre provides therapeutic services to children and young people experiencing difficulties such as bereavement, substance misuse, abuse, unstable accommodation.

Off Centre also provides ‘Right Track Peer Mentoring’ a service, which supports the mental health and wellbeing needs of 30 young people (16-25 years) by pairing them with trained experienced Peer Mentors.

The aim of this service is to provide mentee’s with access to healthy living & lifestyle support, informal learning, social and nurturing activities. This project offers fast-track access into Off Centre’s holistic psychotherapeutic, psychosocial and advice information services and supports delivery of the integrated services key theme.
3.2.5 CAMHS Alliance Non-recurrent Investment

The CAMHS Alliance was formed in April 2015 and brings together an acute provider a mental health provider and a third sector provider together with the CCG to increase integrated care. The Alliance agreement ensures that partners work together on shared projects towards shared aims and shared outcome measures. The current Alliance signatories to the Alliance agreement are:

- East London Foundation Trust,
- Homerton University Hospital Foundation Trust and
- Off-Centre
- City and Hackney CCG.

The London Borough of Hackney (LBH) Social Care are in attendance at Board meeting and are included in the delivery of projects. In 2016 it is planned that LBH will be a signatory to the Alliance agreement. The alliance is funded by the CCG on a non-recurrent basis to deliver projects that promote integrated care. These projects include:

- The creation of more integrated referral systems and care pathways
- The development of a single point of access.
- Expansion of the range of therapies
- Increased training and mental health awareness

More detail on the alliance governance arrangements are presented in the Governance section of this document (see Section 8).
4. Gap Analysis and Vision

4.1 The Demand Challenge

The needs analysis in the preceding section identifies the following challenges for CAMHS services.

- **Increased demand** as a result of a growing young population with increasing levels of diversity and migration and immigration.
- **There is a prevalence of groups, which are challenging to reach** including BME communities, young offenders, substance misusers, young people in gangs, those struggling at school and deprived families.
- **Inequality**: BME groups and deprived areas tend to have poor access to community services and are over represented at the acute end and in terms of looked after children and child protection plans.
- **High admission rates**: admission rates are relatively high for City and Hackney there is a need to intervene early and increase community services and community resilience to reduce admissions.
- **Pressure on schools**: high levels of conduct disorder, high proportion of statemented children and young people.
- **Increased prevalence of eating disorders**: This trend has occurred across all three boroughs at all ends of the spectrum of severity.

4.2 Gap Analysis of service provision

Reviewing the current level of service provision against the needs analysis and also the recommendation outlined in 'Future in Mind' (DOH, 2012) the following gaps in service provision emerge:

- **Lack of integrated pathways**: there are a wide range of services but services need to work more closely together to create more integrated pathways which support early intervention a stronger community services. In particular, services for the early years lack an integrated care pathway between the Mother and Baby Service, the NICU and First Steps. This would support earlier interventions before birth and better community follow up after birth. Another area is Paediatric services, which require stronger community follow up through paediatric liaison. There also needs to be greater integration in the crisis pathway between mental health services and liaison diversion services.
- **Lack of services which build resilience**: services tend to be reactive responding to problems rather than helping people and communities pro-actively manage mental health and promote wellbeing. More work is needed with whole communities and families in order to develop greater resilience and reduce inpatient admission.
• **Skills:** there are a number of third sector organisations which have access to children and young people in BME communities. However, to function effectively these organisations need to develop better skills in identifying mental health problems to support better access.

• **CYP outcome standardisation and access.** Whilst, CYP services routinely measure outcomes, there is a lack of standardisation of recording and reporting. This makes it difficult to compare and benchmark recovery rates. There is also a need to make the patient rated outcome measures more user-friendly and accessible to young people.

• **ASD in mainstream schools.** There is a gap in provision for children and young people in schools at the higher functioning end of the Autistic Disorder spectrum, with the result that many children become hyperactive and there is a high incidence of conduct disorder.

• **Lack of community eating disorder service.** There is currently no specialist community eating disorders service within the East London boroughs. Young people with eating disorders require and significant and specialised clinical input for both mental health and physical health and generic teams struggle to provide an adequate service. It is envisaged that a community eating disorder service will support early intervention and treatment in the community and will reduce the number of inpatient admissions for eating disorders.

4.2. Vision

The preceding gap analysis has informed the development of our vision for CAMHS Transformation. This vision has also been jointly worked on through the East London Mental Health Commissioning Consortium and is therefore aligned with the vision for Newham and Tower Hamlets. The vision is also aligned with Future in Mind recommendations. Our vision is as follows:

• **Strengthen community resilience,** working with children, families and communities.

• **Intervene early** – focus on early years and community based interventions that avoid acute admissions.

• **Integrate care pathways** through partnership working to promote better, more equitable access, early intervention, community follow up and the integration of support in terms of physical health, mental health, social care and youth justice. Ensure information systems are integrated.

• **Integrate Information Systems:** investment will ensure that third sector organisations can share and access data and report on standardised KPIs.

• **Equitable access for groups that are challenging to reach,** e.g. BME communities, deprived communities, young offenders, people struggling at school.

• **Promote recovery** through standardised user friendly outcome measures

A key challenge is the need to address the potential rising demand from a larger young population. A central principle of the vision is this will be done by measures, which reduce demand rather than simply increase capacity. This includes intervening early, building
community resilience and strengthening community services to avoid inpatient admissions. The figures below illustrate this vision for community and inpatient services. The green line illustrates the option to increase capacity to match demand, the orange line showing a planned reduction in demand. As can be seen the target for inpatient services is a 1% year on year reduction in Occupied Bed Days.

**Figure 17: East London CAMHS Demand Strategy for Community Services**

*Source: NEL CSU (November 2015)*
Figure 18: East London CAMHS Demand Strategy for Inpatient Services

Source: NEL CSU (November 2015)

- **Building Reach and Resilience.** We will invest in delivering training and supervision to third sector organisations, which have access to challenging to reach communities to develop their skills level to better identify mental health problems. We will increase work with families to develop resilience.

- **Developing CYP Outcomes.** We will develop more user-friendly methods of collecting patient reported outcome measures and develop standardised reporting systems, which allow benchmarking.

- **Early Years:** We will create more integrated pathways for the early years to support the early diagnosis and intervention of mental health problems and stronger community based services. This will involve improved liaison and links between the Mother and Baby service the NICU the perinatal service and First Steps.

- **ASD mainstream capacity:** we will invest in educational psychology capacity in mainstream schools for ASD and to increase ASD identification and the creation of SEND plans for each child diagnosed with ASD.

- **Crisis pathway:** we will ensure there is a greater integration between mental health and physical health including improved Paediatric Mental Health Liaison in A&E. We will also ensure greater integration between the police and mental health working with the pathway for young offenders in crisis.
- **Integrating Information Systems**: the investment will ensure that third sector organisations can share and access data and report on standardised KPIs.

- **Community Eating Disorders**: we will establish a single community eating disorder service across City and Hackney, Newham and Tower Hamlets. The service will conduct early assessment, diagnosis and treatment, and liaise and interface with other services as part of an integrated pathway.

The table below summarises the links between the needs analysis, the gap analysis, the vision and our proposed investment.

**Figure 19: Summary of Needs, Gaps, Vision and Investment**

<table>
<thead>
<tr>
<th>Needs</th>
<th>Service Provision Gaps</th>
<th>Vision</th>
<th>Investment streams</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% increased demand in 5 years</td>
<td>Lack of integrated pathways</td>
<td>Integrate care pathways</td>
<td>Crisis pathway</td>
</tr>
<tr>
<td>Hard to reach population groups: BME, deprivation, schools, young offenders</td>
<td>Insufficient services building resilience</td>
<td>Strengthen community resilience</td>
<td>Reach and resilience</td>
</tr>
<tr>
<td>Inequality of access</td>
<td>Need for higher skills levels in third sector organisations with community reach</td>
<td>Intervene early</td>
<td>Early years investment in integrated pathway: mother and baby, perinatal, NICU</td>
</tr>
<tr>
<td>High admission rates</td>
<td>Lack of standardised reporting for easy to use outcome measures.</td>
<td>Standardise systems</td>
<td>IAPT Outcomes. Develop standardised reporting and user friend outcomes. Integrate information systems in third sector.</td>
</tr>
<tr>
<td>Pressure on schools</td>
<td>Lack of ASD provision in mainstream schools</td>
<td>Equitable access for hard to reach groups</td>
<td>Increase ASD services in mainstream schools</td>
</tr>
<tr>
<td>Increase in eating disorders</td>
<td>Lack of specialist community eating disorder service</td>
<td>Promote recovery through standardised outcome easy to use outcome measures.</td>
<td>Develop Community Eating Disorder service</td>
</tr>
</tbody>
</table>
5. Engagement

An extensive multi-agency engagement exercise was conducted to develop our vision and investment priorities. This involved a series of workshops from August to mid-November with the CAMHS Alliance and wider stakeholders including, service users, public health, the local authority, social care, youth justice, education and third sector organisations. From these workshops the following outline principles were agreed in line with the CAMHS Alliance vision:

- Build a system where we are confident on what therapies work in which settings
- Ensure we’re measuring the right things across the system
- Move away from rigid tiered models towards seamless pathways
- Ensure a common language where possible and have a common understanding across educational, medical and social models
- Develop an integrated approach
- Identify unmet need and support vulnerable CYP and families
- Work towards recovery oriented settings and services
- Work towards community models that promote better well-being
- Work towards CYP understanding their own role in their MH and Well-being
- Work towards every person in community understanding their role in supporting CYP

In addition to the workshops, the CAMHS service user reference group was engaged with throughout the process. The group is funded by the CCG and well established with members having received training in interviewing and promotional film making. This group has been included in the governance structure (see Governance section) and will continue to be consulted throughout the programme. Local young people are actively involved via the service user group in a range of different service areas including training parents in the community to deliver evidence based parenting, tailoring CAMHS promotional materials, designing the website and active members of interview panels recruiting Specialist CAMHS staff. This work shows the level of positive impact that can be made with dedicated involvement and participation resource. By establishing clear priority areas and systems to generate feedback, young people are starting to feel they are increasingly more involved in local service design, as well as at the same time becoming more knowledgeable on services and able to advocate on part of themselves and / or peers. Recent initial feedback from local young people on how to develop local CAMHS services has suggested we consider:

- Community based locations and ordinary spaces where young people feel comfortable to deliver awareness, support and services e.g. cafés, religious places
• Reaching out to young people who may become socially isolated… Online forums are good for some young people, for others think about local youth clubs / groups
• Help everyone understand more about Mental Health, so that young people and others in the community can support each other or know what to do / where to go in the run up to a Crisis

Following on from the initial feedback, additional focus group/s are planned for late Nov / Early Dec 2015. These focus group will specifically target perspective and feedback from:

- Clients currently in CAMHS
- Clients in Adult Mental Health Services who were previously in CAMHS
- Families of CYP in CAMHS – Parents and siblings
- Clients who have received counselling for Eating problems
- Families of CYP who have received counselling for Eating problems
- Young people who have been in a crisis situation (City and Hackney Mind Recovery College)

Further feedback was obtained from stakeholders at a Five to Thrive Workshop (see Appendix 2).

The Trust will arrange groups as representative as possible to meet the above. For clients who are currently in Adult Mental Health services (i.e. over 18 years) the CAMHS team will approach Adult Mental Health about the Transformation plans and make contact with clients who may wish to get involved.

The Participation leads are currently designing Mental Health Awareness Sessions for schools, to be piloted in 3 Hackney schools during Nov – Dec 2015.

These will promote awareness and knowledge of local services / support and how to access.

The service is also considering a “volunteer with CAMHS to deliver school sessions” option whereby young people can be trained up to deliver sessions on Mental Health Awareness.

Peers are often the first to spot signs of Mental Health issues and this approach would support knowledge and understanding amongst peers and also presents a longer term sustainable approach to de-stigmatising mental health problems. It supports wider community based education on Mental Health and gives young people a chance to be more directly involved in tackling stigma, and raising awareness of Mental Health and promoting good emotional well-being.
6. How we will deliver our Vision

As set out in the vision in this document (Section 4) the Transformation Plan priority investment areas are:

- Building Reach and Resilience.
- Developing CYP Outcomes
- Early Years
- ASD in mainstream schools
- Crisis pathway
- Integrating Information Systems
- Community Eating Disorders

During the remainder of Q3 will we complete the preparatory work before the investment starts in Q4 in order to be in a position work intensively and efficiently from the outset. We have already lined up many of the staff involved in the programme but will use Q4 finalise this. We will create a Transformation Programme Management Office (TPMO) led by a programme manager who will oversee all the investment work streams. Each stream will also have project management input. The project managers will also be part of the TPMO. The commissioners from both the CCG and local authority will also be able to attend to ensure processes of assurance are in place. TPMO sessions will be open with conference call facilities making them accessible for other parties, such as clinical leads to attend. The TPMO will meet at least weekly and report to the Alliance Board on a monthly basis on:

- The delivery of objectives and milestones against the programme plan
- Programme risk
- Financial spend against budget
- KPIs
How the TPMO relates to the overall governance structure is set out in the Section 8 on Governance. We are using the CAMHS Alliance to deliver the Transformation Programme for the following reasons:

1. **Project Management Experience.** The CAMHS Alliance is already established and has been operational since April 2015. It is experienced at delivering project based work and already has a programme manager.

2. **Governance and Joint Reporting Structures.** The Alliance has established effective reporting and governance structures for risk, spend, programme planning and outcomes. These are detailed in section 8 and will be used for the Transformation Programme.

3. **Experience of integrated work and joint working.** The Alliance has been undertaking collaborative work between acute, mental health the third sector, social care and schools. This kind of collaborative work is at the heart of the Transformation Plan and therefore it makes sense to build on this.
The sub-sections below detail how we will deliver each priority area in terms of: what will be delivered, how and when it will be delivered, the cost and performance measurement.

6.1 Building Resilience and Reach

6.1.1 Deliverables and Costs

We aim to train youth workers to provide support to young people demonstrating early signs of mental health deterioration. This will enable early identification and treatment leading to improved health outcomes. To ensure sustainability, group based clinical supervision will also be provided following the training.

Where mental health issues have been identified and children/young people are taking part in a formal programme of support/therapy, face to face contact is significantly greater with their youth workers. Therefore, particularly for early diagnosis and support, there is significant potential for the training of youth workers to have an earlier impact on the development of mental health issues in the young. By giving them the skills to identify and support young people needing help at an early stage, we reduce the need for more intensive support when issues are identified at a much later stage.

The training will consist of nine mental health training days using the “Young Minds” accredited structure to be delivered to 102 youth and frontline workers including those in similar roles such as those working as mentors to ‘at risk’ young people in schools. The trained youth workers will support an average of five young people experiencing mental health issues over the subsequent 12 month period.

There is a second strand to the work that aims to pilot new delivery models that break the cultural stigma about mental health in targeted “difficult to reach” communities. This will be facilitated via five pilot community In-Reach initiatives led by VCS organisations combined with a series of regular support groups and community conversations sessions delivered in partnership with professionals and community organisations.

The service will be conducted at a range of accessible community settings including children centres, the youth hubs and other venues in the third sector. Nineteen parents from five organisations will actively engaged in mental health awareness and reach parents in regular parents support groups.
6.1.2 Implementation Plan

Hackney Council for Voluntary Service (HCVS) will manage this project in joint partnership with East London Foundation Trust. The training will be delivered by approved trainers who have completed the Mental Health First Aid and Young Minds Training.

The following organisations will identify the appropriate youth workers to take part in the training:

- The Crib, African Community School
- Claudia Jones Organisation
- DERMAN
- Voyager, (based at Hackney Community College)
- Huddleston Centre.

Following delivery of this initiative, HVCS will seek further engagement and delivery through school based Parent Involvement Officers via Hackney Learning Trust. This investment will then be developed jointly with First Steps and other Alliance partners for stronger, sustainable links with the wider community and the voluntary sector.

By introducing a joint post between statutory and voluntary sector services, we intend to eliminate cross-work boundaries and engage grassroots local organisations. There will be a strong narrative to develop a meaningful system of active local participation in order to present the views of children, adolescents and parents/carers at a strategic level. The post will be hosted by East London Foundation Trust as part of this investment, with an agreement to be based within the community part-time with Hackney VCS.

The investment will embed City and Hackney CCG’s Five2Thrive agenda with the local community and CAMHS services and ensure that service users help to shape this and work towards:

- Self-sustaining community led and run services that empower ordinary people and community health workers to deliver mental healthcare with appropriate training and supervision from experts.
- Increasing resilience, normalising, de-stigmatising with the aim of reducing the burden of need across statutory services.
- Inclusive services involving a range of communities, young people with complex needs and families of disabled children.

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32
Support worker training and supervision

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<td>Identify support workers</td>
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<td>Identify training provider and venues including dates</td>
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<td>Report course attendance and delegate feedback</td>
<td>21/02/2016</td>
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<tr>
<td>Monitor support worker skills and training in mental health</td>
<td>On-going</td>
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<tr>
<td>Develop supervision framework including forms</td>
<td>21/02/2016</td>
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<tr>
<td>Assign supervisors</td>
<td>24/02/2016</td>
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<tr>
<td>Book supervision; report attendance an outcomes</td>
<td>27/02/2016</td>
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Community In-Reach

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<tr>
<td>Establish project team</td>
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<tr>
<td>Develop implementation plan from in-reach proposals</td>
<td>14/01/2016</td>
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<td>Develop material</td>
<td>31/01/2016</td>
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<td>Market in-reach sessions</td>
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<tr>
<td>Deploy and deliver</td>
<td>14/03/2016</td>
</tr>
<tr>
<td>Report feedback and outcome</td>
<td>18/03/2016</td>
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<tr>
<td>Submit pilot report for review</td>
<td>31/03/2016</td>
</tr>
<tr>
<td>Develop Gangs Assessment tool; Deploy and review</td>
<td>31/03/2016</td>
</tr>
</tbody>
</table>

6.1.3 Outcomes and Key Performance Indicators

Expansion of the workforce will better support young people in Hackney with newly trained workers feeling confident in supporting young people. These professionals will have increased skills and cultural competency to engage hard to reach families / communities and reduced cultural stigma around Mental Health. There will be greater confidence of how to access professionals support in a crisis and a greater understanding of signs and symptoms of key conditions.

**Key KPI:** % of open cases with suspected mental health involvement having a support worker who’s received accredited mental health training.

**KEY KPI:** % access rates to CAHMS services to reflect % BME group population size.
6.2 Developing CYP Outcomes

6.2.1 Deliverables and Costs
The CAMHS Data Set has now been incorporated into the Mental Health Services Data Set. It will be mandatory for NHS funded care providers (including fully NHS funded independent sector providers) to submit the data set to HSCIC from January 2016. Outcome data collected will be used to develop greater understanding of service performance; identifying areas for improvement and strategic decision making. Improved and increase use of clinical outcome measures is therefore considered crucial in terms of developing better cost effective services.

Learning from experience with CORC and CYP IAPT indicate that the most effective way to improve outcome data collection is through systematic support to clinicians from assistant psychologists. Operationally this has worked when the assistant has been based exclusively within one service so that their job plan and management are specific to the needs of the individual service. We therefore plan to assign three Assistant Psychologist posts to work across the Alliance partnership. The assignments will be for a fixed three month period and will support services to continue working towards embedding the principles of CYP IAPT and support services get ready for the first CAMHS dataset submission to HSCIC.

The Assistant Psychologist posts will support the facilitation and monitoring of outcome collection across the CAMHS Alliance and also build on the protocols in place to remind clinicians to ensure that outcomes measures are being utilised and incorporated into clinical practise. To manage the data element of the project, the Assistants will be supported by two informatics support staff based in the two main provider sites.

<table>
<thead>
<tr>
<th>Post Title / Unit Description</th>
<th>Unit</th>
<th>Band</th>
<th>WTE</th>
<th>Cost per Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informatics &amp; IT System Support - Data management and reporting &amp; improving front end support HUHFT</td>
<td>6</td>
<td>0.4</td>
<td>£5,636</td>
<td></td>
</tr>
<tr>
<td>Informatics &amp; IT System Support - Data management and reporting &amp; improving front end support ELFT</td>
<td>6</td>
<td>0.4</td>
<td>£5,636</td>
<td></td>
</tr>
<tr>
<td>Increasing skills to offer more evidence based interventions in line with CYP IAPT include parent training, Solihull, CBT refresh and clinical supervision training to support work in services and other areas</td>
<td>2,000</td>
<td>6</td>
<td>£12,000</td>
<td></td>
</tr>
<tr>
<td>First Steps Assistant Psychologist (Project Team)</td>
<td>4</td>
<td>1</td>
<td>£9,663</td>
<td></td>
</tr>
<tr>
<td>ELFT Assistant Psychologist (Project Team)</td>
<td>4</td>
<td>1</td>
<td>£9,663</td>
<td></td>
</tr>
<tr>
<td>Off Centre &amp; CAMHS Disability Assistant Psychologist (Project Team)</td>
<td>4</td>
<td>1</td>
<td>£9,663</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>£52,260</strong></td>
</tr>
</tbody>
</table>

6.2.2 Implementation Plan
Once the project teams are established, a full review of the current use of clinical outcome measures across all CAMHS will take place. This will identify limiting factors preventing better outcome measure use. Working with clinical leads, the data collected in the review period will be used to develop a policy around the use of specific outcome measures for key pathways. Promoting adherence to this policy will then be achieved as the Assistant Psychologists are deployed to front-line clinical areas to facilitate adherence. During this phase, any refinements to data collection, processing and reporting mechanisms will take place and these processes finalised and signed off. Following a period of supported data collection, the data sets will be evaluated to ensure they meet requirements. After this
process, a period of handover and sustainability procedures will take place to ensure the performance is maintained once the project support team is disbanded.

**Key Milestones**

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish project team: Assistant Psychologists (x3); Informatics / Project Support (x2) (Homerton and ELFT)</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>Complete AS-IS analysis of Outcome Measure use in each clinical area including data capture mechanisms, system processing and reporting systems.</td>
<td>14/01/2016</td>
</tr>
<tr>
<td>Develop operational policy on outcome measure use for each clinical area with clear definitions for outcome measure choice, frequency and recording mechanism.</td>
<td>21/01/2016</td>
</tr>
<tr>
<td>Develop framework for and conduct front-line support for clinicians to achieve requirements set out in outcome measure policy.</td>
<td>Start 21/01/2016, End 21/01/2016</td>
</tr>
<tr>
<td>Finalise data capture / processing and reporting mechanism</td>
<td>21/03/2016</td>
</tr>
<tr>
<td>Evaluate new data sets</td>
<td>25/03/2016</td>
</tr>
<tr>
<td>Handover / Business as usual / Sustain</td>
<td>31/03/2016</td>
</tr>
</tbody>
</table>

**6.2.3 Outcomes and Key Performance Indicators**

We aim to deliver 10% uplift in the number of open cases that have at least two outcome measures recordings (i.e. where a measurable change can be identified) in line with the new clinical policy.

**Key KPI:** % of outcome measures being recorded at 2 points in time (i.e. change can be evidenced)

**6.4 Early Years**

**6.4.1 Deliverables and Costs**

**Specialist Perinatal Mental Health**

Future in Mind states: ‘enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support.

We are aware of an unmet need in the borough for this client group where there is currently no dedicated perinatal post in CAMHS in Hackney. This has long been a successful approach in neighbouring boroughs. We therefore intend to develop Specialist CAMHS to work with colleagues at the Homerton Hospital Special Care Baby Unit, Adult Mental health colleagues in the Mother and Baby Unit, First Steps and from Hackney social workers.
Ultimately we aim to meet the needs of this client group in order to provide specialist input to the same level as the surrounding boroughs’ services where funding for perinatal psychotherapy and group work has been provided.

Through the Alliance Partnership, we are committed to supporting this group of clients who often fall between services using a more partnered, strategic way. We aim to improve the outcomes in the longer term for this group of infants and their parents by providing effective evidence based interventions.

We will establish a perinatal specialist CAMHS post, which will increase our ability to work with those families where there are attachment concerns, risk of trauma or experience of trauma using evidence based interventions. This post will link together perinatal services in City & Hackney and ensure a much more community orientated approach to perinatal support with links to IAPT and Primary Care.

The post-holder will have specialist training in parent-infant psychotherapy, expertise in teaching and training and the provision of supervision in this field. They will be committed to evidence-based practice and have research experience so that we can develop best evidence based practice for the borough in this relatively new CAMHS specialism.

They will run evidence-based parenting groups with colleagues and develop groups which involve previous service users supporting those currently in difficulty. This investment will develop strategic thinking and closer working links with the existing perinatal services provided by the Homerton Hospital NICU, (SCBU) and Adult mental health including Mother & Baby Unit and Adult First Steps, Children’s Social Care and community based services such as those for the Orthodox Jewish community.

They will also assess and treat with CAMHS colleagues across the tiers those infants whose mental health needs are more complex, where there has been trauma, parental substance abuse and attachment disorders.

<table>
<thead>
<tr>
<th>Recurrent?</th>
<th>Post Title / Unit Description</th>
<th>Cost per Unit</th>
<th>Unit Num</th>
<th>Band</th>
<th>WTE</th>
<th>Q4 2015/16</th>
<th>Q1-Q4 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Parent and Infant Psychotherapist</td>
<td></td>
<td>8a</td>
<td>0.8</td>
<td>£15,926</td>
<td>£63,703</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>Team Administrator</td>
<td></td>
<td>4</td>
<td>0.1</td>
<td>£966</td>
<td>£3,865</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>System Specification, development and implementation including Establishing Inter-organisational interfaces, referrals and CME Systems</td>
<td></td>
<td>8a</td>
<td>0.6</td>
<td>£11,844</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Setting up data management and reporting (Operational and Clinical Data)</td>
<td></td>
<td>6</td>
<td>0.4</td>
<td>£5,636</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Leaflets and publicity material including update to website</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,000</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NICU Trauma and Attachment Clinic

In line with Future in Mind, this investment will promote resilience, prevention and early intervention for children and families. Other therapy service are currently funded to work in Homerton Hospital NICU (SCBU), e.g. speech and language therapy, Occupational Therapy and Physiotherapy. However, there are no mental health clinicians. Direct referrals from
NICU are seldom received and the service tends to pick up families from other professionals when a child reaches 1 - 2 years of age.

This investment will introduce a new post of 0.5 WTE Child Psychotherapist who will work in partnership with NICU, Premature baby clinic with Consultant Paediatricians, MDT at Hackney Ark and CAMHS Disability who will manage the post. The post holder will link with CAMHS Disability who have set up a Trauma and Attachment Clinic at the Hackney Ark to deal with the attachment and trauma concerns arising from children born early or with known developmental disabilities and/or with traumatic birth histories. The clinic is comprised of experts in EMDR and Narrative Trauma Therapy and has an experienced Child Psychotherapist who specialises in couples therapy, attachment, early infant observation and trauma work.

### 6.4.2 Implementation Plan

**Specialist Perinatal Mental Health**

A full review of the current systems of work and data will occur to establish a clear “AS-IS” picture of current service delivery. This analysis will identify the service and system gaps which will be used to inform the development of the system’s future state reflected in a subsequent draft operational policy.

Once the new operational policy is in place, the project team will begin embedding the new systems of work in to front-line operation. They will promote the service to ensure flow of referrals and establish networks across the full care pathway.

Once embedded, transition to business as usual will occur to sustain the new system of work and the project team will be disbanded.

<table>
<thead>
<tr>
<th>Recurrent?</th>
<th>Post Title / Unit Description</th>
<th>Cost per Unit</th>
<th>Unit</th>
<th>Band WTE</th>
<th>Q4 2015/16</th>
<th>Q1-Q4 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Child Psychotherapist</td>
<td>7</td>
<td>1</td>
<td>0.5</td>
<td>£8,278</td>
<td>£33,113</td>
</tr>
<tr>
<td>Y</td>
<td>Admin Support</td>
<td>4</td>
<td>0.1</td>
<td>0.1</td>
<td>£966</td>
<td>£3,865</td>
</tr>
<tr>
<td>N</td>
<td>Integration system development with existing services</td>
<td>8a</td>
<td>0.6</td>
<td>0.6</td>
<td>£11,944</td>
<td>£0</td>
</tr>
<tr>
<td>N</td>
<td>Establishing inter-organisational interfaces; referrals and Coms Systems</td>
<td>8a</td>
<td>0.5</td>
<td>0.5</td>
<td>£9,954</td>
<td>£0</td>
</tr>
<tr>
<td>N</td>
<td>Setting up data management and reporting (Operational and Clinical Data)</td>
<td>8a</td>
<td>0.4</td>
<td>0.4</td>
<td>£7,963</td>
<td>£0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>£39,105</strong></td>
<td><strong>£36,978</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Date of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish project team: Project Lead (x1); Parent and Infant Psychotherapist (x1); Informatics Support(x1); Administrator(x1)</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>Review current systems : Mechanisms for identifying patients, referral systems, communication systems, networks</td>
<td>14/01/2016</td>
</tr>
</tbody>
</table>
Develop operational policy for new system of working to meet requirements. Establish performance markers for 21/01/2016
Establish new systems of work; Build networks; Develop 31/01/2016
Evaluate system data; refine systems of work 21/03/2016
Finalise new systems of working; Embed 25/03/2016
Handover / Business as usual / Sustain / Disband non-recurrent project team. 31/03/2016

NICU Trauma and Attachment Clinic
A full review of the current systems of work and data will occur to establish a clear “AS-IS” picture of current service delivery. This analysis will identify the service and system gaps which will be used to inform the development of the system’s future state reflected in a subsequent draft operational policy.

Once the new operational policy is in place, the project team will begin embedding the new systems of work in to front-line operation. They will promote the service to ensure flow of referrals and establish networks across the full care pathway.

Once embedded, transition to business as usual will occur to sustain the new system of work and the project team will be disbanded.

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Date of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish project team: Project Lead (x1); Child Psychotherapist(x1); Informatics Support(x1); Administrator(x1)</td>
<td>07/01/2016</td>
</tr>
<tr>
<td>Review current systems : Mechanisms for identifying patients, referral systems, communication systems, networks</td>
<td>14/01/2016</td>
</tr>
<tr>
<td>Develop operational policy for new system of working to meet requirements. Establish performance markers for reporting.</td>
<td>21/01/2016</td>
</tr>
<tr>
<td>Establish new systems of work; Build networks; Develop</td>
<td>31/01/2016</td>
</tr>
<tr>
<td>Evaluate system data; refine systems of work</td>
<td>21/03/2016</td>
</tr>
<tr>
<td>Finalise new systems of working; Embed</td>
<td>25/03/2016</td>
</tr>
<tr>
<td>Handover / Business as usual / Sustain / Disband non-recurrent project team.</td>
<td>31/03/2016</td>
</tr>
</tbody>
</table>

6.4.3 Outcomes and Key Performance Indicators

Specialist Perinatal Mental Health
The new service will use goal based outcome measures in clinical practice and will use client feedback to evaluate services both with service users and colleagues. New systems to
establish feedback on teaching and training will also be developed and implemented. This will include numbers of clinicians whose learning objectives have been achieved in relation to feeling better able to support this client group.

We expect to see an increase in the number of infants being referred and treated in specialist CAMHS and will ensure services are able to support any anticipated demand. We will strengthen partnership working within both the alliance and adult mental health. The dedicated post-holder will be able to provide clinical input across the different services in order to build working relationships with professionals staff from other agencies particularly colleagues in paediatrics (both hospital and community), adult mental health services, and to break down the tier boundaries. This will also include provision of step down care following discharge from Homerton University Hospital Trust so that patients experience smoother transition from in-patient care and are at less risk of relapse.

**Key KPI:** % services receiving intervention reporting that they are fully supported in meeting the mental health needs of patients.

(Note the baseline for this KPI has not currently been established. Baseline data relating to the number of services that feel fully supported will be collected by the project team at the beginning of Q4 prior to the implementation phase)

**NICU Trauma and Attachment Clinic**

Following the implementation of this new service, families will receive a timely intervention therefore preventing the problem becoming chronic and affecting the whole life of the family; reducing the likelihood of longer term mental health interventions later on.

The work will be scrutinised in line with all CAMHS services, with outcome measures following CORC/CYP IAPT.

**Key KPI:** % of appropriate patients referred from NICU

### 6.5 ASD Mainstream Schools

**6.5.1 Deliverables and Costs**

Currently, children who require an MDT approach and have significant MH needs will access CAMHS Disability or Homerton Row CAMHS services, but children with needs that are emotional behavioural but not requiring complex care pathways have a limited service. For these families there is limited access to preventative and early intervention as they are referred straight into traditional Tier 3 services because Tier 2 services do not have the expertise required in the community.

Our plan is to develop the early intervention offer to families with ASD to break down the barriers that the tiered system presents and focus on the prevention of mental health. This intervention is funded by the CCG to provide support across home and school in the borough.
This investment enhances the single point of entry (for up to 6 session short term intervention work) as it will be offered all at one site. Hackney Ark will augment the new Social and Communication Clinic (SCAC) as well as existing ASD assessment forums. With all assessments taking place in one setting, an ‘Autism Hub’ will be created which follows the wishes of parents (and HiP) and makes the referral process easy. This investment aims to alleviate the behavioural and anxiety effects consistent with an ASD diagnosis. It is a systemic approach for the whole family in improving quality of life and parental mental health, supporting families to prevent anxiety escalating early on.

As part of existing Alliance plans, the partnership also plans to increase the parenting group support offer for all families across the borough with children with ASD 2-19. This will increase family and parental mental health by having a single point of entry into the ASD hub with support post diagnostically both within health and education.

The work will build on the partnership arrangements for SCAC (HUH, ELFT and Social Care) and MDT at Hackney Ark in the assessment and treatment of ASD, with the addition of 0.5 WTE Link Educational Psychologist to support the multi-agency assessment and take this forward into the SEND process to support families not to duplicate their child’s needs and story. Also a critical part of this post would be to disseminate the findings of ASD and SEND reports to schools to tailor educational intervention to meet the child’s needs in the setting and thus decrease mental health presentations. This post would support all ASD children and be able to access all schools.

<table>
<thead>
<tr>
<th>Recurrent?</th>
<th>Post Title / Unit Description</th>
<th>Cost per Unit</th>
<th>Unit</th>
<th>Band</th>
<th>WTE</th>
<th>Q4 2015/16</th>
<th>Q1-Q4 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Assistant Psychologist</td>
<td>£4,832</td>
<td>4</td>
<td>0.5</td>
<td>£19,326</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>Educational Psychologist</td>
<td>£9,954</td>
<td>8a</td>
<td>0.5</td>
<td>£39,814</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Waiting list initiative (clinical Agency)</td>
<td></td>
<td>7</td>
<td>2</td>
<td>£24,835</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Clinic Setup</td>
<td>£11,944</td>
<td>8a</td>
<td>0.6</td>
<td>£0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Project Development Lead - Establishing Inter-organisational interfaces, referrals and Coms Systems</td>
<td>£7,963</td>
<td>8a</td>
<td>0.4</td>
<td>£0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Informatics Support - Setting up data management and reporting (Operational and Clinical Data)</td>
<td>£7,963</td>
<td>8a</td>
<td>0.4</td>
<td>£0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Capacity Building - ADOS Training</td>
<td></td>
<td>16</td>
<td>4</td>
<td>£9,600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>£77,090</td>
<td></td>
<td></td>
<td>£59,141</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 6.5.2 Implementation Plan

A full needs assessment will be conducted covering clinical, operational and IT system requirements to formulate a proposed operational policy and implementation plan. The project team will establish the clinic infrastructure including developing awareness and marketing ready for the opening of clinics. They will promote the service to ensure flow of referrals and establish networks across the full care pathway. Once embedded, transition to business as usual will occur to sustain the new system of work and the project team will be disbanded.
Establish project team: Project Development Lead (x1); Educational Psychologist (x1); Informatics Support (x1);

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop implementation requirements and plan</td>
<td>31/01/2016</td>
</tr>
<tr>
<td>Establish systems of work</td>
<td>14/02/2016</td>
</tr>
<tr>
<td>Set up clinic</td>
<td>01/03/2016</td>
</tr>
<tr>
<td>Develop networks and marketing</td>
<td>14/03/2016</td>
</tr>
<tr>
<td>Report and evaluate</td>
<td>31/03/2016</td>
</tr>
<tr>
<td>Disband project team / Business as usual</td>
<td>31/03/2016</td>
</tr>
</tbody>
</table>

6.5.3 Outcomes and Key Performance Indicators

Through this investment, families will have improved support while going through a significant transition in their own life - coming to terms with how to parent a child using a different set of skills, and coming to terms with a diagnosis. There will also be a reduction in ASD behavioural interventions referred on to the current Tier 3 services. We aim to achieve a true sense of the “no wrong door” policy and ultimately:

- Improved Quality of life.
- Prevention of stress / anxiety.
- Improved family relationships.
- Potential reduce parents being prescribed anti-depressant medication.

The work will be scrutinised the same as all CAMHS services, with outcome measures following CORC/CYP IAPT/minimum data set as applicable.

**Key KPI:** % of children with ASD diagnosis having SEND plan

(Note the baseline for this KPI has not currently been established. Baseline data relating to the number of children with an ASD diagnosis having a SEND will be collected by the project team at the beginning of Q4 prior to the implementation phase)

6.6 Crisis Pathway

6.6.1 Deliverables and Costs

**Psychiatric and Paediatric Assessment**

The cost of undetected and untreated mental ill health is high in terms of both patient suffering and the financial cost to the NHS. Mental health conditions may present as medically unexplained symptoms and re-present repeatedly to GP’s and hospital staff. They may involve many exploratory tests at great cost to the child, the family and the hospital. An example of this is the child who presents with non-epileptic seizures or chest pain as a result of being caught in the centre of an acrimonious parental relationship. If undiagnosed and untreated, these conditions can continue into adult life presenting again at times of stress.
We know that 12% of CYP live with a chronic condition (Sawyer 2012). Many with chronic conditions have Medically Unexplained Symptoms. 12.5% of children presenting to hospital have medically unexplained symptoms and 1/3 have anxiety/depression (Campo 2012). Locally, we are seeing an increase in the numbers of children and young people presenting at A&E and on the wards with self-harm and mental health problems.

Reasons for emergency referral often include:
- overdoses
- deliberate self-harm
- acute anxiety and dramatic and unexplained changes in mood or behaviour

Future in Mind has firmly placed the principles of liaison work at its core. Highly skilled clinicians see patients and families in crisis can direct these outwards towards appropriate sources of treatment and support. A&E and the general hospital at the Homerton serve as this kind of centre.

We aim to increase Paediatric Liaison capacity to address the unmet psychological needs of children and young people presenting with mental health needs at A&E/ Starlight Ward and those with physical illness and mental health needs arising out of their physical ill-health or treatment (Starlight and paediatric outpatients). Without a dedicated CAMHS Psychiatric/ paediatric liaison team there is evidence that children seen in hospital have poorer outcomes and more go on to be diagnosed with emotional and behavioural disorders including conduct disorder.

The current provision for the Homerton Hospital is 1 day per week of a band 7 psychiatric nurse. Urgent mental health admissions are seen by the CAMHS Team with back up from a consultant psychiatrist, who has a full-time Community CAMHS commitment. Lack of continuity of CAMHS staff working on the self-harm rota on the paediatric ward and in A&E, or familiarity with working in an acute hospital setting and as a result communication can be less than optimal between the CAMHS and hospital staff are both areas to be addressed as part of this investment.

As well as assessing and treating young people who self-harm, we provide a 24 hour service (out of hours on-call specialist registrar with consultant psychiatric back-up) to manage all psychiatric emergencies in A&E and inpatient wards. This out of hours service is already provided by East London Foundation Trust CAMHS who work closely with community-based mental health and substance misuse services, the police, and local statutory (social care in particular) and voluntary agencies to provide mental health care and treatment. This includes crisis care and brief therapy.

The new post will provide a point of liaison with the established RAID service for 16-18 year olds and support the team in their understanding of child and adolescent development to help the RAID Team in their assessment and treatment of young people, particularly in establishing the reasons for frequent re-attendance at A&E. This knowledge would improve
the access of young people to psychological therapies in CAMHS, First Steps and on the Ward.

Psychiatric and Paediatric liaison work not only involves an understanding of the connections between physical symptoms and mental health, but also knowledge of paediatric conditions and the appreciation of the work of paediatricians and other disciplines. We know that liaison services can save money, e.g. the work of RAID in Birmingham, where lengths of stay were reduced. The overall time spent in A&E and hospital beds can be reduced to the benefit of both the patient and the hospital.

The new service will provide emergency assessments, triage and interventions via:

- Comprehensive mental state assessments
- Psychometric assessments
- Bio-psychosocial assessment, formulation, diagnosis and treatments
- Medication review and prescribing
- Treatment planning with the referring team: joint assessments with paediatricians
- Supervision and training in child mental health
- Brief interventions advice and signposting to services in a range of agencies for children and young people seen at the Homerton Hospital
- Participation in mental Health Act and Mental Capacity Act assessments and risk assessments for harm to self and others.

<table>
<thead>
<tr>
<th>Recurrent?</th>
<th>Post Title / Unit Description</th>
<th>Cost per Unit</th>
<th>Unit Num</th>
<th>Band</th>
<th>WTE</th>
<th>Q4 2015/16</th>
<th>Q1-Q4 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Consultant Psychiatrist</td>
<td>Cons 0.2</td>
<td>£6,409</td>
<td>£25,634</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>Clinical Nurse Specialist</td>
<td>7 0.8</td>
<td>£13,245</td>
<td>£52,981</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>Team Administrator</td>
<td>4 0.05</td>
<td>£483</td>
<td>£1,933</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Review Current operational and clinical systems in place and develop operational framework supporting cons psych</td>
<td>8a 0.5</td>
<td>£9,954</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£30,091</td>
<td>£80,548</td>
</tr>
</tbody>
</table>

**Off Centre YIAC**

Currently, Off-Centre operates only on weekdays. We plan to enable Off-Centre YIAC to provide a 4 hour Saturday drop-in session which means young people can attend outside of the school week and parents who work can also attend with their children if they wish to. This will allow greater access to Off-Centre’s holistic In-house & outreach counselling, AIG (advice, information & guidance), psychosocial & peer mentoring in line with CAMHS Transformation Plan (& Future in Mind) objectives.

The service provides In-house or outreach 1:1 and group counselling, Art Therapy and Drama-therapy (support for CYP mild- moderate/severe MH issues including but not limited to:
- Young women with emotional problems
- Self-harm, suicide & ideation
- Child sexual abuse/exploitation
- Bereavement, loss & separation
- Gang-affiliated/affected
- Gender and Sexuality
- LGBT+
- Young Black Men/BME

This investment also aligns with the following local objectives:

- Developing integrated working partnerships, empowered to deliver real change for patients
- Developing integrated services to mitigate the increasing cost of hospital based unscheduled care
- Recovery, Self-determination, Participation, Support for Transition, Social Value including use of community assets

Young Offenders

As can be seen from the Needs Analysis, gang culture is prevalent in City and Hackney and there is a high incidence of young offenders many of whom have mental health problems. In order to ensure these young people have a future we believe that is vital that care pathways between probation services, the police, social care and mental health services are better integrated.

The current Liaison Diversion and Young Hackney Units, led by the London Borough of Hackney are an important driver towards a more integrated model. However, links to mental health assessment and treatment need to be improved in order to ensure the early detection of problems and effective treatment.

Oversight of the pathway is provided by the Youth Offending Management Board, which is led by the local authority and includes the secondary care mental health provider and a representative from the East London CCG MH Commissioning Consortium.

Another important forum is the City and Hackney Crisis Concordat, which covers both adults and children and young people. The Concordat signatories include the police, local authority
(including liaison diversion services and social care) and East London NHS Foundation Trust, Homerton University Hospital NHS Foundation Trust and third sector representatives. Following a November 2015 workshop it is planned the Concordat will meet bi-monthly to agree and monitor joint working objectives.

We are proposing that an initial investment is made to the CAMHS Alliance to assess the interfaces between organisations and develop a set of proposal for improvement. These proposals will then be taken forward in Youth Offending Management Board and through the City and Hackney Crisis Care Concordat. The Alliance will also work closely with the Liaison Diversion Service and the Young Hackney Units provided by the local authority. The Alliance is a useful vehicle to do this because board meetings are attended by both the local authority and mental health providers. We have conceived this work as part of the Crisis Pathway because of the links to the Crisis Concordat. However, like the Concordat itself this is as much about avoid crisis through pre-crisis work and early intervention as responding to a crisis.

### 6.6.2 Implementation Plan

**Psychiatric and Paediatric Assessment**

The aim of the project is to ensure the mental health needs are met for children and young adults presenting in a crisis situation at Homerton A&E and in the acute wards.

There is currently 0.2 WTE psychiatric nurse dedicated to facilitating mental health case management for children and young adults attending A&E or once admitted to acute wards. A full review of the current systems of work and data will occur to develop a clear “AS-IS” picture of current service delivery. This analysis will identify the service and system gaps which will be used to inform the development of the system’s future state reflected in a subsequent draft operational policy.

Once the new operational policy is in place, the project team will begin embedding the new systems of work in to front-line operation in A&E and the acute wards. They will promote the service to ensure flow of referrals and establish networks across the full care pathway. Once embedded, transition to business as usual will occur to sustain the new system of work and the project team will be disbanded.

<table>
<thead>
<tr>
<th>Recurrent?</th>
<th>Post Title / Unit Description</th>
<th>Unit Num</th>
<th>Band</th>
<th>WTE</th>
<th>Q4 2015/16</th>
<th>Q1-Q4 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Crisis pathway links and development</td>
<td>7</td>
<td>0.4</td>
<td></td>
<td>£6,623</td>
<td>£26,491</td>
</tr>
</tbody>
</table>

**Key Milestones**

<table>
<thead>
<tr>
<th>Establish project team: Project Lead (x1); Consultant</th>
<th>Date of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>07/01/2016</td>
</tr>
</tbody>
</table>
Review current systems: Mechanisms for identifying patients, referral systems, communication systems, networks.

Develop operational policy for new system of working to meet requirements. Establish performance markers for reporting.

Establish new systems of work; Build networks; Develop Evaluate system data; refine systems of work Finalise new systems of working; Embed Handover / Business as usual / Sustain / Disband non-recurrent project team.

14/01/2016

21/01/2016

31/01/2016

21/03/2016

25/03/2016

31/03/2016

Off Centre YIAC

The work relates to building capacity in an existing service so that drop-in clinics are available on Saturdays. By improving accessibility into the weekend, the service aims to meet the needs of services users, who would otherwise be unable to drop-in during normal working hours. No up front development process is required as all systems and facilities are already in place.

Young Offenders

- In Q3, the pathway review process will be agreed and diarized in key forums such as the Crisis Concordat, the local Youth Offending Management Board and the CCG Programme Board.
- In Q3 evidence will be collated on other models nationally and internationally, including Street Triage.
- In Q4 the care pathways and organisational interfaces will be reviewed against the international evidence based.
- At the end of Q4 the findings will be reported to the Crisis Concordat and the Youth Offending Management Board and the CCG Mental Health Programme Board.

6.6.3 Outcomes and Key Performance Indicators

Psychiatric and Paediatric Assessment

This investment aims to meet the increased demand for psychiatric services and ensure that patients are assessed and treatment is arranged rapidly by:

- Treating young people with medical conditions who also have psychological difficulties and psychiatric illnesses which are pre-existing, secondary to or co-morbid to their medical conditions.
- Seeing young people who have long-term medical conditions, difficulties taking medication or adhering to special diets, coping with pain, trauma following illness or injury, anxiety, depression, grief and bereavement, treatment after serious assault and medically unexplained physical symptoms

This increased service will provide scope to see 17 and 18 year olds and provide more effective consultation and joint working with A&E and RAID and improve the outcomes of young people presenting to A&E in crisis.

- **Patient well-being and clinical effectiveness**: To be evaluated using the ESQ and SDQ and the CGAS and DAWBA (Development and Well-being Assessment) measurement tool to give a more accurate baseline indication of symptoms. This could be done by patients on pre-loaded touch screen tablets and the data collected for monitoring and research purposes.

- **Staff satisfaction**: A&E and Paediatric staff to be surveyed to find out their opinions of the new service. The Friends and Family Test could be used to see how much staff confidence there is in the service.

- **Length of time in A&E/ breaches**: Indication of how efficient the service is in terms of seeing patients in a timely fashion.

- **Number of readmissions due to a mental health cause**: Much of the cost of mental health admissions is caused by a relatively few patients who are admitted over and over again, often because their problems have not been adequately managed. Assessing and treating mental health problems and managing the complex social problems that are related to these presentations can relieve the pressure on A&E and paediatric staff and promote better health in children and young people via good multiagency liaison and care planning.

- **Length of stay**: Children and adolescents with mental health problems can become ‘stuck’ on the ward because of lack on inpatient beds at the adolescent unit or because they cannot be kept safe at home because of emotional and behavioural problems secondary to deprivation and lack of adequate care. These difficulties require considerable time spent on interagency liaison and the child can become secondary to the process rather than at the centre of it. Such young people continue to need regular mental state assessments and an appreciation of how they are feeling and what their social and educational needs might be. More psychological input at an earlier stage together with good interagency liaison can help children and young people to come through a period of crisis sooner and more safely and crucially reduce the need for an inpatient spell in the first place.

**KEY KPI** : % patients reporting improved Patient well-being and clinical effectiveness outcomes (using ESQ and SDQ and CGAs and DAWBA measurement tools)

(Note the baseline for this KPI has not currently been established. Baseline data relating to aggregated clinical outcome data will be collected by the project team at the beginning of Q4 prior to the implementation phase)
**Off Centre YIAC**

We aim to improve access to effective support (a system without tiers) at the Right time, right place right offer, provide care for the most vulnerable and promote resilience, prevention & early intervention.

We intend to increase:

- Recognition of need
- Acceptance of the need to seek help
- Ability to trust and engage
- Understanding of the situation and their own role in it
- Understanding of what can and can't be controlled
- Self-esteem and self-confidence
- feeling more comfortable opening up
- sense of empowerment and self-efficacy

We intend to Improve:

- access to information and services
- sense of hope and of a positive future
- access to effective support - system without tiers

**Key KPI:** % of services users reporting that the service is accessible during hours suitable to them.

(Note the baseline for this KPI has not currently been established. Baseline data relating to the number of service users reporting that the service is accessible during hours suitable to them will be collected by the project team at the beginning of Q4 prior to the implementation phase)

**Young Offenders**

**Key KPI:** % increase in referrals to CAMHS from police services

6.7  **Integrated Information Systems**

6.7.1 **Deliverables and Costs**

Off Centre currently use paper based systems for clinic and case management. To improve information and data flow with other CAMHS who are electronically based, the project aims to align all CAMHS in relation to information systems.
6.7.2 Implementation Plan

An IT systems development manager will carry out the work and will be assigned full time. The post holder will work with off-centre and link with current IT systems teams in the rest of CAMHS to develop the system requirements.

Once this has been established, the IT development manager will create a system specification that will be reviewed and signed off by CAMHS IT Systems leads. Following this, procurement of hardware, software and networks will begin including installation. Whilst the installation is taking place, Off Centre staff will be trained to use the software ready for full system use at the end of Q4.

<table>
<thead>
<tr>
<th>Key Milestones</th>
<th>Date of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assign systems setup and development manager</td>
<td>01/01/2016</td>
</tr>
<tr>
<td>Develop IT system requirements</td>
<td>14/01/2016</td>
</tr>
<tr>
<td>Develop system specification and sign off</td>
<td>31/01/2016</td>
</tr>
<tr>
<td>Procure hardware, software and networks and install</td>
<td>14/02/2016</td>
</tr>
<tr>
<td>System Implementation</td>
<td>31/02/2016</td>
</tr>
<tr>
<td>System Test / Sign off</td>
<td>07/03/2016</td>
</tr>
<tr>
<td>Train Staff</td>
<td>21/03/2016</td>
</tr>
<tr>
<td>System in full use</td>
<td>31/03/2016</td>
</tr>
</tbody>
</table>

6.7.3 Outcomes and Key Performance Indicators

Key KPI: % of IT system implementation plan complete

6.8 Community Eating Disorders

6.8.1 Deliverables and Costs

As this is a joint service between City and Hackney Newham and Tower Hamlets we are awaiting the completion of a jointly agreed plan for spending and deliverables, implementation and KPIs. This will be completed once received ELFTs business case on 30th November 2015.

6.8.2 Implementation Plan

See above
6.8.3 Outcomes and Key Performance Indicators

The aims of a community service are to provide evidence based treatment which reduces the need for inpatient admissions. The KPIs reflect these objectives.

Key KPIs:

- % of cases receiving NICE concordant treatment within the standard's timeframes
- A fall in the number of inpatient admissions per annum to the Coburn Unit for Eating disorders. Baseline data for previous years will be established in Q4 based on patient records.
7. Managing Risk

By investing the time to work closely with front-line services, the CCG is confident that the implementation plan, including timescales and costs, are accurate and deliverable. All parties have committed to clearly defined deliverables and agreed deadlines. All resources have been identified and are in place to begin in Q4 2015/16.

To manage any remaining risk, contingency plans are in place for each work stream. This flexibility and regular reporting and reviews of the budget spend via the Transformation Programme Management Office and the Alliance Board will ensure that any underspend kept within acceptable thresholds and reinvested appropriately in areas within the project that need it.

The table below summarises the key risks identified in delivering the Transformation Plan investment and the mitigation strategies that will be put in place to reduce the risks.

Figure 20: Managing Risk

<table>
<thead>
<tr>
<th>No.</th>
<th>Risk</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Risk Rating</th>
<th>Mitigation</th>
<th>Residual Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stakeholder disagreement causes delay</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Extensive stakeholder consultation (already completed)</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>Time taken to recruit causes delay</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>In Q4 a combination of existing staff (with backfill pay) and agency staff are used. Staff have already been identified.</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Poor planning causes delay</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>1. Sufficient project management capacity has been included. 2. Project planning has already started. 3. A PMO will be created.</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Inaccuracies in cost estimates causes underspend or overspend</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>1. A degree of flexibility has been built into the cost estimates allowing money to be transferred to manage the budget. 2. The Alliance will create a Transformation PMO, which will meet weekly to review costs.</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Investment fails to deliver value for money</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>1. Investment in regular reporting of clear KPIs. 2. Monthly investment line reviews against VFM. 3. Disinvestment/re-investment considered.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Planned interventions have a detrimental impact on patient care</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>1. Pre-Clinical Project Start-up Phase. 2. Clinical sign off before operational 3. Robust clinical governance processes</td>
<td>5</td>
</tr>
</tbody>
</table>

...
8. Governance

The investment will be delivered through the existing CAMHS Alliance, which already has robust governance arrangements in place to cover joint working between organisations. The Alliance was established in April 2015 and contains mental health providers, who undertake joint work funded by City and Hackney CCG.

The Alliance’s governance arrangements are stated in the signed CAMHS Alliance Agreement in section 9 and schedule 7 (see Appendix 1). The Alliance agreement consists of individual NHS Standard contracts and an overarching alliance agreement, which governs joint working. These together ensure that each organisation is ultimately responsible for the governance of clinical activities it undertakes. At the outset the CCG approves whether an organisation is appropriate to undertake the activity proposed. Where activity is jointly undertaken by two or more providers and a joint investigation is required the CCG will be the final arbiter of who will lead the investigation. The CCG will also determine the extent to which the Alliance Board is involved. The Alliance Board members are:

- East London NHS Foundation Trust (provider)
- Homerton University Hospitals NHS Foundation Trust (provider)
- Off Centre (Provider)
- City and Hackney CCG (Commissioner)
- London Borough of Hackney (strategic advisory capacity)

As can be seen the Alliance contains three providers and the commissioner of the services they provide. The local authority attend board meetings in a strategic advisory capacity. It is planned that they will become a signed member in 2016.

The only provider in this proposal not listed above is the City and Hackney VCS service. As the organisation is not currently a signatory to the Alliance agreement, their work will be subcontracted from East London NHS Foundation Trust, which is a signatory.

Each Alliance provider organisation works to an agreed budget for project deliverables and the Alliance is experienced at delivering projects to agreed aims, budgets and KPIs. The budgets are signed off by the Alliance Board. In essence an alliance is a partnership of equals and this distinguishes the alliance model from other partnership models such as Consortia or Prime Contractor model. However, a need for leadership is recognised and for this reason East London NHS Foundation Trust has the role of ‘Lead Representative’. This means it is responsible for the interface with the CCG and for co-ordinating the work of the Alliance.

The Alliance Board is responsible for providing the CCG with assurance about the Transformation Programme in terms of: the achievement of objectives and deliverables, KPIs, project risk and expenditure. The Transformation Programme Management Office (TPMO) is responsible co-ordinating monitoring the programme on a weekly basis in between Board meetings and for supplying the Alliance Board with reports on the programme, risk, spend, quality, SUIs and KPIs. The TPMO will be led by the overall programme manager and also have work steam project managers. The CCG will also be in attendance to provide additional oversight.
The Alliance Board reports to the CCG Mental Health Programme Board and the CCG are also members of the Alliance and present at Board meetings. The CCG has the power to reclaim any funding, which is not appropriately utilised by the Providers.

The East London Mental Health Commissioning Consortium co-ordinates strategy and joint projects across the boroughs of City and Hackney, Newham and Tower Hamlets. Whilst the Board’s role is advisory it has played and will play an important role in the development of the Eating Disorder CAMHS transformation investment, which is a project across three boroughs and ensuring there is strategic alignment between boroughs over the plans.

For the CAMHS Transformation Plan, the Alliance will also report to the Health and Well Being Board. The Board have approved these plans.

There is an established CAMHS service user clinical reference group, which is briefed and advises on all clinical proposals. The Youth Offending Management Board is hosted by the Local Authority. Members of the Alliance Board from East London NHS Foundation sit on the Board and supporting the sharing of information and advice. The CCG Consortium of City and Hackney, Newham and Tower Hamlets are also represented on the Board via the Newham Mental Health CCG Lead.

The governance arrangements are illustrated below. The bold blue single directional arrows show the lines of accountability for the CAMHS transformation project. The smaller dotted blue two way arrows show bodies which receive information on the project and have and advisory capacity but which are not accountable for the programme’s delivery. The governance arrangements are set out below.
Figure 21: Governance Arrangements

Key
Accountable to
Reports to and advises

City and Hackney Health and Wellbeing Board

City and Hackney CCG Board and MH Programme Board

CAMHS Alliance Board

City and Hackney Local Safeguarding Children Board

CCG Consortium Transformation Board

Youth Offending Management Board

Service User Clinical Reference Group

London Borough of Hackney

East London NHS FT

Homerton University NHS FT

Off Centre

CH CVS

Transformation PMO
9. Summary of Investment Priorities

The table below summarises the investment plan over the next four years and demonstrates how the KPIs are linked to objectives. As can be seen, these align with the vision set out in Section 4.

**Figure 22: Summary of Investment Priorities and KPIs**

<table>
<thead>
<tr>
<th>Investment Priority</th>
<th>Investment (£)</th>
<th>KPI</th>
<th>KPI Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach and Resilience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015-16</td>
<td>82,766</td>
<td>1. % CAMHS access rates to reflect % BME group population sizes. 2. % of open cases with mental health involvement having a support worker who’s received accredited mental health training.</td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>66,355</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18</td>
<td>66,355</td>
<td>% of outcome measures being recorded at 2 points in time (i.e. change can be evidenced)</td>
<td>Timely meaningful standardised reporting of clinical effectiveness.</td>
</tr>
<tr>
<td>2018/19</td>
<td>66,355</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing CYP Outcomes</td>
<td>52,260</td>
<td>% of services receiving intervention reporting that they are fully supported in meeting the mental health needs of patients</td>
<td>Integrated pathways as perceived by staff and patients from agreed survey.</td>
</tr>
<tr>
<td>Early Years: Perinatal</td>
<td>36,472</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015-16</td>
<td>-</td>
<td>% of appropriate patients referred from NICU</td>
<td>Successful delivery of integrated pathway evidenced by cross referral.</td>
</tr>
<tr>
<td>2016-17</td>
<td>67,568</td>
<td>% patients reporting improved Patient well-being and clinical effectiveness outcomes (using ESQ and SDQ and CGAs and DAWBA measurement tools)</td>
<td>Improved clinical outcomes from better liaison services.</td>
</tr>
<tr>
<td>2017-18</td>
<td>67,568</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>67,568</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early Years: NICU Trauma and Attachment Clinic</td>
<td>39,105</td>
<td>% of children with ASD diagnosis having SEND plan</td>
<td>All children with ASD supported by effective planning</td>
</tr>
<tr>
<td>2015-16</td>
<td>36,978</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>36,978</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18</td>
<td>36,978</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>36,978</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASD</td>
<td>77,090</td>
<td>% of services users reporting that the service is accessible during hours suitable to them</td>
<td>Better access as evidenced by service users.</td>
</tr>
<tr>
<td>Crisis: Psych and Paediatric Liaison</td>
<td>30,091</td>
<td>% patients reporting improved Patient well-being and clinical effectiveness outcomes (using ESQ and SDQ and CGAs and DAWBA measurement tools)</td>
<td>Improved clinical outcomes from better liaison services.</td>
</tr>
<tr>
<td>2015-16</td>
<td>80,548</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>80,548</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18</td>
<td>80,548</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis: Off-Centre YIAC</td>
<td>10,205</td>
<td>% of services users reporting that the service is accessible during hours suitable to them</td>
<td>Better access as evidenced by service users.</td>
</tr>
<tr>
<td>2015-16</td>
<td>39,316</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>39,316</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18</td>
<td>39,316</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis: Youth Offending Team</td>
<td>6,623</td>
<td>% increase in referrals to CAMHS from police services</td>
<td>More integrated pathway from police to mental health.</td>
</tr>
<tr>
<td>2015-16</td>
<td>26,491</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>26,491</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18</td>
<td>26,491</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Information Systems</td>
<td>41,785</td>
<td>% of IT system implementation plan complete</td>
<td>Successful delivery of new IT system.</td>
</tr>
<tr>
<td>Eating Disorder Service</td>
<td>150,372</td>
<td>150,372</td>
<td>150,372</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------</td>
<td>---------</td>
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<tr>
<td>Total</td>
<td>526,769</td>
<td>526,769</td>
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1. % of cases receiving NICE concordant treatment within the standard’s timeframes. 2. Decrease in inpatient admissions. Evidenced based community treatments which reduce inpatient admissions.
Appendix 1: CAMHS Alliance Agreement

THIS AGREEMENT is made the ............................ day of .............................................2015
BETWEEN:

(1) NHS CITY AND Hackney Clinical Commissioning Group of 3rd Floor, A Block, St Leonards, Nuttall Street, London N1 5LZ ("Commissioner")

(2) East London NHS Foundation Trust of 9 Alie Street, London E1 ("Provider 1")

(3) Homerton University Hospital NHS Foundation Trust of Homerton Row, London E9 6SR ("Provider 2")

(4) Off Centre of 25-27 Hackney Grove, London E8 3NR ("Provider 3")

Parties (2) to (4) are each a "Provider" and together the "Providers".

The Commissioner and Providers are each a "Partner" and together the "Partners".

INTRODUCTION:

(A) The Providers have been selected by the Commissioner to provide the Services. Each Provider has entered into a Service Contract with the Commissioner obliging the Provider to provide Services and deliver the Alliance Outcomes.

(B) The Partners will work together in accordance with this Alliance Agreement to decide the specific arrangements for the provision by the Providers of the Services and what each Provider shall do to ensure the delivery of the Alliance Outcomes. These arrangements, as amended from time to time, shall be recorded in an Integrated Services Schedule.

(C) The Partners recognise that over the term of this Alliance Agreement there will be changes in the way that individual Providers provide Services and how responsibilities are allocated between them. This Alliance Agreement aims to ensure that, collectively, the Providers will be responsible for providing the Services in an integrated way.

(D) The aim of this Alliance Agreement is also to ensure that the delivery of Services by the Providers is incentivised to be seamless and patient focussed. To achieve this outcome the Partners have agreed a reward and payment mechanism as detailed in the Schedules to this Alliance Agreement and the Commissioner has agreed to operate and enforce the individual Service Contracts in a manner that is consistent with the aims and objectives of this Alliance Agreement.

(E) The Commissioner is entitled under each Service Contract to enforce that Service Contract's terms against the Provider which is party to it. However the Commissioner agrees to treat the Providers as if they were a single entity with respect to their performance of the Alliance Outcomes.

(F) The Partners have agreed that one Provider shall be a Fund Holder and receive payment from the Commissioner, to hold on trust on behalf of the other Providers. The Partners have also agreed that a Lead Representative from the Providers, who shall be the lead point of contact as between the Providers and the Commissioner.

(G) In consideration of the above, the Partners have agreed to enter into this Alliance Agreement to set out the terms and conditions of how they will work together to facilitate the integrated provision of the Services in order to deliver the Alliance Outcomes.
NOW IT IS HEREBY AGREED as follows:

1. DEFINITIONS AND INTERPRETATION

1.1. The provisions of this Alliance Agreement shall be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2. PRE COMPLETION

2.1. Each Partner acknowledges and confirms that as at the date of this Alliance Agreement it has obtained all necessary authorisations to enter into this Alliance Agreement.

2.2. The Partners have agreed the terms of reference of the Alliance Provider Board as set out in Schedule 2 (Alliance Provider Board – Terms of Reference).

2.3. The Partners have agreed which Provider will be the Fund Holder and which Provider will be the Lead Representative and this has been specified in this Alliance Agreement in Schedule 1 (Definitions and Interpretation).

2.4. The Partners have agreed the Integrated Services Schedule as set out in Schedule 11 (Integrated Services Schedule).

3. COMPLETION

3.1. Completion is conditional upon the execution of a Service Contract between the Commissioner and each of the Providers. Each Service Contract shall include a Specification incorporating the Alliance Outcomes.

3.2. The Providers shall ensure compliance with the 1998 Act and shall enter into an information sharing agreement for sharing patient information as soon as reasonably practicable following the completion of this Alliance Agreement.

4. COMMENCEMENT AND TERM

4.1. Clauses 1 (Definitions and Interpretation), 2 (Pre Completion), 3 (Completion) and 4 (Commencement and Term) will be effective from the Commencement Date.

4.2. The remainder of this Alliance Agreement will be effective from a date specified in a notice from the Commissioner to the Providers confirming that a Service Contract between the Commissioner and each of the Providers has been executed (the “Completion Date”).

4.3. This Alliance Agreement shall remain in force until the Initial Expiry Date unless terminated in accordance with Clause 17 (Termination, Exit and Expulsion) or extended in accordance with Clause 4.4.

4.4. The Commissioner may extend this Alliance Agreement in order that it remains in force until the Revised Expiry Date by mutually agreeing such extension in writing.

5. PRINCIPLES

Alliance Principles

5.1. The Providers agree to work together at all times in accordance with the Alliance Principles to collectively achieve the Alliance Outcomes and to meet the Alliance KPIs.
5.2. Each Provider shall be severally responsible for delivering its obligations under each respective Service Contract and for meeting the requirements allocated to it under the Integrated Services Schedule.

**Commissioning Principles**

5.3. The Commissioner acknowledges and accepts that each Provider holds a Service Contract which includes the Alliance Outcomes that are to be achieved collectively by the Providers.

5.4. The Commissioner agrees:
   a. to enforce the Service Contracts in a manner consistent with this Alliance Agreement;
   b. treat the Providers as a single entity with respect to the performance or non-performance of the Alliance Outcomes;
   c. not seek to enforce the provisions of any Service Contract against any individual Provider in respect of any failure to achieve any Alliance Outcome without first operating the Commissioner-Provider Issues Procedure under this Agreement, subject always to Clause 5.5; and
   d. adopt transparency on all aspects of the Alliance subject to competition law compliance.

5.5. The Commissioner shall be under no obligation to follow the Commissioner-Provider Issues Procedure prior to enforcing a Service Contract against an individual Provider where the Commissioner considers that there is a risk to patient safety or risk of material financial loss to the Commissioner.

6. **PAYMENT ALLOCATION**

6.1. The Providers acknowledge that each Service Contract includes details of payments due from the Commissioner to the Providers collectively.

6.2. In order to discharge its payment obligations under each of the Service Contracts, the Commissioner shall be responsible for making payments to the Fund Holder in accordance with Part 1 of Schedule 3 (Alliance Payments).

6.3. Payment by the Commissioner to the Fund Holder in accordance with Clause 6.2 shall be accepted by the Providers in full satisfaction of the Commissioner's responsibilities to make payment to it under the relevant Service Contract.

**Fund Holder Responsibilities**

6.4. The Fund Holder shall receive payment by the Commissioner and hold such payment on trust for the Providers.

6.5. The Fund Holder shall be responsible for allocating payments to the individual Providers in accordance with Part 2 of Schedule 3 (Alliance Payments) and in accordance with the instructions of the Alliance Provider Board where relevant.

6.6. Each Provider shall ensure that any Overpayments made by the Commissioner (whether related to Performance Payments or otherwise) to the Fund Holder, and subsequently made to the Providers (or retained by the Fund Holder as the case may
Payment Issues

6.7. Where a Provider raises an Issue relating to the amounts due or payable to it under this Alliance Agreement by the Fund Holder, that Issue shall be resolved in accordance with the Provider-Provider Issues Procedure. Save for in accordance with Clause 6.8, no individual Provider shall be entitled to make any individual claim for payment or non-payment directly against any Commissioner until it has first exhausted the remedies under the Provider-Provider Issues Procedure.

6.8. Where any Provider (or all Providers) raises / raise an Issue relating to the amounts payable by the Commissioner to the Fund Holder under this Alliance Agreement, that Issue shall be resolved in accordance with the Commissioner-Provider Issues Procedure. No individual Provider shall take any action against the Commissioner in respect thereof until it has first exhausted its remedies under the Issues Procedure.

7. ESTABLISHMENT OF THE ALLIANCE PROVIDER BOARD

7.1. The Partners hereby agree to establish the Alliance Provider Board. For the avoidance of doubt the Alliance Provider Board shall not be a committee of any Partner or any combination of Partners.

7.2. The primary role of the Alliance Provider Board shall be to monitor and oversee the provision of the Services and ensure performance of the Alliance Outcomes.

7.3. The Terms of Reference for the Alliance Provider Board shall be as set out in Schedule 2 (Alliance Provider Board – Terms of Reference).

Admitting new members to the Alliance

7.4. Where a Partner or Partners wish to admit a new member to be a provider under this Alliance Agreement, such a proposal shall be considered at the next Alliance Provider Board meeting. The relevant Partner or Partners that wish to admit a new member shall serve a written notice on the Alliance Provider Board setting out the details of the proposed new party (where known), reasons and rationale for the proposed admission of a new party, the likely impact on the Services and the likely impact on the payments to be made under Schedule 3 (Alliance Payments).

7.5. Following receipt of the notice referred to in Clause 7.4, the Alliance Provider Board shall then consider the proposal and decide what actions (if any) need to be taken, in terms of varying this Alliance Agreement, for example.

Appointment of the Alliance Project Manager / Project Co-ordinator

7.6. The Partners agree that the Providers shall engage an individual to undertake project management on behalf of the Partners ("Project Manager / Project Co-ordinator"). The responsibilities of the Project Manager / Project Co-ordinator include supporting the co-ordination of reporting information and compiling reporting information from different organisations into a single coherent document for review by the Alliance Provider Board on a Quarterly basis. The Project Manager / Project Co-ordinator is also responsible for supporting the management of the Alliance Outcomes, facilitating deliverables being achieved in accordance with the Specifications, within the financial envelope set out in this Alliance Agreement, and in accordance with the timescales agreed with the Commissioner.
7.7. The Partners agree that the detailed responsibilities / job description for the Project Manager / Project Co-ordinator shall be determined by the Alliance Provider Board. The Project Manager / Project Co-ordinator will report regularly (no less than every Month) to both the Alliance Provider Board Chair and the Commissioner.

8. INTEGRATED PROVISION OF THE SERVICES

8.1. All Providers intend for the Services to be provided in an integrated and patient-centred way by the collective of Providers.

8.2. Each Service Contract between the Commissioner and a Provider shall specify the entire scope of the Services and all of the Alliance Outcomes, and the Providers shall collectively be obliged to achieve the Alliance Outcomes.

8.3. The Providers shall determine between themselves how they shall collaborate to achieve the Alliance Outcomes, and shall record the manner of their collaboration in the Integrated Services Schedule.

8.4. The Integrated Services Schedule may be varied by agreement of Providers at the Alliance Provider Board, subject to the written consent of the Commissioner.

8.5. Whilst the Partners acknowledge and agree that each of the Service Contracts would each need to be varied to reflect any variations to the Integrated Services Schedule in accordance with Clause 8.4, the Partners agree to work on the basis that the latest agreed Integrated Services Schedule is binding upon each of them.

Lead Representative Responsibilities

8.6. The Lead Representative shall be responsible for liaising with the Commissioner on behalf of the Providers, and for ensuring that all Providers are kept informed in respect of any such liaison.

8.7. The Lead Representative shall report to the Commissioner in accordance with the reporting requirements of Schedule 5 (Reporting Requirements).

8.8. The Lead Representative shall provide reports and information to the Alliance Provider Board in accordance with Schedule 2 (Alliance Provider Board – Terms of Reference).

9. GOVERNANCE

9.1. The Providers are individual organisations and each has their own individual governance arrangements. Each Provider has detailed its own Governance and Regulatory Leads in each Service Contract.

9.2. Nothing in this Alliance Agreement shall absolve any of the Providers from their obligations under each Service Contract, particularly in relation to ensuring that the Services are provided in accordance with National Standards.

9.3. Where there are any Patient Safety Incidents or Information Governance Breaches, for example, the Providers shall ensure that they each comply with their individual Service Contract and, where required by the Commissioner, work collectively and share all relevant information to that Patient Safety Incident or Information Governance Breach (or other similar issue) for the purposes of any investigations and/or remedial plans to be put in place, as well as for the purposes of learning lessons in order to avoid such Patient Safety Incident or Information Governance Breach in the future.
9.4. Without prejudice to any obligations in the Service Contracts, the Providers shall each notify the Commissioner and Alliance Provider Board of any Serious Incident that has arisen in connection with the relevant Provider's involvement in providing the Services set out in the Service Contract, without delay and no longer than two (2) Working Days of that Serious Incident taking place.

9.5. Without prejudice to any obligations in the Service Contracts, the Providers shall comply with Schedule 6 (Governance Protocol).

10. TRANSPARENCY BETWEEN PARTNERS

10.1. The Providers shall seek to operate in an open and transparent manner with each other for the purposes of this Alliance Agreement, save for ensuring compliance with competition law requirements.

10.2. The Providers shall (through their Lead Representative) provide information to the Commissioner within 10 Working Days of the Initial Expiry Date and Revised Expiry Date (where relevant) setting out the payments received from the Commissioner and the amount spent by the Providers for the purposes of the provision of the Services, in order that the Commissioner can carry out a reconciliation and claim reimbursement for any Underspends.

11. INTELLECTUAL PROPERTY RIGHTS

11.1. Nothing in this Alliance Agreement or any activity undertaken that is contemplated by this Alliance Agreement shall affect the ownership by any Partner of any Intellectual Property Rights it held immediately prior to this Alliance Agreement coming into effect ("Pre-existing IPR").

11.2. Each Partner (the "Granting Partner") shall grant to the other Partner a royalty free, non-exclusive licence to use its Pre-Existing IPR for as long as the Granting Partner remains a Partner under this Alliance Agreement solely to the extent that this is necessary for the carrying out of the obligations in this Alliance Agreement and for the collective delivery of the Alliance Outcomes and the Services by the other Partners.

11.3. Subject to Clause 11.2 any Intellectual Property Rights created individually by a Provider or jointly by more than one of the Providers in the course of the activities contemplated by this Alliance Agreement during the term of this Alliance Agreement ("Shared Intellectual Property Rights") shall be jointly owned by the Providers (as at the date of creation of the relevant Intellectual Property Rights) unless otherwise agreed by the Alliance Provider Board.

11.4. The Providers shall:

a. subject to Clause c, not enter into any licence or other contract exploiting or disposing of the Shared Intellectual Property Rights without the agreement of all of the Providers (which could be evidenced by a resolution of the Alliance Provider Board);

b. share any receipts produced by such exploitation with the Providers from time to time in the same proportions as may be agreed by the Providers (which could be evidenced by a resolution of the Alliance Provider Board); and

c. grant to each of the Partners at the time of creation of the relevant Shared Intellectual Property Rights a perpetual, non-terminable, royalty free,
licensure to use the Shared Intellectual Property Rights for the purposes of commissioning or providing NHS services.

12. CONFIDENTIALITY AND ANNOUNCEMENTS

12.1. No Partner shall make any public announcement about the matters set out in this Alliance Agreement without the written agreement of all of the Partners.

12.2. The Providers acknowledge that the Commissioner is subject to the provisions of the Freedom of Information Act 2000 ("FOIA") and will facilitate the Commissioner's compliance with its information disclosure requirements and FOIA in connection with this Alliance Agreement, at all times in accordance with the relevant Service Contract.

12.3. The Commissioner and Providers acknowledge that some of the Providers are subject to the provisions of FOIA and will facilitate each such Provider's compliance with its information disclosure requirements and FOIA in connection with this Alliance Agreement, at all times in accordance with the relevant Service Contract (where obligation is upon the Commissioner) and in accordance with the Alliance Principles.

13. LIABILITY AND INDEMNITY AND INSURANCE

13.1. Without prejudice to the operation of the Service Contracts, no Partner shall have any liability to any other Partner and no Partner shall bring any claim against any other Partner under or in connection with this Alliance Agreement whether in contract or under common law (whether in negligence, tort, breach of statutory duty or otherwise) for any direct, indirect, incidental or consequential loss or damage howsoever arising in respect of the following:

   a. failure to achieve the Alliance Outcomes;
   
   b. loss of any opportunity or entitlement to perform the Services;
   
   c. loss of business;
   
   d. loss of actual or anticipated profit or income; or
   
   e. damage to reputation,

arising from the performance or non-performance, variation, breach, termination or expiry of the Service Contracts or the exclusion or expulsion of any Provider pursuant to Clause 17 (Termination, Exit and Expulsion).

13.2. The remedies set out in the Service Contracts shall be the sole and exclusive remedies of the Commissioner in respect of the performance by each Provider of the Service Contracts.

13.3. Subject to Clause 14, the provisions of Clause 13.4 of this Alliance Agreement shall be the sole and exclusive remedies of the Commissioner and sole and exclusive liabilities of each Provider to the Commissioner in respect of the obligations set out in this Alliance Agreement. The provisions of Clauses 13.5, 13.6 and 13.7 shall be the sole and exclusive remedies of the Providers and sole and exclusive liabilities of the Commissioner to the Providers in respect of the obligations set out in this Alliance Agreement.

13.4. The Commissioner may bring a claim against the Providers (or such Provider as it reasonably considers relevant) in respect of or arising from:

   a. any Overpayment;
b. any Misappropriation; or

c. any loss or damage suffered by the Commissioner from breach of the provisions of Clauses 11 (Intellectual Property Rights), 12 (Confidentiality and Announcements), 13.9 and Clause 16 (Exit Plan).

13.5. The Fund Holder may bring a claim against the Commissioner in respect of or arising from any breach of the provisions of Part 1 of Schedule 3 (Alliance Payments).

13.6. Any Provider may bring a claim against the Commissioner or another Provider in respect of or arising from any loss or damage suffered by the Provider from breach of the provisions of Clause 11 (Intellectual Property Rights) or Clause 12 (Confidentiality and Announcements).

13.7. Any Provider may bring a claim against the Fund Holder in respect of or arising from any breach of the provisions of Part 2 of Schedule 3 (Alliance Payments).

13.8. The Commissioner and Providers agree and acknowledge that there may be variations to the elements of Services that each Provider might provide in accordance with Clause 8.4 under an agreed variation to the Integrated Services Schedule.

13.9. Each Provider agrees to ensure that it shall, at all times, have in place adequate Indemnity Arrangements for the purposes of the Services that it is providing at any relevant time, and shall provide details of the same to the Commissioner in accordance with the terms of the relevant Service Contract.

14. REMEDIES IN THE EVENT OF FAILURE

14.1. If the Commissioner is of the opinion that any one or more Provider(s) is:

   a. in material and/or persistent breach of any provision of a Service Contract and that material or persistent breach is inconsistent and/or detrimental to the achievement of the Alliance Outcomes; or

   b. bringing or has brought any of the Partners into disrepute by its acts or omissions, including but not limited to that Provider's use of public money

the Commissioner shall provide written notice to the Alliance Provider Board setting out details of the breach of the relevant Provider(s) with supporting evidence and a recommendation for action ("Breach Notice").

14.2. On receipt of a Breach Notice, the relevant Provider(s) shall be obliged to provide a notice to the Commissioner setting out the steps that the relevant Provider(s) shall take to rectify the breach and the timescales that such steps shall be taken ("Rectification Notice").

14.3. If the relevant Provider(s) fail to comply with the Rectification Notice in accordance with the timescales set out within it, or if the Commissioner reasonably considers the breach to be incapable of remedy, then the Commissioner shall notify the Alliance Provider Board as soon as reasonably possible.

14.4. Following the Commissioner's notification under Clause 14.3, the Commissioner shall then be entitled to terminate the relevant Provider(s) involvement in this Alliance Agreement immediately by providing written notice of such termination to the Provider(s) and the Alliance Provider Board. The provisions of Clause 18 shall apply to the relevant Provider(s).

14.5. Where a Provider is of the opinion that any one or more Provider(s) is:
a. not complying with the Integrated Services Schedule to the extent that such non-compliance is detrimental to the achievement of the Alliance Outcomes; or

b. bringing or has brought any of the Providers into disrepute by its acts or omissions, including but not limited to that Provider's use of public money

the Provider shall give written notice to the Commissioner, and seek to resolve the dispute under the Provider-Provider Issues Procedure.

14.6. This Clause 14 is without prejudice to any other right of the Commissioner to terminate any Service Contract.

15. ISSUES PROCEDURE

15.1. Issues between any Providers and the Commissioner in connection with this Alliance Agreement, the Service Contracts and/or the achievement of Alliance Outcomes shall be resolved by a meeting of the Alliance Provider Board in the first instance.

15.2. Where there is a failure to resolve an Issue between the Commissioner and:

a. any one Provider; or

b. more than one Provider,

at the Alliance Provider Board under Clause 15.1, the Commissioner or the Provider may give notice to the other Partner (i.e. to the Commissioner Representative or Provider Representative) that it wishes for the matter to be resolved in accordance with the Commissioner-Provider Issues Procedure, and the Partners agree to follow the Commissioner-Provider Issues Procedure in those circumstances.

15.3. Any Issues that arise between Providers in connection with the Integrated Services Schedule or any other matter related to this Alliance Agreement shall be resolved by the Providers in accordance with the Provider-Provider Issues Procedure.

16. EXIT PLAN

16.1. The Providers shall produce and maintain an exit plan ("Exit Plan") setting out:

a. the likely impact on the Services should a Provider exit this Alliance Agreement;

b. the steps that the Providers shall take in respect of any equipment or premises that has been used for the purposes of providing the Services;

c. any administrative steps that the Providers must take where, for example, a Provider that is the Fund Holder or Lead Representative exits this Alliance Agreement; and

   d. the steps that the remaining Providers must take to mitigate any detrimental impact upon patients receiving the Services should a Provider exit this Alliance Agreement.

16.2. The Exit Plan shall be reviewed periodically by the Alliance Provider Board and any changes must be agreed by the Commissioner and Providers.
17. TERMINATION, EXIT AND EXPULSION

17.1. If a Provider ("Outgoing Provider") wishes to terminate its involvement in this Alliance Agreement, it must give notice to terminate its Service Contract, in accordance with the terms of that Service Contract. Save for where expressly referred to in this Alliance Agreement, the Outgoing Provider's obligations in this Alliance Agreement shall terminate simultaneously on termination of its Service Contract.

17.2. Where the Commissioner has served notice to terminate a Provider's Service Contract in accordance with that Service Contract, that Provider mutually agrees with all other Partners to terminate its involvement in this Alliance Agreement simultaneously on termination of its Service Contract.

17.3. Where the Commissioner has served notice to terminate a Provider's involvement in this Alliance Agreement, each relevant Provider hereby mutually agrees to terminate its Service Contract simultaneously on termination of the Alliance Agreement, as specified in the relevant notice from the Commissioner.

17.4. Where the Commissioner and Provider mutually agree to terminate a Service Contract, the relevant Provider mutually agrees with all other Partners to terminate its involvement in this Alliance Agreement simultaneously on termination of its Service Contract.

17.5. The Alliance Provider Board may resolve to terminate this Alliance Agreement if an Event of Force Majeure renders the continuation of the Alliance Agreement impossible pursuant to Clause 19.4.b.

18. CONSEQUENCES OF EXIT

18.1. Where a Provider's Service Contract or a Provider's involvement in this Alliance Agreement has terminated for any reason, that Provider must comply with the requirements set out in Clause 18.2.

18.2. Where the circumstances set out in Clause 18.1 have taken place in respect of a Provider, that Provider:

   a. hereby agrees that it shall have no voting rights on the Alliance Provider Board on termination if its involvement in this Alliance Agreement, and agrees that the Alliance Provider Board Terms of Reference shall be immediately amended to reflect that the Provider is no longer part of the Alliance;

   b. shall comply with the Exit Plan;

   c. shall provide a statement of account to the Alliance Provider Board, setting out the payment it has received for providing the Services up to the date of termination of the Services, and what it has spent up to the date of termination of the Services within 10 Working Days of the relevant termination date;

   d. shall return any Underspend or Overpayment to the Commissioner where directed to do so by the Alliance Provider Board or the Commissioner within 30 days of such a request by the Alliance Provider Board or Commissioner; and
e. shall provide all reasonable assistance and co-operation to the Commissioner and other Providers in order to facilitate a smooth handover and continuity of care, including working with any third party or third parties that may be admitted to this Alliance Agreement by the agreement of the Alliance Provider Board.

19. **FORCE MAJEURE**

19.1. Where the Provider is (or claims to be) affected by an Event of Force Majeure, it shall take all reasonable steps to mitigate the consequences of it, resume performance of its obligations as soon as practicable and use all reasonable efforts to remedy its failure to perform.

19.2. Subject to Clauses 19.1 and 19.3 the Provider shall, when claiming relief, be relieved from liability under this Alliance Agreement to the extent that because of the Event of Force Majeure it is not able to perform its obligations under this Alliance Agreement.

19.3. The Provider shall, when claiming relief, serve initial written notice on the Commissioner and the Alliance Provider Board immediately when it becomes aware of the Event of Force Majeure. This initial notice shall give sufficient details to identify the particular event.

19.4. The Provider shall, when claiming relief, then either:

a. serve a detailed written notice on the Commissioner within a further five (5) Working Days. This detailed notice shall contain all relevant available information relating to the failure to perform as is available, including the effect of the Event of Force Majeure, the mitigating action being taken and an estimate of the period of time required to overcome it; or

b. in the event it reasonably believes that the effects of the Event of Force Majeure will make it impossible for the Alliance to continue, serve notice of this to the Commissioner and the Alliance Provider Board in order that the Partners can consider and agree whether this Alliance Agreement should terminate in accordance with Clause 17.5 of this Alliance Agreement.

20. **VARIATION**

20.1. Save for:

a. variations to the Integrated Services Schedule, which must be carried out in accordance with Clause 8.4;

b. variations to the proposed payment schedule set out in Table 2, Schedule 3 part 2, which may be effected by a unanimous written resolution of the Alliance Provider Board

no variation of this Alliance Agreement shall be effective unless it is in writing and signed by all of the Partners.

21. **NOTICES**

21.1. A notice given under this Alliance Agreement to the Commissioner:

a. shall be in writing in English;
b. shall be sent for the attention of the Commissioner Representative to the address (whether e-mail or postal) set out in Schedule 10 (Notices); and

c. shall be:

21.1.c.1. delivered personally;
21.1.c.2. sent by pre-paid first class post or recorded delivery; or
21.1.c.3. sent by e-mail.

21.2. A notice given under this Alliance Agreement to any of the Providers or to the Alliance Provider Board:

a. shall be in writing in English;

b. shall be sent for the attention of the Provider Representative to the address (whether e-mail or postal) set out in Schedule 10 (Notices); and

c. shall be:

21.2.c.1. delivered personally;
21.2.c.2. sent by pre-paid first class post or recorded delivery; or
21.2.c.3. sent by e-mail.

d. shall be deemed served on all of the Providers and/or the Alliance Provider Board where the Commissioner has served the notice in accordance with this Clause 21.2.

21.3. A notice will be deemed to have been received:

a. if delivered personally, when left at the address referred to in Clause 21.1.b (in the case of a notice served on the Commissioner) or in Clause 21.2.b (in the case of a notice served on the Provider); or

b. if sent by pre-paid first class post, on the second business day after posting; or

c. if sent by e-mail, received when a read receipt has been obtained, or where a read receipt is unavailable, the day after the e-mail was sent.

21.4. To prove service, it will be sufficient to prove that the envelope containing the notice was properly addressed and posted or that the e-mail was sent to the correct e-mail address.

22. GENERAL

22.1. The failure of any Partner to enforce at any time or for any period of time any of the provisions of this Agreement shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Partner thereafter to enforce such provision either under this Alliance Agreement or any Service Contract.

22.2. No waiver in any one or more instances of a breach of any provision hereof shall be deemed to be a further or continuing waiver of such provision in other instances.
22.3. No Partner shall assign, novate mortgage, charge, sub-contract or otherwise dispose of any or all of its rights and obligations under this Alliance Agreement without the prior written consent of all other Partners.

22.4. This Alliance Agreement and the Service Contracts constitute the entire agreement and understanding of the Partners and supersedes any previous agreement between the Partners relating to the subject matter of this Agreement.

22.5. The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Alliance Agreement and accordingly the Partners do not intend that any third party should have any rights in respect of this Alliance Agreement by virtue of that Act.

22.6. If any term, condition or provision contained in this Alliance Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Alliance Agreement.

22.7. Each Partner shall be responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Alliance Agreement.

22.8. Subject to the Issues Procedure, this Alliance Agreement shall be governed by and construed in accordance with English law, and the Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Alliance Agreement.

22.9. This Alliance Agreement may be executed in any number of counterparts, each of which shall be regarded as an original, but all of which together shall constitute one agreement binding on all of the Partners, notwithstanding that all of the Partners are not signatories to the same counterpart.

22.10. Nothing in this Alliance Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners or any of them or render any Partner directly liable to any third party for the debts, liabilities or obligations of any other Partner.

22.11. Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

22.12. Clauses 12, 13, 15, 18, 20, 21 and 22 shall survive the expiry or termination of this Alliance Agreement.

22.13. The expiry or termination of this Alliance Agreement will be without prejudice to any other rights or remedies of any Partner under this Alliance Agreement or at law, and will not affect any accrued rights or liabilities of any Partner or any provision of the Alliance Agreement which comes into, or continues in, effect after expiry or termination.
Appendix 2: Five to Thrive Engagement Event Feedback.

Red: What should change?
“Education on self-management is lacking”
“Budget cuts are affecting access as a result, poorer outcomes for mental health lack of community and social isolation”
“Less use of buzz words and short down words are not understood by users”
“Fast food can be as detrimental as drugs and alcohol”
“Don’t refuse someone a service even though at face value the may look well, people need services even though they may have used them a long time”
“Peoples voices are sometimes suppressed”
“Too many buzz words”
“I’ve heard the word ‘dependence’ a lot lately, its not a negative it means you are developing trust and have a sense of belonging or community which is priceless”
“Don’t rely on ‘indicators’, speak to people. They can be useful, but there needs to more context and more understanding than just

Amber – What's Good?
“The conventional model is shifting (but too slowly)”
“The Crisis line”
“Been referred for brilliant Mindfulness courses by GP in Hackney, have helped a lot!”
“Mindfulness and medication, has meant less medication”
“Lots of stuff going on”
Green: New Ideas / how to improve!

We should debate our differences to find knowledge
Express the positives of diagnosis
Its not all talking and thinking, practical activity and stimulus is better
User involvement in Crisis Team
Challenge negative stereotypes, promote a positive message
Family Liaison officers in Hackney
Needs more money in Arts in mental health rehabilitation
Hold everyone using services with positive regard, rather than eligibility or standardising, see the potential
More experts by experience being employed as their role is inspirational and communicates wider
Expression through the arts is a management tool that has not been harnessed fully yet!
Supported volunteer opportunities