# Item No: 7

**Meeting Date:** **Wednesday 18th April 2018**

# Glasgow City
# Integration Joint Board
# Performance Scrutiny Committee


**Report By:** **Stephen McLeod, Head of Specialist Children's Services**

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## IMPROVING ACCESS TO CAMHS (CHILD AND ADOLESCENT MENTAL HEALTH SERVICES) FOR VULNERABLE CHILDREN AND YOUNG PEOPLE

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| **Purpose of Report:** | To demonstrate the improved access to CAMHS for those children across Greater Glasgow & Clyde and in particular, to demonstrate work identifying local need with a focus on areas of high deprivation to eradicate health inequalities at a community level. |

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| **Background/Engagement:** | Community CAMHS have experienced success in improving the access and efficiency of its service by providing care for a large increase in demand, whilst reducing the length of wait experienced by children and young people.<br><br>This is accompanied by analysis at a local level to highlight potential health inequalities in areas of vulnerability to ensure young people in this area are supported in accessing service. |

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| **Recommendations:** | The IJB Performance Scrutiny Committee is asked to:<br><br>a) consider the levels of performance in balancing demand and capacity over recent years in relation to increasing the access to CAMHS; and<br><br>b) consider the approach used to highlight health inequalities at neighbourhood level as a method of identifying vulnerability. |

**Relevance to Integration Joint Board Strategic Plan:**

| This paper cuts across the Children's Services Strategy Map and the Mental Health Strategy Map by considering the following: the GIRFEC (Getting it Right for Every Child) outcomes, in particular Safe, Healthy, Nurtured and Respected. It also considers the long term outcomes of the Mental Health Strategy and in particular, reducing health inequalities. |
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**Implications for Health and Social Care Partnership:**

| **Reference to National Health & Wellbeing Outcome:** | Outcome 3<br>Outcome 4<br>Outcome 5<br>Outcome 9 |
|---|---|

| **Personnel:** | Child and Adolescent Mental Health Services Personnel |
|---|---|

| **Carers:** | n/a |
|---|---|

| **Provider Organisations:** | NHS Greater Glasgow and Clyde |
|---|---|

| **Equalities:** | Reduction in health inequalities, particularly focusing on vulnerability and deprivation |
|---|---|

| **Financial:** | n/a |
|---|---|

| **Legal:** | n/a |
|---|---|

| **Economic Impact:** | n/a |
|---|---|

| **Sustainability:** | n/a |
|---|---|

| **Sustainable Procurement and Article 19:** | n/a |
|---|---|

| **Risk Implications:** | n/a |
|---|---|

| **Implications for Glasgow City Council:** | Reduction in health inequalities |
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| **Implications for NHS Greater Glasgow & Clyde:** | Improved access to service<br>Reduction in health inequalities |
|---|---|

## 1. Overview

1.1 Following an extensive redesign and improvement process, NHS Greater Glasgow and Clyde CAMHS have delivered increases in productivity, improved access and improved outcomes for children. From a difficult starting position pre 2010, with extremely long waiting times (longest wait 123 weeks in East Glasgow), poor demand and capacity management and a non-standard service model across the board area, there has been a positive turnaround. The implementation of the CAMHS Framework throughout 2012/13, led to a standard workforce proportionate to the local population across seven Tier 3 teams, with an eighth team being introduced in 2014. The implementation of the Choice and Partnership Approach (CAPA) has been pivotal in managing the significant increase in referrals, whilst achieving and maintaining the Scottish Government Referral to Treatment (RTT) HEAT Target of 90% of waits to be no longer than 18 weeks referral to treatment.

1.2 Throughout this time period, CAMHS has also delivered Cost Reduction Efficiency Savings and changing organisational structure across NHS GG&C e.g. demit of CHCPs and introduction of HSCPs. Clinical caseloads are now exceeding what was planned and budgeted for in the CAMHS Framework and this is having an impact of the activity performance and the demand and capacity balance of the service. Further issues around access to service have been studied with a view to increasing access, particularly for the most vulnerable children and young people across the board area.

1.3 This paper aims to demonstrate the performance gains since the implementation of the framework in terms of improving access to services by looking at waiting time and referral data. An overview of work around targeting vulnerability at a neighbourhood level will also be explained to highlight the continual work in improving access to CAMHS in NHS GG&C for the most vulnerable children.

## 2. Improving the Access to CAMHS – Waiting Times

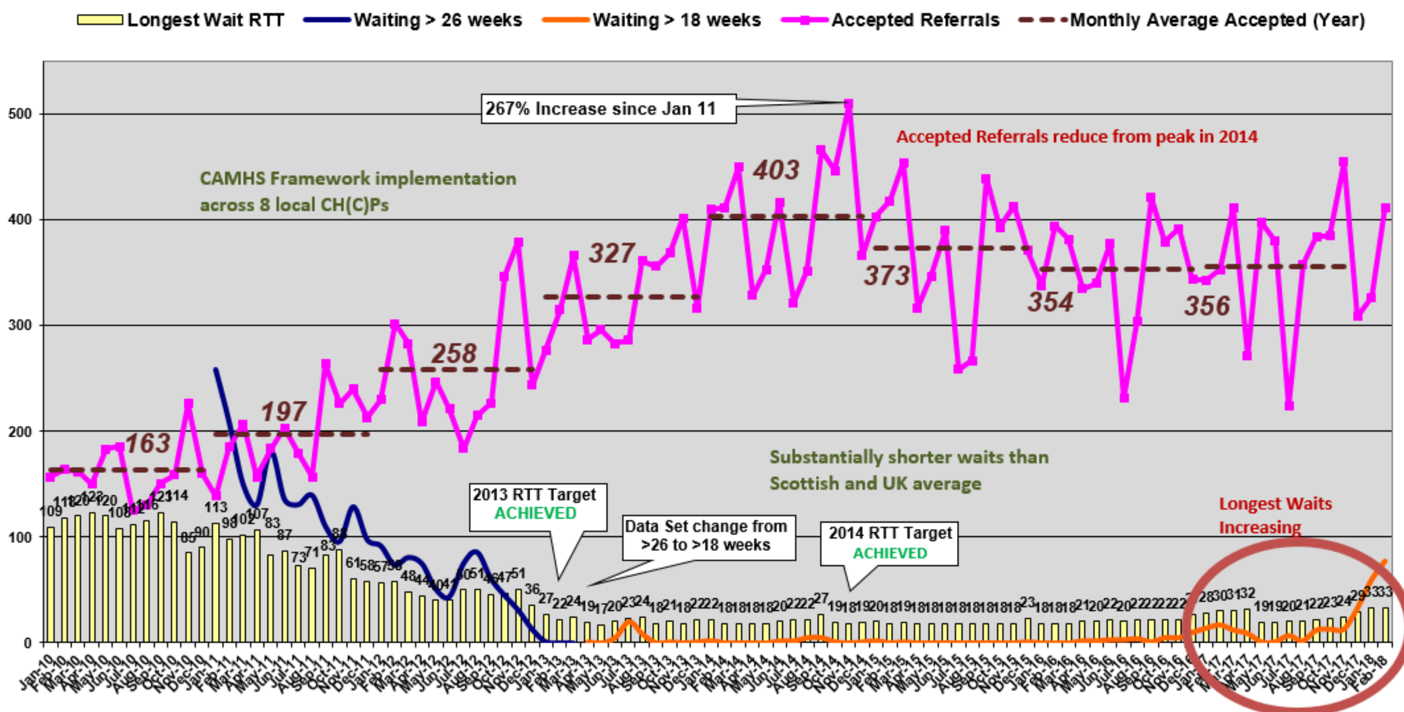
2.1 Reduced Waiting List

Over the last decade, Scottish Government polices has focused on a reduction in CAMHS waiting times, supported by the implementation of a HEAT Target which states that no more than 90% of children and young people who are waiting for CAMHS intervention should wait longer than 18 weeks (previously 26 weeks prior to April 2013).

In 2010, NHS GG&C CAMHS recorded a longest wait of 123 weeks (April 2010, East Glasgow team) for a child who had been referred and was waiting for a first treatment appointment (2nd CAMHS appointment). Following an extensive redesign of Tier 3 Community CAMHS, NHS GG&C reduced the CAMHS waiting times, working towards March 2013 HEAT Target of 26 weeks. This was achieved and improvements continued with the December 2014 target of 18 weeks being met almost a year early. This level of performance has been stable in NHS GG&C, where the CAMH Services has regularly outperformed all mainland Scottish

boards in relation to waiting times and continue to operate within the shortest waiting times across the UK. However, in recent months, from late 2017, demand and capacity issues have caused an increase in longest waits, with the longest wait at February 2018 confirmed at 33 weeks. Action plans are in place to ensure that waiting times performance returns to the required level.

However, it is also noted, that although the waiting times have increased, since meeting the March 2013 HEAT Target, NHS GG&C have never breached the 90% threshold, with current performance at February 2018 at over 95% achievement to the target. Waiting list performance is shown in the graph below.




2.2 Increases in Demand

Also shown in the graph above, is a significant increase in accepted referrals from 2010 through to its peak in November 2014 and thereafter, it's stabilization up until the current levels.

In 2010, NHS GG&C CAMHS accepted 163 referrals per month on average throughout the year. This average increases each year until 2014, where accepted referrals had risen to an average of 403 per month (147% increase). This then reduces slightly over the next few years, with 2017 finishing with an average of 356 accepted referrals per month.

With the CAMHS Framework being implemented in 2010 to the resource agreed at that time, the service has had to deal with this unprecedented demand rise, utilising the same resource planned in 2010.

2.3 Open Cases

The CAMHS Framework planned for an open caseload of **4800 open cases** across the eight Tier 3 Community CAMHS teams, based on CAPA methodology and the agreed workforce model. As agreed at the time, the framework plans a CAMHS case holding capacity of 40 cases per clinical WTE.

In December 2010, there were **1707 open cases** in Community CAMHS across NHS GG&C.

By December 2017, this figure has increased to **4897 open cases**. This is an increase of 187% in open cases and highlights that there are 97 open cases more than what is planned and budgeted for in the CAMHS framework.

## 3. Improving the Access to CAMHS – Referrals

3.1 Accepted and Redirected Referrals

As stated above, there has been a significant increase in referrals both received and accepted over the last decade. NHS GG&C CAMHS operate to the Scottish Government definition of a Tier 3 Community CAMHS service (ISD CAMH Waiting Times Definitions Document) and the referral criteria has been agreed on this basis. Where a child or young person is not accepted to CAMHS, then the CAMHS team will signpost the child/young person and/or family to a more relevant organisation or resource.

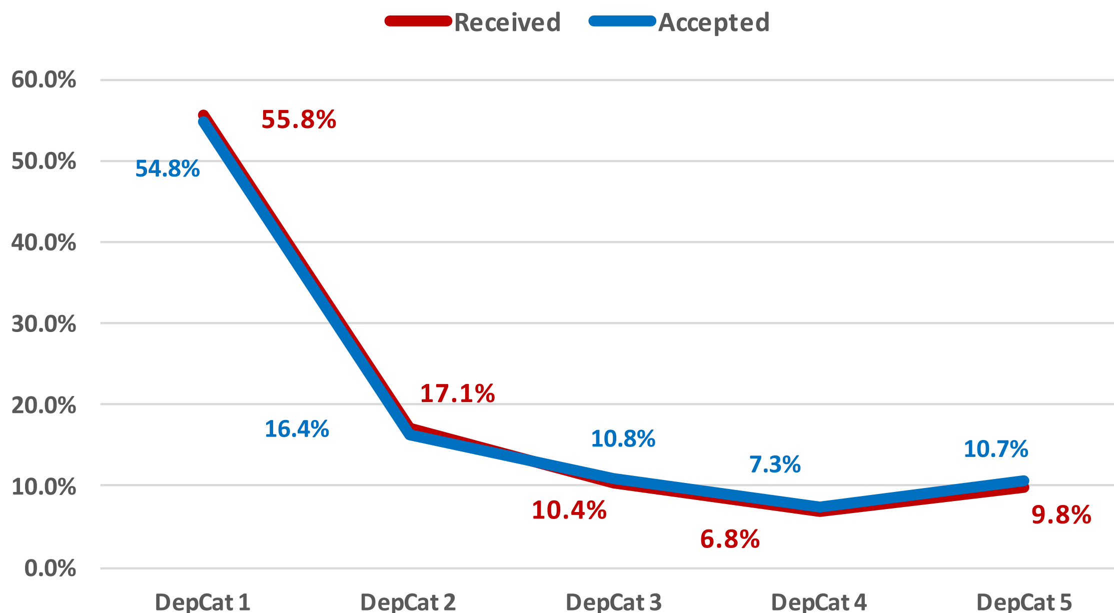
As of February 2018, the NHS GG&C CAMHS referral acceptance rate is at 73%. This compares well to the national UK average where the acceptance rate is also at 73% (2016/17), though is lower than the Scottish average of 79%. However, the Scottish figures include boards that include Tier 2 and Tier 4 services, so does not compare exactly to NHS GG&C.

Ongoing development work is underway to increase the understanding of which children and young people are not accepted to CAMHS and why a referral was made in the first instance. From a recent audit over several months across NHS GG&C, the following reasons were given for children and young people not being accepted into CAMHS.

| REJECTED REASON | | |
|---|---|---|
| Early stage MH problem with no other services previously involved | 15 | 3.9% |
| Mild MH problem - little impact on life | 21 | 5.5% |
| No MH problem | 153 | 40.3% |
| Would benefit from support from another service | 125 | 32.9% |
| Not enough information on referral | 37 | 9.7% |
| Outwith GGC catchment | 15 | 3.9% |
| Already open to CAMHS | 2 | 0.5% |
| Other | 12 | 3.2% |
| **TOTAL** | **380** | **100.0%** |

The majority of not accepted referrals were due to the CAMHS clinician assessing from the referral information, that the young person did not have a mental health problem and a further third being identified that they would benefit from another service, instead of CAMHS treatment.

Further to the reasons for not accepting, the vulnerability aspect has also been recorded and highlighted in the graph below.




Of all received referrals, 56% of those were from the most deprived areas across GG&C, whereas 55% of all accepted referrals were from these areas. This hints that there is a slight health inequality in accessing service, with the most vulnerable children being slightly less likely to be accepted. On the other side of the scale in Deprivation Category 5 (most affluent), slightly more young people who reside in the most affluent areas are being accepted across all accepted

referrals to CAMHS. It seems that more affluent young people are slightly more likely to be accepted to CAMHS. This is a concern within CAMHS, which is currently being discussed with action and improvement plans, as discussed in Section 4 of this report.

3.2 Referral Sources

In 2017, CAMHS in Glasgow City received 3901 referrals, with 2644 being accepted. These referrals are received from a variety of sources and the breakdown of these sources by referral status is shown in the table on the right.

| Referrals to CAMHS - 2017 | Received | Accepted | Rejected |
|---|---|---|---|
| Education | 9.8% | 9.9% | 9.6% |
| GP | 72.6% | 69.6% | 78.7% |
| NHS (outwith SCS) | 4.6% | 5.2% | 3.4% |
| NHS (within in SCS) | 8.0% | 9.9% | 4.2% |
| Social Services | 3.4% | 3.6% | 3.0% |
| Universal Children's Services | 0.6% | 0.5% | 0.7% |
| Voluntary Orgs | 0.4% | 0.5% | 0.2% |
| Other | 0.6% | 0.8% | 0.2% |
| **TOTAL** | **100.0%** | **100.0%** | **100.0%** |

Almost three-quarters of referrals are received from GPs with just under 10% coming from Education.

Proportionately less referrals are accepted from GPs and this statistics is being considered within the Neighbourhood Profiling work described in Section 4 of this paper.

## 4. Tackling Health Inequalities through Neighbourhood Profiling of CAMHS Data for Vulnerable Children and Young People

4.1 Overview

NHS GG&C Specialist Children's Services (SCS) Quality Improvement Team used NHS data to generate neighbourhood profiles. A neighbourhood profile maps data at a very local level, and demonstrates need and demand within areas. The SCS Neighbourhood Profiles show activity and performance data across the NHS GG&C Board area as well as at neighbourhood level. This shows activity in far more detail than previously possible, providing insights and more nuanced understanding of performance levels at local level based on locally available resource, targeted demand and on local population need,

Neighbourhood Profiles are being used to highlight population based trends, as well as supporting comparisons locally and relative to board wide benchmarks. This means managers can plan how resources are used in specific areas and also serves to highlight local inequalities.

As a result of this innovative data analysis, locally developed service improvement action plans have been designed by clinical teams and service managers. This has allowed clinicians to supplement neighbourhood profile data with their local knowledge, such as availability of resources, service issues and geographical issues. The plans are designed to reduce health inequalities by improving access to and the quality of services where issues have arisen at neighbourhood level that may have previously been missed in broader service wide data analysis.

4.2 Driver

Data modelling at this level of granularity and on this scale has not been used before in Children's Services in Scotland, and is beginning to provide some fascinating results.

Prior to the Specialist Children's Services Neighbourhood Profiles, data and analysis was only available on a team or Board wide basis. This provided a general overview of activity, but did not facilitate targeted service development initiatives. This also meant local inequalities could be hidden as data was reviewed at a larger geographical level.

Part of reducing health inequalities includes addressing levels of access to and use of services, including addressing the known link between deprivation levels and non-attendance. We have submitted data to the CAMHS National NHS Benchmarking Network, which has highlighted some inequalities. NHS GG&C are very close to the national average for most CAMHS benchmarking indicators, including waiting times, and referrals received and accepted. When comparing rates of missed appointments or Did Not Attends (DNA), however, NHS GG&C had the fourth highest in the UK in 2016. The neighbourhood profiles were developed to allow us to pinpoint areas with relatively high DNA rates and thereby help target interventions to improve access to services.

4.3 Innovative Use of Data

Traditionally, medical records have been stored on paper making population level analysis difficult, due to time required to collate, cleanse and address issues with missing or poor quality data. For the last four years, Specialist Children's Services have been working with EMISWeb, an electronic health record system. Yet data from this NHS Board wide system has until recently only been used for administrative purposes. We are now expanding this by investigating the analytical potential that electronic health records in an NHS Board with an under 18 population of 215,000 can provide.

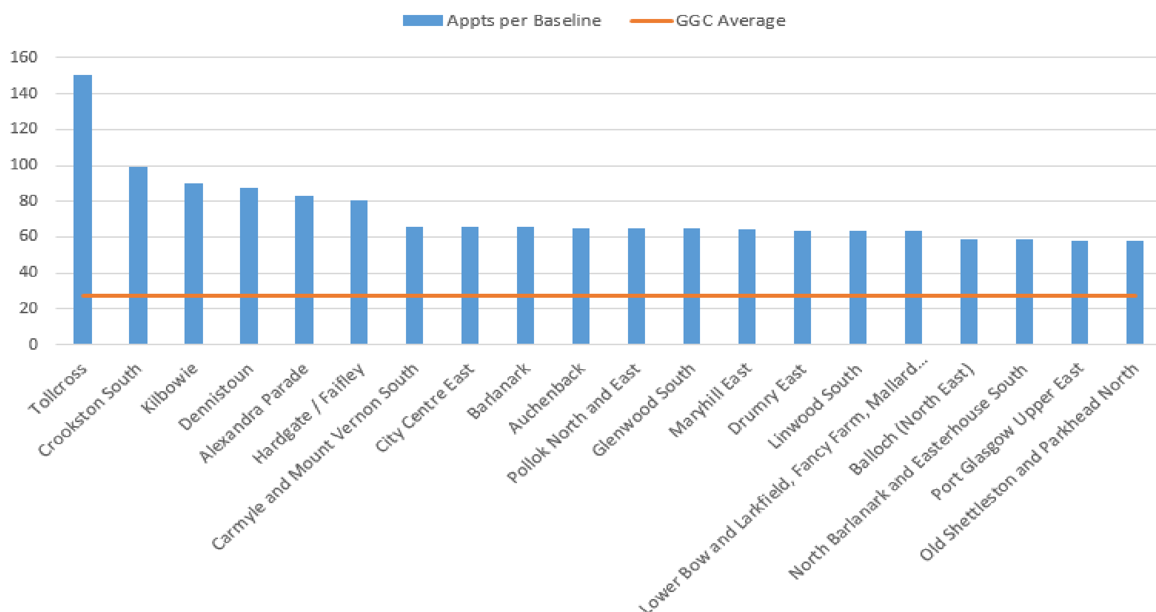
For this project, operational data was extracted from EMISWeb. Patient-level population-based analyses were undertaken on data variables including referrals, open cases, appointments and DNAs. The data extract included 60,000 data points. These were analytically linked to 273 neighbourhoods across Greater Glasgow and Clyde. Neighbourhoods were derived from intermediate zones, a statistical geography that sit between data zones and local authorities. Intermediate zones also represent a relatively stable geography that can be used to analyse change over time.

To uncover health inequalities through analytics, patient level data was linked to geographic and population data to help identify outlying areas of demand. This provided analysis of 'hot-spots' where activity was exceptionally high and 'cold-spots' where the same measures were particularly low.

Results are presented as a geomap to give an infographic for instant and simple understanding of where issues on activity, demand and population need are prevalent and vary. This allows improvement efforts to be targeted in the most relevant areas of local population need.

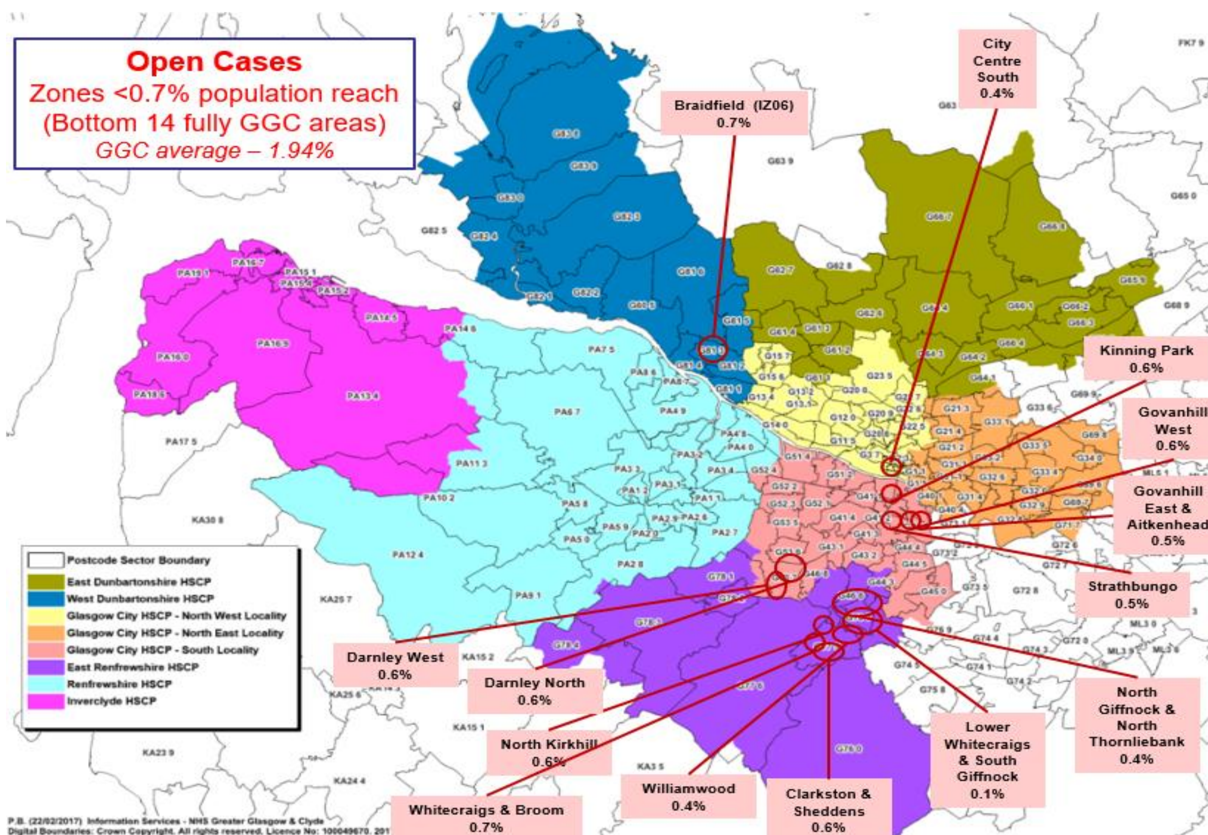
4.4 Value

Findings have been presented to senior staff within CAMHS and this has generated considerable interest and enthusiasm for using this analysis to inform local improvements. The findings are also being used to target neighbourhoods and children and young people who would benefit most from improvement projects. The anticipated benefits of this is to reduce health inequalities locally to support children, young people and their families to access an equitable and quality service regardless of where they live in the board area. An example of this is to increase the ability to access appointments by reducing missed appointments. Areas have been identified which have particularly high levels of missed appointments and plans have been discussed to obtain local clinical space in these areas. This is shown in the chart below. Some teams have noticed exceptionally high DNA rates in some of their neighbourhoods, which are both geographically distant from their most local clinics. An action is to consider the introduction of satellite clinics in these areas to assist with the ability to attend by




reducing travel time and costs for children and families. There are a range of action points which have a similar purpose and credibility which are being included in the action plans all with the view and benefit of reducing health inequalities for children, young people and families.

Other findings include areas of high vulnerability, particularly around Govanhill, that have very poor access rates to CAMHS with low numbers of referrals being received for these neighbourhoods. This is shown in the map of open cases, where highlighted areas represent the proportionately smaller caseloads across GG&C. Actions are being discussed with a view to increase the access by better engaging with these local populations, GPs and schools. These children not receiving the same level of service as many other GG&C areas, and the neighbourhood profiles have allowed us to identify this and develop actions plans.




Work is ongoing at the moment, using the CAMHS Neighbourhood Profiles to further increase the level of access to CAMHS and to help reduce any health inequalities found in areas of high vulnerability.

## 5. Recommendations

5.1 The IJB Performance Scrutiny Committee is asked to:

a) consider the levels of performance in balancing demand and capacity over recent years in relation to increasing the access to CAMHS; and

b) consider the approach used to highlight health inequalities at neighbourhood level as a method of identifying vulnerability.