1. About Oxford Health Foundation Trust (OHFT)

Oxford Health NHS Foundation Trust is a mental health and community trust providing services in Oxfordshire, Buckinghamshire, Bath and North East Somerset (BaNES), Swindon and Wiltshire. It relates to the Berkshire, Oxfordshire and Buckinghamshire (BOB) ICS and BaNES, Swindon and Wiltshire (BSW) CCG, which have an estimated under 18s population of 481,914.

The Trust provides a full range of Child and Adolescent Mental Health Services (CAMHS) across this footprint, with some variations based on local commissioning. Community CAMHS services are organised around the iThrive model, with Getting Help, Getting More Help, Outreach and Crisis Teams, as well as specialist eating disorders services and Neurodevelopmental Clinics. The trust provides Wave 1, Wave 2 and now also Wave 4 MHST teams.

Oxford Health is also the host of the Thames Valley Tier 4 Provider Collaborative, which provides inpatient psychiatric beds for young people in BOB, BSW and Gloucestershire from Willow House in Berkshire, Highfield Unit in Oxford, Marlborough House in Swindon and Huntercombe in Maidenhead. The Trust is also lead provider for 2 nationally commissioned regional forensic CAMHS teams (covering our Tier 3 catchment and wider areas: South Central (Thames Valley, Hants/IoW and Dorset) and South West (North) covering BSW, Gloucestershire and adjoining areas).

With regards to CAMHS inpatient services, OHFT provides:

- 12 general adolescent beds in Swindon, Wiltshire.
- 18 general adolescent beds in Oxford, with an additional 2 high dependency beds.
- 8 bed Psychiatric Intensive Care Unit (PICU) in Oxford, scheduled to open in 2021.

2. General reflections on the government’s progress in mental health

2a) Factors which are contributing to the increase in children’s mental health needs.

During this period children’s mental health needs have increased due to several contributing factors. These include:

- The recession
- The pandemic
- Cuts to universal services
- Cuts to social care and education
- Parental mental health and wellbeing deterioration

2b) Where need has increased the most

Increased need is highest for:
• Young people with eating disorders.
• Emergency presentations for self-harm or suicidal acts.
• Young people with Autistic Spectrum Conditions (ASC) and/or Learning Disabilities (LD) with complex mental health needs (often experiencing crisis).
• Young people who are in crisis due to residential educational and social care placements which have broken down (at least in part as a result of their mental health needs).
• Young people presenting with complex trauma especially the impact of sexual and physical harm, neglect, peer on peer abuse & domestic abuse.
• Children experiencing criminal and sexual exploitation.

2c) Additional investment into children’s mental health services is welcome but has often required working to rushed deadlines and has not provided additional funding to Core CAMHS to reflect the increase in demand.

• The Trust is forward-thinking and innovative, but there has been underfunding for some years across provision. Although the Five Year Forward View, NHS Longterm Plan / Mental Health Investment Standard have provided funding and opportunities for transformation, the full effect is yet to be established and has not addressed the gaps in core CAMHS services. We continue to transform and implement new services across the three CAMHS footprints, including Crisis Resolution and Home Treatment Services, In-Reach, LAC and enhanced community services for children and young people with eating disorders.

• We are now able to access more opportunities to increase funding (e.g. winter pressures funds, transformation funds, Community Services Framework) but funding is usually targeted at new posts/services rather than increasing core services which is where the main pressures are.

• Our transformation programmes are aligned to the CYP mental health key deliverables in the NHS Long-term Plan. Our ICS plans and local transformation plans go some way to address service provision, but they do not bridge the gap in funding required to provide core services.

• The impact of the initiatives from the Green Paper are very difficult to assess after a year of the pandemic due to the disruption to schools and the change in referrals (i.e. lower rates overall but a significant increase in crisis and acute presentations).

• New funding opportunities (such as the Community Services Framework) often involve a very rapid turnaround times for bids. This means that planning, engagement with staff, young people and their families and stakeholders cannot be accommodated in a meaningful way. This can have a detrimental effect in terms of engaging staff with new services and does not allow the co-production which the Trust aspires to.

• A number of initiatives are funded for short periods of time (e.g. the 4 week wait initiative in Oxfordshire and Buckinghamshire provides funding for 2 years which means that permanent staff cannot be recruited), therefore creating gaps in service from the secondments which are required to fill these roles. These frequently cannot be backfilled and cause uncertainty about long term planning. The timescales for knowing if funding will be extended have been so tight that service continuity has been impossible, and the services have had to resort to commissioning private provision such as Healios for CBT assessments, NDC assessments and Getting Help assessment and treatment, as this was the only possible use for this funding before it expired to gain the intended outcome.

• At the present time staff are exhausted due to the demands of the pandemic and managing more complex and more unwell young people in crisis. It is difficult to put the time and energy into service development in this context.
2d) The ability to identify suitable inpatient beds for children and young people continues to be an area of difficulty, with the system under a lot of pressure.

The national and regional bed capacity has been significantly depleted over the last 2 years, with no replacement provision planned. The Thames Valley footprint has lost the following capacity:

- 11 General Adolescent Unit beds – Priory Bristol
- 11 Psychiatric Intensive Care Unit beds – Priory Bristol
- 9 General Adolescent Unit beds – Willow House, BHFT (closure Qtr 1 2021/22)
- 12 Learning Disability and Autism beds – High Wycombe

The South of England has significantly lower numbers of beds per capita. There are no beds in the South for young people with moderate/severe ASC/LD. Our PICU, planned to be opened this year, will contain the first NHS PICU beds in the South.

Referrals for young people with complex eating disorders and ASC have significantly increased. The provider collaborative has reduced the inappropriate use of out of area beds by 74%, but waiting time for access to beds has increased due to bed closures.

- Additional provision is needed for complex Looked After Children.
- The need for more ASC / LD beds is acute.
- Additional social care provision is needed.
- Inpatient services need to have the capacity to support time-limited admissions – e.g. for 72 hours.
- Inpatient settings are having to manage more patients with increased eating disorder needs, requiring Naso-Gastric feeds.
- There is a gap in suitable inpatient provision for children and young people who present with disordered eating (often in conjunction with another difficulty such as an Autistic Spectrum Condition or emerging personality disorder) but do not meet the criteria for an eating disorder diagnosis. These young people do not meet the criteria for specialist eating disorders inpatient and outpatient units. This means they are admitted to / supported by General Adolescent Units and Community CAMHS services who lack expertise in supporting disordered eating. This issue continues when the young people transition to adult services. There is also a lack of evidence base in relation to treatment for these young people. Radically Open Dialectic Behaviour Therapy is used to treat adults (but not routinely in the UK), but the evidence base for young people is lacking, although pilot studies in OHFT suggest that it is a useful treatment for young people.
- Better integration with the acute sector is needed, with an understanding that some young people may benefit from short admissions to paediatric wards to manage e.g. eating disorders which avoids a tier 4 admission and the associated risks this brings. A national directive which sets out the expectations for the role of the acute sector in supporting children and young people’s mental health would be very helpful in addressing this issue.
- We are still waiting for the outcome of the medium-term funding bid but it is imperative that there is capital funding to increase the beds in the Thames Valley Provider Collaborative back to the original level prior to bed closures.
- The Thames Valley are running at 100% bed occupancy, so it is impossible to respond in a timely way to emergencies. This results in waiting times for beds increasing, with young people either putting strain on family relationships in the community or occupying paediatric beds.
- CQC inspections have precipitously closed beds due to poor quality. There needs to be a longer-term view about supporting hospitals. There have been no compliance visits by NHSE since the pandemic started. A lack of quality oversight has led to quality deteriorating more quickly. There needs to be better integration between NHSE and the CQC to maintain good practice and avoid deterioration in standards which precipitates closure.
- Private sector beds are opened at pace, but then quality issues mean they are also closed at pace. We need local provision, managed by NHS services.
• We have secured additional funding for day hospital for a 6-month pilot. This is likely to be helpful particularly for young people with eating disorders.
• Adolescent-friendly de-escalation / ligature reduced rooms within paediatric wards would be helpful. These could be used by young people who need to be calm (e.g. after an overdose) or who are waiting for a bed.
• More High Dependency Unit facilities are needed as they should only be used for 48-hour periods but are currently being used as Psychiatric Intensive Care Unit overspill.

2e) Stigma in relation to mental health remains

A lot of work has been done to promote awareness of mental health for young people, resulting in increased demand on services. However, stigma remains (including in services, such as amongst acute sector and social care colleagues). This is a barrier which stops people from accessing the help they need. There is also an expectation that mental health services are the only route to addressing mental health issues, rather than the support being jointly owned by social care, families, the voluntary and community sector and universal services.

2f) Transition continues to be a challenge

There are ongoing issues with transitions for young people. This is being addressed through the 16 – 25 work, but funding for this new pathway is at such an early stage that it is not yet possible to tell whether funding is sufficient or whether the planned transformations will have significant impact. Support tends to be low-level (e.g. from the Mental Health Academy) and some University mental health services are not linked to NHS services, causing fragmentation and discontinuity.

There is some feeling that the issue of difficult transitions is getting worse during the Covid pandemic. This is because mental health staff have been redeployed (reducing available resources in core adult mental health services) whilst acuity has increased (meaning that resources are disproportionately used for a small number of patients, leaving those with lower levels of need with a lower level of service.

There remain key differences between the support you can get in CAMHS and in Adult services. CAMHS services tend to be more systemic and work with schools, families and social care. The thresholds for admission to community and inpatient services are much higher for adults. Many young people have difficulties accessing IAPT services as they have to instigate the contact and their issues with social anxiety make this difficult for them. Early intervention / low level support provided by services such as the Mental Health Support Teams for children and young people do not have equivalents for the college-age population.

Young people also experience difficulties when transitioning from children to adult services in social care. Service provision is either insufficient to provide continuity, or thresholds are so high that it is impossible for some young people to access support.

In Oxfordshire, the CAMHS Partnership consists of several VCSE organisations integrated into the service provision which has positive outcomes for young people. However, it is challenged by differences in commissioning as CAMHS are commissioned to 18 but the VCSE organisations work with young people up to the age of 24.

2g) Eating disorder services are experiencing a lot of pressure

These services have been experiencing significant growth in demand without corresponding increases in capacity (and funding) for several years. This trend has continued and increased during the Covid pandemic due to a variety of issues including a lack of social contact, the increasing pressure from social media, anxiety about school and difficulties with parental mental health. Please see data section for more detail about increasing demand.
New investment is just beginning, so it is too early to see its impact. Additional investment has also been modelled to meet only pre-Covid growth in demand. There is also a concern that under-funding in Adult Eating Disorders Services means that young people who would benefit from continued treatment from an eating disorders service in adulthood may not meet criteria for these services. There is some funding for the First Episode Rapid Early Intervention for Eating Disorders (FREED) model across the country, but access to this funding is not universal. Young people who have already been in a CAMHS service do not meet the criteria for the FREED pathway.

There is a requirement to provide a specialist pathway for children and young people with Avoidant and Restrictive Food Intake Disorder (ARFID), but this is not possible to do without dedicated additional investment over and above the investment which has been provided to meet demand in eating disorder services. Young people with ARFID also experience a lack of commissioned pathway when they transition to adult services.

2h) Access to NHS-funded services is improving, but more needs to be done to make this meaningful

We have increased access to CAMHS through creating Single Points of Access (SPAs – these are small teams of administrators and clinicians who coordinate all incoming referrals into CAMHS) and delivering MHSTs, but this has led to an increase in demand (e.g. for NDC assessments).

- The current pressures since the pandemic of increased acuity has meant there is less resource available to treating children and young people who are not as acutely unwell.
- This demonstrates how increasing access needs to run alongside increasing the capacity of the service to meet the increased needs.
- The new access projects (such as the MHSTs) are increasing access to therapeutic training at a lower level, but neglecting the need to provide higher level interventions, such as family therapy or psychological therapy.
- Online referral and self-referral options have led to an increase in young people and families seeking help. A significant proportion of these referrals are signposted to other sources of support / self-help. Increased resources at this point of first contact would be helpful as there would be more capacity to support people to get the right support from the right place at the right time.
- Please see data section for evidence about how these initiatives have increased access.

2i) There are advantages and disadvantages to re-focusing the system to work more with early intervention in children and young people’s mental health, to prevent more serious illnesses from developing

- Whilst there are clear benefits from earlier intervention, there is a need to retain focus also on children and young people with more complex needs.

- We know that CAMHS services currently lack the resources to have a significant impact on some young people with more serious illness. Currently 50% of young people improve as a result of a mental health intervention (this is an international phenomenon). Some people deteriorate and some do not improve at all. This mirrors trends in adult services, but we need to innovate and improve treatments for this cohort.

2j) Tackling self-harm and suicide
There are more measures which we could be taking to tackle self-harm and suicide. However, trying to prevent suicide entirely is not possible as some suicides are unaccompanied by warning signs.

- Inconsistency of model for crisis services leads to variety and variability in provision, so support is different in different counties. This needs to be addressed.
- Social media is making the problem worse – for example, young people wanting to self-harm are connecting on SnapChat groups. This is difficult to monitor and control.
- Technology can be very helpful, e.g. the BlueICE self-help app. It is available when children and young people want to self-harm and provides instant access to a toolbox of self-help.
- Better links are needed between schools, parents, partners and services. Keeping children and young people safe needs to become everyone’s responsibility.
- It is getting easier to access drugs online. This is making it easier to overdose.

2k) There is a need for a dedicated workforce strategy for children and young people’s services

This is essential if CAMHS services are to increase in capacity, as recruitment and retention are an ongoing area of difficulty.

- There is still significant difficulty in recruiting child and adolescent psychiatrists, learning disability trained staff, CAMHS nursing staff both in inpatient settings and in the community.
- Particular difficulties are experienced in the recruitment of band 6 senior mental health practitioners, social workers, occupational therapists or nurses who can work in the community. There is also difficulty recruiting clinical psychologists and family therapists.
- Increases in medical school places have not yet increased doctor numbers and while there has been a campaign by the Royal College of Psychiatrists to “Choose Psychiatry”, it is too soon to see a significant increase in the number of consultants.
- As the number those qualifying for mental health officer status reduces it will be important to consider how to retain the workforce to work to increasing pension age, particularly considering the current level of acuity and workload which can lead to burnout.
- The opportunities for Nursing Assistant Training Schemes have reduced due to Covid and we have not been able to offer the mental health training in the same way as acute training opportunities. The programme also takes a longer time to become a qualified nurse compared to a standard nursing degree.
- Trainee and junior doctor placements need senior staff to provide supervision. With current workloads it is difficult to provide this without impacting services.
- It would be useful to develop dual paediatric / mental health nursing training. (e.g. a 4 year course with 3 year basic paediatric training).
- There are difficulties retaining staff due to pressure and the workload being too high. This was a problem prior to Covid. However, it is likely to be an increasing issue due to community staff often working digitally and separated from their teams due to inadequate buildings and the need for social distancing, as well as working with more unwell young people. Burnout is likely to be an increasing issue.
• The difficulty is perpetuated by the use of agency staff. Many have chosen not to work substantively as they are paid more. Pay caps are ineffective as rates are increased as agencies are aware that services are unable to run without the use of agency staff, particularly psychiatrists. Oxford Health has done a lot of work around recruitment and use of bank staff for inpatient units.

• Using companies such as Helios does not support retention as good staff going to work for private companies we are subcontracting work to our services. Private organisations offer flexible working outside of NHS T&C’s and higher rates of pay.

• There is a need for high-quality training for less highly specialised staff who are managing the front door into mental health services. There is some evidence from Scandinavia (adult services) that if you front load a service and have the first point of contact (SPA) staffed with highly qualified staff who do assessments you improve a wide variety of outcomes on topics such as duration of input / staff time / cost / social disability etc. This is a model which it would be helpful to consider in children’s mental health service.

• Service transformation and new services can lead to employees from core CAMHS moving to these new roles. This causes gaps to the core service and contributes to it being under pressure.

• The cost of living across our area (particularly in the South East) is high. Staff retention can be challenges by the availability of London allowances or the improved terms and conditions of private healthcare providers, as well as by their decision to move to other regions where the cost of living is lower and they can get a better quality of life on an NHS salary.

2) Best practice / innovation we are delivering

• Digital interventions

We are regularly using the following apps across CAMHS:

Sleepio app - NHS [www.nhs.uk]
Bluelice app - NHS [www.nhs.uk]
harmLESS | Oxford Health NHS Foundation TrustOxford Health NHS Foundation Trust

• The NDS service

We have dedicated teams providing high standard neurodevelopmental assessments and treatment which are consistent with NICE guidance. During the pandemic these teams have developed assessment tools and treatment protocols so that this work has continued. We have shared these developments with other areas who stopped this work during the first lockdown.

The teams are multidisciplinary with efficient use of skills for example Non-Medical Practitioners work with psychiatrists to maximise the number of young people seen and ensure appropriate high-quality care. The parent groups (educational, parenting, anxiety, challenging behaviours) have been developed so that they are delivered virtually and with videos that can be watched independently.

The service experiences pressure from the fact that demand frequently exceeds capacity. The service is often the only provision offering interventions for young people with non co-morbid NDS (for example, in Buckinghamshire there is a lack of Educational Psychology and Early Help provision for this group of children and young people).
• OSCA and Crisis DBT

The outreach and crisis teams have had to adapt to deal with increased frequency and complexity of presentations, alongside the current pandemic restrictions. This has included:

• Running Dialectical Behavioural Therapy (DBT) groups online, allowing high risk young people to continue to access this treatment
• We have placed a CAMHS crisis support worker within an acute general hospital, in order to facilitate closer working and allow rapid response to situations, alongside regular meetings between the crisis and paediatric leadership teams.

However, the out of hours offer is very thinly spread as one duty worker covers two counties.

• Use of MS Teams

Staff across CAMHS have adapted well to delivering digital interventions. Productivity has increased but the evaluation of digital interventions on the outcomes for patients is yet to be completed.

• Self-help material for parents

We have increased the range of self-help materials available to young people and their families. These are on our website and include anxiety, low mood and sleep advice and particular resources for parents of young people with neurodevelopmental disorders.

• Participation

We have a strong ethos of children and young people’s Participation Teams being involved in shaping services.

• Horizon and Forensic CAMHS (FCAMHS)

Our community FCAMHS provision provides an accessible and authoritative service for children with high risk behaviours whether in the youth justice system or elsewhere. The service model developed by the Trust within FCAMHS in the Thames Valley has been recently adopted and applied to the national development of FCAMHS provision and there are now 13 such services covering the whole of England. OHFT now provide two FCAMHS services. The OHFT FCAMHS team is now actively involved in consideration of further services for children with complex needs in line with the NHSE Health and Justice Long-Team Plan.

There has been a sustained doubling of referrals to the Horizon service (Supporting Children and Families after Sexual Harm). Most of these young people have also experienced other forms of trauma and adversity, especially domestic abuse, peer on peer abuse or other forms of child maltreatment. A substantial number are presenting with abuse experiences that have occurred during the pandemic.

Horizon aims to have a highly flexible approach to meet the complex needs of our patients in the way that works for them. We intentionally have no fixed criteria for offering consultative support to other professionals other than that sexual harm has occurred and offer advice to professionals worried about broader issues outside our consultation remit such as suspected sexual harm, perpetrators within the family, or childhood trauma.

We have worked hard to build capacity and confidence through extensive regular training to multiagency professionals through Oxfordshire Safeguarding Children’s Board, within CAMHS, to junior doctors. We recently introduced a new 2-hour complex trauma lecture into the first day of the Oxford medical student Brain and Behaviour course, which has generated multiple requests to visit our team for learning. We host visitor meetings around twice per month and adapt the pace and content of our discussions to maximise learning for visiting
professionals and students. We have recently trained staff in EMDR (eye movement desensitisation and reprocessing) so we can now offer four different types of psychological intervention, tailored to individual needs and increasing patient choice.

• **LAC posts and In-Reach Team**

There are an increasing number of highly complex young people presenting to mental health services who are either Looked After Children or are families at risk of breakdown. They often combine complex family situations with significant risky behaviours, are open to multiple services with complex webs of care and intensive resource to support. When their mental health difficulties are not best treated by an inpatient psychiatric provision, but they cannot return to their family or placement, there is a lack of non-inpatient provision that can support these young people. This often leads to placement out of county, breaking links with family and with services that have cared for these young people. Improving multi-agency provisions for these young people is vital. Resolving this would require commissioning of a new provision, with a radically different model of care to what is traditionally provided by social care, or within the Tier 4 CAMHS inpatient network. This work would be led by our colleagues in Children’s social care, but CAMHS and other agencies involvement would be vital.

These situations often place significant strain on relations between mental health services and social care providers-the lack of appropriate provision can create conflict over which inappropriate provision should be used- a social care placement with inadequate ability to manage risk or a tier 4 inpatient provision that may cause iatrogenic harm. This inhibits a collaborative approach which vital in these cases.

Our In-reach team offers consultation, liaison, advice, support and reflective practice for Families and Children’s Services professionals as well as interventions focused on complex trauma and attachment issues (where there is also a mental health or significant wellbeing need identified). The team is informed by the needs of the young person and their family rather than using strict access service criteria, using the terminology of the THRIVE Framework. This group of young people also receives considerable input from the FCAMHS teams.

Through consultation, screening and joint assessment the team will identify the most appropriate intervention. This could be:

- Supporting request for service to another CAMHS team better able to meet the CYPF need
- Information and advice
- Signposting with support to early help and community-based provision with close liaison with the community CAMHS SPA and Wiltshire Council Early Help Hub
- Shared assessment and planning as well as monitoring of risk
- Direct evidence-based interventions including family work or therapy
- Child and parenting assessments
- Group work, such as parenting groups
- Clinical thinking with the network (through complex case discussion or ‘thinking together’)
- Indirect work, which is when CAMHS professionals are part of the network and therefore attend Strategy, Child in Need and Child Protection meetings
- Training and skills development for local authority staff

3. **The impact of the Covid 19 pandemic on children and young people’s mental health**

It is important to note the significant impact that the pandemic has had on young people’s mental health.
3a) Reduced referral numbers but increased acuity. There have been fewer referrals for most disorders. However, there has been a significant increase in eating disorders referrals and these presentations tend to be at lower weights which increases the risk to physical health and the need for paediatric admission, as well as more entrenched illness and as a result a higher need for inpatient use.

3b) Increased need amongst children and young people with autistic spectrum conditions. We have seen a significant increase in young people presenting with autistic spectrum conditions and mental health disorders and/or challenging behaviour. This group of young people are particularly difficult to treat as a lot of the evidence-based treatments need modification for those who have ASC and the uncertainty and changes in routine has had a significant impact on their mental health and wellbeing. These young people are presenting with more extremes of behaviour and self-harm that under usual circumstances would cause significant anxiety amongst social care and acute sector colleagues, as well as in CAMHS. This is coupled with a lack of alternative provision such as respite care, social care or foster care placements.

3c) Increased anxiety due to change and unpredictability. i.e. loss of control and lack of predictability for the immediate future, loss of peer support contact, loss of daily routine/purpose, health anxiety for self and family, unpredictability regarding GCSE’s and A Levels leading to increased exam/future plans anxiety, less protection from/time away from unhealthy/unsafe family relationships or parents with deteriorating mental health.

3d) The advantages and disadvantages of more digital working by mental health services. Due to the significant change as a result of Covid to digital working this is harder to assess. Some young people have found digital working very helpful. The number of appointments not attended has reduced increasing productivity. However, there are concerns about the fact that young people may not be able to have a confidential appointment with their therapist as their parents or siblings may be able to overhear. Some young people are reluctant to be seen on camera and there are concerns that they cannot be properly assessed. Some need to be seen face to face but this brings its own difficulties due to social distancing and use of PPE which can affect the therapeutic relationship. Engaging young people with ASC and delivering Multi-Family Therapy has proved surprisingly successful.

4. Data supporting these conclusions

4a) Access target data

CAMHS Access: National Target

The National Access Target for CYP MH CAMHS is based on the national estimated number of CYP requiring an intervention for a diagnosable mental health condition. The purpose is to increase the number of CYP who access evidence-based MH interventions in line with the government target of 35% of CYP received support by 2020/21. Oxford Health is overperforming against the national target but this has implications for demand/capacity/waiting times.

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<tr>
<th>Region</th>
<th>% Access Rate</th>
<th>20/21 Target</th>
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<td>National</td>
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% Access Rate

NATIONAL SOUTHWEST SOUTHEAST BUCKS CAMHS OXON CAMHS BSW CAMHS

- % Access Rate
- 20/21 Target
Currently services are only funded for up to 35% of young people who need a service, but we are currently achieving 54% in some areas. (Please note data quality issues for BSW and Getting Help in Swindon is commissioned differently which is not captured in this report). This was for pre-Covid levels of mental health need. The estimate is that this has now increased to 1 in 6 young people having a mental health need.

The Access performance data highlights the increasing demand for CYP MH Services where an expectation has been set that only 35% of young people with mental health needs can access services. This is not ethical or equitable to meet the complex and distressing needs of young people. We are not funded for the over performance (cost pressures) and without funding we are not able to staff to appropriate levels to meet demand.

4b) Eating Disorders – increasing need data

BSW

During 2020/2021, the BSW CAMHS service has seen a significant increase in the number of young people presenting with an eating disorder compared to previous years. Compared to a 3-year average, the service saw an increase of 39% between April and December 2020. Referrals for eating disorders during and after the first national lockdown, between April and May 2020, were significantly lower than 2019, but quickly picked up in June. Between June and December, the service has experienced an increase of 69% when compared to the previous 3 years.

The data in BSW mirrors the national picture, which shows a 65% increase in eating disorder referrals in quarters 2 and 3 in 2020/21 (Figures 2 and 3).
BSW TEDS referrals by quarter - 2020/21 compared to a 3 year average (17/18 to 19/20)

Nationally completed ED pathways - 2020/21 compared to a 3 year average (17/18 to 19/20)

Oxfordshire and Buckinghamshire

Data from Oxfordshire and Buckinghamshire mirrors this pattern.

How do referrals compare to previous years?

The level of increasing demand is not reflected in the uplift applied to CYP MH services and block funding allocations, so waiting times will continue to increase.

As an organisation we are engaged with the national NHSE I CYP MH team on the CAMHS Waiting Time Standards programme, working on appropriate waiting times, tools to support patient tracking and standard rules to determine access and waiting times. There is huge variation across services nationally on how access, first appointment and waiting times are measured and recorded.

5. Reflections on the MHSTs

The table below shows the MHST provision by the Trust:

<table>
<thead>
<tr>
<th>Area</th>
<th>MHST Phase</th>
<th>No. of Teams</th>
<th>Investment per annum</th>
<th>No. of Schools</th>
<th>School Population</th>
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<td>Total Schools</td>
<td>Schools Breakdown</td>
<td>Population</td>
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<td>23 Secondary, 23 Primary and 3 colleges</td>
<td>24,266</td>
</tr>
</tbody>
</table>

5a) Advantages of MHSTs

- They have increased access to a CAMHS mental health intervention.
- Beginnings of some successful working partnerships with schools, able to increase teaching staff’s knowledge and awareness of some mental health difficulties.
- Improved pathway from those schools with an MHST into specialist CAMHS.
- In some areas we have seen improved partnerships across service agencies and positive workforce strategies across VSC and NHS organisations for employing support roles and trainees.

5b) Challenges to the MHST model

- They are not available in higher education / alternative provision, therefore missing a significant population who may be transitioning to adulthood / university.
- Whilst there may be a certain number of CYP who would benefit from early, low intensity work, many do not fit the limited criteria for this work. Therefore, many of the cases that come through to specialist CAMHS will not be picked up by the MHSTs and will still need more specialist, intensive care. This will always be the case.
- It has also been very difficult to build effective relationships with schools in some areas over the last year. This means that there has sometimes been difficulty getting appropriate referrals and allowing the MHSTs to deliver whole school approaches.
- The provision is currently only available in 25% of schools. This does not reflect the fact that 1 in 6 children and young people have a mental health problem. Greater coverage is needed.
- We cannot yet demonstrate the benefits in terms of lessening demand on specialist services – it’s too early to be able to evidence.
- The pandemic and school closure has been a challenge to good roll-out. Digital working is possible, but it has been a difficult context to operationalise this service within.
• The training is quite low level and does not cover self-harm or eating disorders. It is these young people who we would want to catch early to prevent them requiring a specialist CAMHS service.

• Oxford Health had already been running CAMHS services in schools with good results. These services had qualified CAMHS staff in post. The MHST practitioners, EWPs and MHPs do not have a core mental health qualification and have minimal training. It does not include training around self-harm or eating disorders, two key areas of need. Oxford Health has provided additional training for staff in our services, which has a knock-on effect on workloads, access and waiting times in other parts of the service.

• Attracting supervisors is extremely difficult. There are not enough experienced and qualified staff that we are able to access and attract to the roles of supervisors or those to send on the supervision training.

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1There is some evidence from the ‘open-dialogue’ approach (Seikkula et al 2011) which has been used in services in other parts of the world that ensuring a highly skilled workforce is more effective. The open-dialogue approach places an emphasis on (1) a highly trained universal workforce (2) first contact with professionals to be led by highly trained staff amongst and (3) other practice considerations. Reported evidence has since been reviewed and trialed elsewhere since but indications were that having more trained staff led to more effective services – in terms of costs (reduced input needed / less social costs) and better patient outcomes. Whilst used in adults, this approach holds clinical sense.