Impact and process evaluation of Forward Thinking Birmingham, the 0-25 Mental Health Service:

Final Report

November 2017

The Evaluation Research Team – University of Warwick and Birmingham CLAHRC-WM / GIFT Partnership Collaboration

The Evaluation partnership comprises leading academics and service evaluators from the Universities of Warwick and Birmingham and The GIFT (Great Involvement Future Thinking) Partnership. CLAHRC-WM has a number of PPI advisors attached to the mental health theme through the CLAHRC-WM voices network http://www.clahrc---wm.nihr.ac.uk/ppi/patient-public-involvement.html). GIFT Partnership works on a co-production basis with a team of around 6 young national sessional workers, experienced in research and evaluation in the mental health field as well as links into many other service user groups and projects pioneering new ways of working with children and young people with mental health problems.

The evaluation team includes**:**

Professor Max Birchwood: holds the chair of youth mental health at the University of Warwick and leads the youth mental health theme of CLAHRC-WM. He leads the NIHR national evaluation of early intervention in psychosis services and works with NHS England to operationalize the new national waiting time standards for early psychosis services and children's IAPT. He is the principal academic advisor to the BIG Lottery for the HeadStart 10-16 resilience and mental health programme (£75M). He has sat on various NICE guideline development and quality standard committees.

Dr Cathy Street: co-founder of GIFT, commissioned by NHS England 2012-2015 to support participation of children and young people in CYP IAPT. Cathy has held senior research posts at the National Children's Bureau, Rethink Mental Illness, YoungMinds and Mental Health Foundation and is known nationally for her work on embedding Patient and Public Involvement (PPI) in mental health research. She has acted as an advisor to DH, NICE, NIHR and SCIE, was a member of the CYP Mental Health Taskforce that produced *Future in Minds* and has led many CAMHS capacity building projects, service evaluations and health service reviews commissioned by government departments, CCGs and local authorities.

Professor Swaran Singh: is Head of the Division of Mental Health and Wellbeing at Warwick University, consultant psychiatrist, and a Commissioner for the Equality and Human Rights Commission. He set up the first NHS funded early intervention in psychosis service in London in 2001, led the TRACK study, the first ever prospective study of transition from CAMHS to AMHS and currently leads a €6 million EU project on improving transitional care across Europe. He chairs the NICE Guidance Development Group on paediatric to adult transition. He led the NIHR ENRICH study on pathways to care among BME groups in Birmingham and the DH funded AMEND study on the impact of the 2007 amendments to the Mental Health Act 1983. As a Commissioner at EHRC, he leads the commission's work on Disability and Mental Health.

Dr Clare Lamb: external advisor to the evaluation team, Clare worked as a Consultant Child & Adolescent Psychiatrist with the North Wales Adolescent Service and led an intensive community support team that provides a Tier 4 CAMHS alternative to hospital admission for 12 to 18 year olds from across North Wales. Clare also established the Wirral 16-19 team, a generic community youth mental health team that bridged and worked jointly with child and adult services. She has published policy guidance on workforce and capacity for CAMHS, and has written on alternatives to admission for children and young people and on models of youth mental health service at the transition from CAMHS to Adult Services.

Dr Yvonne Anderson: is a co-founder of GIFT. Yvonne previously held a senior position at HASCAS where she developed many tools to support capacity building in the CAMHS workforce, including producing an annotated bibliography to support best practice in working with young people in transition. Yvonne has worked on a wide variety of mental health service improvement and transformation projects exploring innovation in providing services for young people including developing an App to assist young people in care and care leavers to take care

decisions (Mind of My Own/MOMO).Yvonne was a member of the CYP Mental Health Taskforce that produced *Future in Mind*, working, in particular, on the sections of the report that concern provision for vulnerable groups.

Dr Fiona Warner-Gale: is a co-founder of GIFT. She has worked in the public sector and within academic institutions, as a clinician, service manager, joint commissioner, educator, author and academic. She offers expertise in service improvement and redesign and has specific research and development expertise in the stigma related to mental health in children and young people. She designed a whole systems change approach to tackling stigma across individuals, families and communities, as well as managing and delivering a large scale national evaluation programme. In this capacity, Fiona was appointed to sit on the Executive Board of the Time to Change Programme at Rethink Mental Illness.

Jane Sedgewick: is a co-founder of GIFT. Prior to GIFT, Jane was a Regional Development Worker (RDW) for the National CAMHS Support Service (NCSS) and a project manager for CAMHS workforce development. Jane's work within the public sector, both nationally and regionally, spans planning, commissioning and the management of change within complex environments, including training and consultancy on benchmarking health service transformation activities and training on leadership within health systems.

Dr Andrew Thompson: Associate Clinical Professor in Psychiatry at the University of Warwick and Consultant Psychiatrist in Coventry and Warwickshire Partnership Trust. With a background in implementation science and extensive clinical experience in youth mental health, Andrew's research is within the field of major mental illness, including risk factors and interventions for emerging psychotic disorders and other risk states for major mental illness in young people. Previously he worked at the internationally renowned Orygen Youth Health in Melbourne where he was Associate Medical Director and Senior Research Fellow and he was also involved in the introduction of a new Youth Mental Health Service in Sussex.

Dr Rachel Upthegrove: is a Clinical Senior Lecturer in Psychiatry at the University of Birmingham and Consultant Psychiatrist. Her research is within the field of major mental illness, publishing significant papers on the outcomes of first episode psychosis, affective disorder, self harm and suicide. Clinically she has worked for over 17 years in psychiatry, for 10 years within the field of Early Intervention in Psychosis and Youth Mental Health. She is active in teaching and training, including MBChB, and the neurobiology of mental illness and academic psychiatry.

Notes

1. All funding for this research is being absorbed by the external organisations leading the evaluation – the University of Warwick and the GIFT Partnership. FTB staff receive no financial benefit for working on the project.
2. The service outcomes data are quantitative and generated by the FTB clinical teams using standard service measures, reported using appropriate objective analytical techniques.
3. Since this a service evaluation, no interventions or variables are being compared or manipulated – the evaluation is reporting on the 'business as usual' outcomes and impact of services; full scientific rigour has being applied.
4. The evaluation was procured and funded by the Birmingham Clinical Commissioners responsible for commissioning the FTB service, through a competitive tender. Professor Birchwood and Dr Street were interviewed on behalf of the evaluation partnership.

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Executive Summary

Overview

This report provides the findings of a year-long evaluation of Forward Thinking Birmingham (FTB) which started just after the service went live in October 2015. Undertaken by a team from the University of Warwick and the GIFT Partnership, the purpose of the evaluation was to understand how the changes to mental health service provision for children and young people aged 0-25 and their parents and carers outlined in the new FTB model impact on key stakeholders across a range of service settings and types. The aim was to generate learning about the new model as to whether it worked/was achieving its specified objectives, what was perhaps less successful and needed amendment or further development. The evaluation would also provide an opportunity to think about the future development of the service in order to ensure a robust and sustainable model of provision.

The evaluation was comprised of three interrelated elements, a partnerships/engagement evaluation, an input evaluation and an impact evaluation. A mixed methods methodology has examined the overall evolution and impact of the new service model from the early roll-out and implementation stages capturing key individual stakeholder and organisational staff experiences of engagement, impact and response from both service user/carer and service provider perspectives. Both quantitative and qualitative data have been collected with research ethics committee approval being granted by the University of Warwick Biomedical and Scientific Research Ethics Sub-Committee on 21st December 2016 (REGO-2016-1871).

The context within which Forward Thinking Birmingam (FTB) was mobilized

The 'Case for Change' report, developed by the Birmingham Adult Joint Commissioning Team and the Maternity, CYP Commissioning Team in November 2013 can be seen in many ways as a key starting point for the development of the FTB model. This document noted that in Birmingham there were clear issues within the current system of care. These included a lack of seamless provision for 16-18 year olds and none existence of ASD services, high waiting lists for condition specific services for 16-18 year olds such as ADHD (in October 2013, noted to be 6 months) and high DNA rates amongst 16-18 year olds which were thought to indicate poor patient experience.

Other concerns included CAMHS and Community Paediatricians continuing to hold cases post 16 years to ensure continued medication of complex cases, an increase in inappropriate inpatient admissions within Birmingham for under 18s to mainstream adult acute beds despite having a dedicated Home Treatment service, poor patient experience and outcomes and dissatisfaction within referring agencies i.e. primary care, with senior CCGs managers being alerted as to the lack of provision, in particular for 16-18 year-olds.

The *Case for* Change document goes on to note that Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) had been involved in a CLARHC trial with Birmingham University. This had demonstrated that the transition between child/adolescent services and adult services at 16-18 years was a major weakness in service provision; many young people were described as getting 'lost in transition' at the very point where the age incidence of mental in health problems increases and that many young people up to 25 were not engaging in adult services. It was argued that the commissioning of a mental health service for 0-25s was a key way to address these problems.

At the time of winning the tender to provide mental health services for children and young people aged 0-25, Forward Thinking Birmingham (FTB) was one of first UK service providers to meet the challenge raised by *Future in Mind* (DH & NHS England 2015), the Chief Medical

Officer 2015 annual report and the Health Committee House of Commons 2014/15 report on CAMHS services: to develop an early intervention approach to young people's mental health services which will improve early detection, service access and engagement. In its service specification, FTB set out to achieve a whole system change across the array of mental health services currently provided to children and young people from 0-25 years alongside their parents and carers, with an emphasis on partnership working, integrated specialist approaches and the delivery of a wide range of evidence based treatment options with emphasis on solution-focused approaches.

As a new service model, not surprisingly, the initial development, impact and outcomes of FTB attracted national and international interest as new ways are sought to improve transitions and ways of working across health and social care domains for young people, their carers and the staff that support them. Furthermore, the development and mobilization of the model has come at a time of high level interest, or rather, serious concern, about the provision of UK mental health services for children and young people, with high media coverage about budget deficits and significant geographic clinical commissioning group (CCG) spending variations, service cuts and problems accessing appropriate inpatient care. Major problems with recruitment, retention and staff shortages have been highlighted by, amongst others, the Royal College of Psychiatry and a national review by the Care Quality Council (CQC) has been called. Undoubtedly all of these have had an impact in some form or another on the mobilization and development of the FTB model.

Data collected

The evaluation team collected service activity data from FTB for the period 1st April 2015 – 30th June 2017 and this is presented in Chapter 4 of the report. Unfortunately a significant amount of missing data, including individual clinical outcomes data, limited the amount of analysis that was possible. However, what these data clearly indicate is that FTB experienced a high level of demand in its first year of operation.

With regard to stakeholder perspectives on the mobilization and early implementation of FTB, a wealth of qualitative information was generated via 53 individual baseline interviews, 10 focus groups run at two timepoints with 85 participants and interviews and 3 focus groups with 27 children and young people and 3 parents and carers from seven different settings. Follow-up interviews with a number of those interviewed at baseline and additionally 3 GPs and 4 representatives from two of Birmingham's universities, added to these data.

Additionally, alongside the main evaluation a smaller qualitative study of the commissioning and procurement process was undertaken within the NIHR CLAHRC-West Midlands research programme as part of the 'added value' provided by the evaluation team. A summary is included in Chapter 2 since the learning from this study is highly relevant to the input strand of the evaluation of FTB. Data included 29 interviews with informants in all involved CCGs, Birmingham City Council, Forward Thinking Birmingham and BSMHFT; observations of 10 meetings and workshops; extensive archival data analysis.

Issues raised through the evaluation

Strong support for the model was evident from the outset of the evaluation, in particular, the extended age range and the integration of practitioners for children and young people's mental health services and those from adult mental health services in the community hubs. The ideas for partnership working with the VCS, the provision offered by PAUSE and the referral process via the Access centre were also welcomed.

Findings from the interviews and focus groups indicated that overall, the FTB model was seen to be improving access to mental health services for all age groups via the PAUSE and Access

centre elements of the model. What, however, was much less clear was what happening for those requiring input from the community hubs and running through both the baseline interviews and then the various rounds of interviews and focus groups, a range of issues emerged which included:

> Concerns about the level of FTB staffing and skill mix, also recruitment and retention issues. In particular, shortages of medical staff were highlighted as well as high use of locums/agency staff. Staff were worried about the impact on continuity of care (with young people noting adverse experiences of repeated changes of staff, leading to delays and also a sense of being 'passed round' the system).

> Questions about the capacity of the service to meet demand, with concerns about long waiting times, delays in the pathway after referral to the Access centre and staff disquiet about the implementation of CAPA and caseloads that were seen as increasingly unmanageable (and jeopardizing the ability to intervene early).

> Widespread views, especially from VCS interviewees, that the intended partnership working with FTB was not happening, that there had been only very limited commissioning of this sector and a general sense of these providers being left out of any planning decisions to develop the service. A missed opportunity to draw on high levels of skills and expertise in working with young people was also voiced.

> Inadequate and incompatible data management systems which were impeding information sharing across the model.

> Poor service infrastructure including the availability of space and essential equipment and also the provision of age-appropriate environments for both young children and older adolescents/young adults using FTB.

These and other issues are described in detail in chapters 3, 5, 6 and 7 of the report.

Key recommendations

Chapter 9 sets out a range of detailed recommendations for FTB to consider in building on the successes from the first year of operation alongside addressing the concerns raised. These cover amendments we suggest are needed to **the FTB model overall**, most crucially, to ensure that the 'front doors'/referral entry points are fully aligned with all parts of the service to ensure patient flow, avoid blockages and facilitate timely access to mental health assessment and both low level and higher level interventions, treatment and care.

Other recommendations concern **the FTB Partnership, the implementation of CAPA, 'intelligent' caseload management, building the FTB workforce and leadership.** Getting these right will be crucial to the FTB model surviving in the future.

VCS participants in the evaluation focus groups put forward a series of recommendations for how FTB should develop its **partnership working**. Some of their proposals include: ensuring FTB establishes a data system that is compatible across all relevant agencies; that a protocol for information sharing is needed; that FTB should put in place named person arrangements for the management of referrals into FTB and that a programme of training and CPD opportunities must be developed that take in the FTB core workforce and its VCS partners.

Finally we set out a number of recommendations for addressing the **deficits in data and information recording systems and the infrastructure problems** that were prominent themes in the evaluation interviews and focus groups, the impact of which was clear to see in the high level of missing activity and outcomes data FTB supplied to the evaluators.

Chapter One: Background, aims and methodology

1.1 The national context

Mental health problems can start at an early age and many persist into adult life unless properly treated. It is known that 50% of lifetime mental disorders (except dementia) first appear by age 14 [2] yet the majority of this emerging illness is not appropriately identified or effectively treated at the time [3], with young people's access to mental health services the poorest of all age groups [4] and national referral rates to child and adolescent mental health services rising[5]. This situation of delayed treatment opportunities at the point where interventions could be most effective [6,7] is associated with subsequent lower quality of life; educational outcomes, employment, social life, and health related outcomes [8].

There is growing evidence that a variety of interventions are effective both clinically and financially even if current statutory service provision has been described as '..manifestly inadequate for the unique developmental and cultural needs of young people'.[4] Converging evidence suggests that youth mental health should be prioritised for investment to improve the longer-term health outcomes of the population but there is a current lack of consensus as to the most appropriate models of service provision.

Published by the Department of Health in January 2014, "*Closing the gap: priorities for essential change in mental health*" set out the task of transforming the support available for children and adults with mental health problems.[1] It identified specific areas within mental health services, which are now the focus of change and improvement. These included: access to services; access to psychological therapies for children, young people and young adults; support for new mothers (under 25); the relationship between mental health services and schools; and transition to adult services. Later that year, the Children and Young People's Mental Health Taskforce was established to look at how to improve the organization, commissioning and provision of mental health services for this age group, culminating the following year with the DH/NHS England Report *Future in Mind. Promoting, protecting and improving our children and young people's mental health and wellbeing* (2015).

The proposals within *Future in Mind* can be seen as highly significant in promoting service change and the development of models such as Forward Thinking Birmingham (FTB). For example, these include: early intervention; developing a system without tiers; developing integrated service delivery (with all services working together so that young people only have to 'tell their story once'); single points of access; improving transitional care and where the important role of voluntary and community sector (VCS) partners is a key theme.

Crucially, following publication of the report in March 2015, the Government announced £1.25b of new funding, to be spent over 5 years, to drive forward service transformation and improvement.

The following year, in February 2016, The *Five Year Forward View for Mental Health,* the report from the independent Mental Health Taskforce to the NHS and commissioned by Simon Stevenson was published. Whilst focused on all ages and with an emphasis on life course and addressing inequality and parity of esteem between mental and physical health, this document can also be seen as highly relevant to FTB in that it re-emphasises the importance of prevention and reassert the commitments of *Future in Mind:*

"Children and young people are a priority group for mental health promotion and prevention, and we are calling for the Future in Mind recommendations to be implemented in full. Early intervention and quick access to good quality care is vital…. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting…. This will require a fundamental change in the way services are commissioned…."

1.2 The Birmingham context: demographics and diversity

It is estimated that 420,938 people aged 0-25 live in Birmingham. This was projected to increase by 6% to 445,513 by 2016, and by 8% to 453,373 people by 2021[9]. The prevalence of mental disorder is similarly expected to rise with a 2010 CAMHS needs assessment undertaken in Birmingham by Public Health Action Support Team highlighting that growth is to be expected across the majority of the mental health spectrum from 2011 to 2021. Some of the projected increases are;

- ➢ Emotional conduct and hyper-kinetic increase by 20%
- ➢ Depression increase 16%
- ➢ Eating Disorders increase 19%
- ➢ ASD increase 20%
- ➢ Learning Disabilities increase 11%.

Over 187 different nationalities live in Birmingham. In general, people from black and minority ethnic groups living in the UK are more likely to: be diagnosed with mental health problems; be diagnosed and admitted to hospital; experience a poor outcome from treatment; and disengage from mainstream mental health services. In Birmingham, a longstanding concern is that BME young people are under-represented in the population coming into mental health services for low-level problems and over-represented amongst those coming in with acute/crisis level presentations. As well as deterioration in their mental health, young people in these groups are likely to experience social exclusion and impaired functioning[11]. Consultation with users suggests each ethnic group may be affected by specific barriers to access, either due to the prevalent family structure, cultural norms and stigma on mental ill-health and level of knowledge of English.[12]

Alongside this, Birmingham is significantly poorer than the national average for 'hospital admissions for mental health conditions' and 'hospital stays for self-harm'[10]. Accordingly, it is vital that we develop understanding of how reforms to mental health services incorporated into the FTB Model in Birmingham will impact on the city.

1.3 The Case for Change: Commissioning a 0-25 year old mental health service across Birmingham

This document, developed by the Birmingham Adult Joint Commissioning Team and the Maternity, CYP Commissioning Team in November 2013 sets as its object

"*to improve the transitions for young people when moving between CAMHS and AMHS, ensuring that all young people with mental health issues have every opportunity to continue in education, training and employment, so they have a life that is not defined or limited unnecessarily by their condition*".

It goes on to note that in Birmingham there were clear issues within the current system of care and that these included:

- ➢ A lack of seamless provision for 16-18 year olds and none existence of ASD services.

- ➢ High waiting lists for condition specific services for 16-18 year olds such as ADHD (in October 2013, noted to be 6 months).

- ➢ High DNA rates amongst 16-18 year olds with mapping noted to demonstrate several drop out points within the pathway thought to indicate poor patient experience.

- CAMHS and Community Paediatricians continuing to hold cases post 16 years to ensure continued medication of complex cases. To try and manage a backlog of such cases, some joint CAMHS and BSMHFT YSS services had been put in place but with no recurrent funding, were expected to cease in April 2014.

- An increase in inappropriate inpatient admissions within Birmingham for under 18s to mainstream adult acute beds despite having a dedicated Home Treatment service.

- Poor patient experience and outcomes.

- Dissatisfaction within referring agencies i.e. primary care, with senior CCGs managers being alerted as to the lack of provision, in particular for 16-18 year-olds.

The *Case for* Change document goes on to note that Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) had been involved in a CLARHC trial with Birmingham University. This had demonstrated that the transition between child/adolescent services and adult services at 16-18 years was a major weakness in service provision; many young people were described as getting 'lost in transition' at the very point where the age incidence of mental in health problems increases and that many young people up to 25 were not engaging in adult services. It was argued that the commissioning of a mental health service for 0-25s was a key way to address these problems and had the potential to deliver the following outcomes:

Patient

- Timely access and better engagement of service users; reduced DNA's as youth focussed

- Holistic provision…"You've come to the Right place"…all services under one pathway

- Reduction of (inappropriate) presentations at A&E for young people in distress

- Improved experience and satisfaction of users, families and referrers, with less stigma involved in using services and less burden and impact on families

- Reduced requirement for secondary care

- Reduces impact of mental illness on society, with increased life opportunities for young people / adults with mental ill health including increase in young people remaining in education, training and employment and as a result, decreases in worklessness and presentations to criminal justice as a result of poorly managed / untreated mental ill health

- Reduction of tragic events including suicide and serious self-harm as a result of poorly managed / untreated mental ill health.

System

- Reduction of (inappropriate) presentations at A&E for young people in distress

- Capacity to meet demand, increased flow through system

- Improved interface between primary/secondary care, via shared care protocols where indicated e.g. ADHD

- ➤ Long term reduction in adults requiring specialist mental health services

- ➤ Reduction in unnecessary prescriptions

- ➤ More recovery, integration and join up across strategies such as early help and intervention – wider economic gains for society

- ➤ Focus on the most vulnerable e.g. children in care meaning that financial resources directed to most appropriate need.

1.4 Reports by Mental Health Strategies and by West Midlands Academic Health Science Network

In 2017, two reports were presented to Birmingham Mental Health System Strategy Board which set out a range of issues concerning Birmingham's services for children and young people requiring help with their emotional health and wellbeing. The report by Mental Health Strategies, whose scope did not include services for those aged under 18, presents the findings of a simulation modelling for mental health services in Birmingham and Solihull which are of obvious relevance to FT in terms of its age range going up to 25. This document notes the following local concerns:

- ➤ A surge in demand, particularly for younger adults' services

- ➤ An increase in the numbers of local people being placed outside of area

- ➤ The expectation that new standards in access to acute services will be met in 2017

- ➤ A rise in delayed transfers of care.

Key questions, which it was hoped the modeling would answer, included, amongst others: how many inpatient beds should be commissioned/provided; the size, role and function of crisis and home treatment services and the community mental health teams (CMHTs); the size, role and function of alternatives to inpatient provision including step-down care. The impact of moving to personal health budgets, integrated personal commissioning and Individual Placement Support (IPS).

Getting it right, first time. Prevention of Mental Illness was produced by the West Midlands Academic Health Science Network in April 2017 with the support of FTB and an aim of assessing prevention priorities for Birmingham, Solihull and potentially the region and to set out next steps. Calling for the Mental Health System Strategy Board to support a 'proof of concept' programme, the proposed strategic approach is described as follows:

"This will encompass the Forward Thinking Birmingham (FTB) and Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) models, and involve partners across health and social care, education and policing….. it will collaborate with community resources to provide low-stigma, engaging support from within a community setting, and build on current partnerships for training and interventions within school settings."

In terms of prevention, the report notes the following as key recommended areas to develop or be further built on:

- ➤ Early years – perinatal, parent & child, attachment and school readiness.

- ➤ Work with schools/education to identify vulnerabilities and risk markers for mental illness and build preventative resilience and wellbeing practices in a whole school ethos.

- ➢ Use of digital and social media tools across universal community services and groups to raise awareness, promote self-help and resilience building, reduce stigma and encourage sharing of best practice.

- ➢ Establish integrated partnership approaches including development of a youth mental health service focused on prevention, education and early identification.

The report also calls for the development of a robust bespoke professional and engaging training programme to build a common understanding of the importance of prevention and early intervention:

"*Having a collective understanding of the importance and potential of a prevention of mental illness model is a prerequisite for a shared vision and good quality inter-agency working.*"

1.5 The Service Specification and the FTB model.

At the time of winning the tender to provide mental health services for children and young people aged 0-25, Forward Thinking Birmingham (FTB) was one of first UK service providers to meet the challenge raised by *Future in Mind* report (DH&NHS England 2015), the Chief medical Officer 2015 Annual Report MO's report and the Health Committee House of Commons 2014/15 report on CAMHS services: to develop an early intervention approach to young people's mental health services which will improve early detection, service access and engagement.

In its service specification, FTB sets out to achieve a whole system change across the array of mental health services currently provided to children and young people from 0-25 years alongside their parents and carers. High level aims of the service include:

- ➢ Understanding the risk factors that may lead to potential mental health problems and mitigate these through effective early intervention and promotion of wellbeing at all ages.

- ➢ Developing a specialist integrated approach: joint working and direct work within an integrated collaboration of organisations (community, voluntary sector, private and public provision).

- ➢ Working in partnership with and building front line capacity with emphasis on enablement, empowerment and education, thereby ensuring that fewer children and young people have a need for long-term mental health services.

- ➢ Delivering a wide range of evidence based treatment options with emphasis on solution-focused approaches.

- ➢ Recognising that working with primary care will form the basis of therapeutic and recovery options.

- ➢ Offering community services for 0-25 year olds and inpatient services for 18+ yr olds.

As a new service model, not surprisingly, the initial development, impact and outcomes of FTB have been of national and international interest as new ways are sought to improve transitions and ways of working across health and social care domains for young people, their carers and the staff that support them. Furthermore, the development and mobilization of the model has come at a time of high level interest, or rather, serious concern, about the provision of UK mental health services for children and young people:

- There has been high media coverage about budget deficits and significant geographic clinical commissioning group (CCG) spending variations, service cuts and problems accessing appropriate inpatient care.

- Major problems with recruitment, retention and staff shortages have been highlighted by, amongst others, the relevant Royal Colleges (in particular with regard to nurses and psychiatry).

- The Children's Commissioner for England has been highly active in raising concerns about children and young people's mental health with the Government, including providing a briefing in October 2017 highlighting ongoing problems with children's mental health needs going unaddressed, that NHS spending on mental health is still overwhelmingly going on those at the most severe end and that the discrepancy between spending on children's and adult's mental health persists.

- A national review by the Care Quality Council (CQC) has been called, and a joint DH and DfE Green Paper on children and young people's mental health is expected by the end of 2017.

Undoubtedly all of the above have had an impact in some form or another on the mobilization and development of the FTB model.

1.6 Purpose of the evaluation

The purpose of this service evaluation is to understand how the changes to mental health service provision for children and young people aged 0-25 and their parents and carers outlined in the new FTB model impact on key stakeholders across a range of service setting and types. From the outset, the aim was to generate learning about the new model as to whether it worked/was achieving its specified objectives (e.g. address the issues of concern outlined in the *Case for Change* document), what was perhaps less successful and needed amendment or further development. This would also provide an opportunity to think about the future development of the service in order to ensure a robust and sustainable model of provision.

The evaluation comprises three interrelated elements, a partnerships/engagement evaluation, an input evaluation and an impact evaluation. A mixed methods evaluation methodology has been used to examine the overall evolution and impact of the new service model from the early roll-out and implementation stages alongside key individual stakeholder and organisational staff experiences of engagement, impact and response from both service user/carer and service provider perspectives. Both quantitative and qualitative data have been collected and as much as possible, the evaluation aimed to complement other elements of service evaluation currently in progress. Research ethics committee approval was granted by the University of Warwick Biomedical and Scientific Research Ethics Sub-Committee on 21st December 2016 (REGO-2016-1871) and in line with this, a detailed protocol was developed which all aspects of the data gathering for the evaluation adhered to. These included requirements for the issuing of information/invitation letters and consent forms for participants in the evaluation, the collection and analysis of patient outcomes and service activity data and the recording, storage and anonymised reporting of confidential and sensitive data.

1.6.1 Partnerships and input evaluation

This arm of the evaluation has involved a mainly qualitative methodology based on individual interviews (both face-to-face and by telephone) and focus groups with different key stakeholder groups including FTB staff, those working in partner agencies and with children, young people, parents and carers. A desk-top review of new policies, procedures and other local documents about the historical or context in which FTB was developing, informed the development of the topic guides for the interviews and focus groups.

As much as possible, and in order to minimise any burden on evaluation participants, the evaluators also considered any secondary data collected by FTB, for example, the feedback from children, young people and families gathered via the Friends and Family Test and service satisfaction surveys that will be administered by the new service as part of the Key Performance Indicators/KPIs agreed with commissioners.

In total, this part of the evaluation aimed to gather information from 50 key local professional stakeholders and 25-30 children, young people, parents and carers and focused on exploring the changes to practice and workforce development/resourcing needed for the new model, the areas of innovative practice and the impact on staff knowledge, skills and ways of working across a large partnership of organisations.

Areas of focus were agreed via the projects' Learning and Evaluation Collaborative Group that met on a regular basis throughout the life of the project and included:

➢ How the new service engages with **voluntary and community sector (VCS) partners** – how do different stakeholder groups think that this addresses local needs, improves previous arrangements and promotes prompt access? What needs to be in place (e.g. governance, protocols, cross-agency working and staff training) to make this work? What has been commissioned and/or what is planned?

➢ Provision for **the 0-5s/new perinatal services** – does the new service improve access to CAMHS for younger children and their families, how does this aspect of the service link with primary care, health visiting and other early years services?

➢ The **extended age range up to 25 years** and how this may affect the style of service delivery, including the formation of new partnerships with services for adults including adult mental health services, further education providers and employer partners.

1.6.2 Impact evaluation

This arm of the evaluation involves collecting data on all cases accessing the service with monthly data examined over specified epochs in the delivery of the new service and broken down by specific age bands (e.g. 0-5, 5-12 and 12-25) and by different clinical streams. Originally the time epochs were proposed as: 0-6 months; 6-12 months; and 12-18 months, however, given the many challenges in accessing a full data-set (see Chapter 4), this was changed to 0-6 and 6-12 months.

Data collected include mainly high-level service and routinely collected individual level data in order to understand the service as it evolves and to feedback at critical intervals. An informatics template was developed in consultation with commissioners and the provider and covered service indices such as DNA, community attendance, admission, occupied bed days, readmission rates, A&E attendance, Place of Safety, home treatment contacts and individual level data, including a clear coding of diagnosis and HoNOS care cluster and NICE approved interventions.

It was also proposed that the evaluation would explore FTB's routinely collected data, to include embedded clinical measures such as the Warwick Edinburgh Wellbeing Scale (WEMWBS) and WHO Disability Assessment Schedule (WHO---DAS).

The key questions the evaluation sought to answer through interrogation of FTB's outcomes and activity (including demographic, DNA and readmissions rate; SUIs etc) data were:

1: Is the new 0-25 model transforming access and equality of access to interventions for those that need it?

2: What are the pathways to care, patient flows and duration of untreated mental health difficulty, including: time to first assessment following first help-seeking contact and time to first assessment following receipt of referral?

3: To what degree is 0-25 successful in maximizing engagement of individuals and their families and delivering interventions, following access to an initial assessment?

4: Is the 0-25 service transforming recovery and resilience such that further service use is reduced?

5: To what degree is 0-25 making use of established and emerging indicated prevention strategies (early identification of emerging mental health disorders), within the service and linked community settings?

It was also hoped to explore basic data from the previous service providers to allow for comparison with the new service model.

Service level data originally proposed included: demographic details by age group and service; admission rate (reported as n per day); readmission within 1 month (n per month); occupied bed days (reported per month); out of area placements (n per month): Home Treatment /Crisis activity data (face to face and telephone n per day and n per month); incidents recorded; RAID Assessment's (n per month); referrals (n per hub per month); referral pathway (n per hub per month); assessments (n per hub per month); number of patient missed appointments (DNA) by age; postcodes of those referred; time to first assessment and DNA by time to first assessment.

With regard to individual outcomes measures, the following were proposed to FTB for routine collection: WEMWBS: Warwick-Edinburgh Mental Well-being scale [1]; HoNOS: Health of the Nation Outcome Scale [2]; HONOSCA: Health of the Nation Outcome Scale (Children and Adolescents) [3]; PHQ9: Patient Health Questionnaire [4]; SDQ: Strengths and Difficulties Questionnaire [5]; GAD7: Generalised Anxiety Disorder 7 [7]; NOS: Nottingham Onset Schedule [9]; CGAS: Children's Global Assessment Scale [10]; GAF: Global Assessment of Functioning [11]; RCADS Revised Child Anxiety and Depression Scale; CHI-ESQ: Experience of Service Questionnaire [16]; Brief Resilience scale [15]

Chapter 2: The Commissioning and Procurement Process

(Giovanni Radaelli)

2.1 Overview

The analysis is an outcome of a qualitative research conducted within the NIHR CLAHRC-West Midlands research programme; this study ran independently alongside the evaluation of FTB as part of the 'added value' provided by the evaluation team and a summary is included here since the learning from this study is highly relevant to the input strand of the evaluation of FTB.

Consistent with the goals and boundaries of CLAHRC Theme 5 (Implementation and Organizational Studies), this report is <u>not</u> an evaluation of individual decisions, competencies and efforts. Rather, it provides an overview of key feedback about the earlier stages of the commissioning of FTB received from stakeholders.

The study provides a qualitative analysis of the commissioning of the new Mental Health Service for Children and Young Adults aged 0-25 (henceforth referred to as '0-25 Service') from the perspective of CLAHRC-West Midlands (Theme 5: Implementation and Organizational Studies). The report provides an overview of key feedback, received from commissioners and providers, regarding the earlier stages of the commissioning process. The report is informed by an *embedded longitudinal case study* asking:

    (i)   How did CCGs manage the relationships internally and externally to stimulate radical change in YMH services?

    (ii)   How did stakeholders respond to the new commissioning approach?

Data includes 29 interviews with informants in all involved CCGs, Birmingham City Council, Forward Thinking Birmingham and BSMHFT; observations of 10 meetings and workshops; extensive archival data analysis.

The study reported six main findings regarding the 0-25 commissioning.

1. Our analysis did not evaluate the 'success' of commissioners' decision, i.e. if and why the commissioned 0-25 service was the "best" or "better" solution for young mental health patients, though we note informants held ambivalent views about this. Still, most informants agreed that the 0-25 commissioning did enable a radical change of services in a relatively brief period of time. Past NHS experiences highlight slow processes of change, only incremental revision or the reinforcement of the status quo. Contrary to this, the 0-25 service was radical and (relatively) rapid.

    Four factors seemingly contributed to this 'success': (i) the providers were already inclined to change, and did not forcefully protect the status quo; (ii) the competitive tender accelerated and controlled the change, but also left room for provider discretion, with providers relatively free to design the new service models; (iii) change was supported by a network of actors, with strong and specific interests towards change – CCGs, patients, voluntary organizations, private firms and NHS actors. Providers (and professional groups, in particular) might be expected to resist radical changes in their practice, but instead displayed a generalised awareness that the system 'had to be redrawn'. This awareness was reinforced by evidence of patient disengagement – so that change conversations were not centred on managerial or economic considerations, but on clinical, medical and social concerns. The engagement of voluntary and private organizations was similarly met positively, once NHS trusts were reassured these would help and not intrude upon their decision-making.

2. Informants accepted and appreciated CCG engagement, often arguing that strong leadership was necessary to overcome inertia and become 'first movers' in the care and cure of young mental health patients.

3. The use of a competitive tender was arguably the most controversial issue highlighted by the informants. The competitive tendering was deemed necessary to overcome inertia, but, at the same time, generated relational damage between the main mental health providers. As a result, existing collaborations (at operational levels) were interrupted. On the one hand, some informants suggested that the best solution for Birmingham would have been collaboration between the main adult and children provider; and thus CCGs should have forced the collaboration between the parties. On the other hand, several other informants suggested that the collaboration had not generated rapid outcomes before, albeit this was still possible within the competitive tender process.

4. Informants generally appreciated that CCGs did not micro-manage the service requirements, but provided only indications about expected outcomes. In doing do, providers were free to "think outside of the box" and generate a new service model. On the downside, the lack of details on service requirements and CCG preferences introduced uncertainty and risks for the providers.

5. Patient and public involvement (PPI) was overwhelmingly appreciated by CCGs and providers. PPI legitimised and informed the change, and both CCG and providers embedded patient groups in their processes of service design and/or evaluation. Overall, we suggest various factors influenced successful PPI: i.e. patients' continuous engagement throughout the commissioning process; patients' engagement in practical decisions and artefacts to channel their contribution (e.g. PAUSE); the formalisation of ad-hoc PPI roles (e.g. experts by experience) to give clear responsibilities; clear boundaries between PPI and professional decision-making; use of multiple channels of communications; multiple uses of PPIs (symbolic, empowering, and expert).

6. CLAHRC-based evidence contributed to stimulate the 'case for change' as it showed service gaps and patient disengagement. Scientific, peer-reviewed, evidence, in this regard, contributed to shift the focus of care toward a 0-25 model. At the same time, CCGs and providers were 'first movers' and thus could not count on operational knowledge related to the design and implementation of a 0-25 model, and could not replicate similar experiences in the UK or internationally. The 0-25 commissioning was thus understood also as a learning point for Birmingham and for the NHS, i.e. it would generate new evidence that could support the providers to fine-tune their original proposals and 'second movers' nationally and internationally to diffuse the 0-25 approach.

2.2. Main findings

The starting point of our analysis was that informants often disagreed on the new 0-25 service as the "best choice possible", but they all agreed that (i) it represented a *radical* change for Birmingham mental health services, and an unprecedented move in the NHS and (ii) occurred in a relatively short time.

The establishment of a radical change in a relatively brief window of time deserves attention since most literature suggests bleak expectations of success. Researchers and practitioners have long shown that radical change mobilising different professional and organizational groups are likely to (i) be very slow and transformed into incremental changes to the status quo or (ii) be blocked by professional groups, which actively work to preserve the status quo (Currie et al., 2012; McNulty and Ferlie, 2004; Thomas and Davies, 2005). Negotiations across professional and organizational boundaries, in particular, usually slow down or obstruct the most radical innovations in favour of more incremental improvements. The 0-25 service could have been expected to meet a similar fate, as it tried to radically reconfigure existing patterns of care and to

integrate two worlds (adult and youth mental healthcare) that most informants regarded as very distant from each other; as one explained:

"Adult psychiatry arose with concerns about individuals with serious mental illnesses. The diagnosis is based on understanding what the abnormal mental experiences are. So, the treatment is geared towards that individual and since the introduction of anti-psychotics it's mostly been delivered through drugs – although you have ECT and now you have more psycho-social interventions as well. But, it is primarily a disease-based model, an individual-oriented approach. Child psychiatry started instead with concerns about orphaned children or what were called juvenile delinquents, kids who were either from broken families or were orphans who were on the street or who were in trouble with society. The services were developed to provide a parental substitute to those children, it was a social care package, wider education and training and love and caring and stability to these young people. Child psychiatry was developed from a sociological model, so its primary focus was family, interpersonal issues, attachment problems, interpersonal, conduct problems, behavioural problems, so the approach was of a child who was struggling within a system so you aim to alter the system as a way of helping the child"

Instead, the competitive tender did enable a radical change in a rather brief period of time, with a new service configuration that revised both processes and providers. While it is not purpose of this report to conclude if and how this change was 'successful' in terms of clinical effectiveness and organizational satisfaction, we can still observe that the commission was 'successful' in terms of radicalness of the solution. Hence, it became relevant for us to understand what made it possible.

Three main factors were highlighted:

First, *service providers did not forcefully protect the status quo against change*. On the contrary, they proved receptive to the idea that "the system needed to be redrawn". Receptivity to change was arguably facilitated by multiple factors, namely: (i) awareness that the effectiveness of care was not as good as it could be; (ii) awareness of patient complaints about the status quo, which undermined established services; (iii) commissioning represented a possibility for clinicians (and their organizations) to address service gaps and thus to improve, rather than lose, jurisdiction.

The engagement of clinicians, in particular, seemed crucial as they command the expert knowledge required to design and implement the new services. McNulty and Ferlie (2004) in this regard observed that "we found no case study in which [business process reengineering] was successfully imposed on a clinician. While senior management could influence clinicians, they could not directly control them" (p.1408).

"The evidence that the current model was failing was quite important and that's all very clearly laid out in the business case. The current model was definitely failing because it was under-financed, but also because there was a lot of demand that couldn't be met. Studies have documented problems especially in the transition… The evidence of failure was very strong, the rationale was understood and it then found its way into some national documents, which I think also helped… Also, we had evidence base that young people in the Adult Service could engage better if the early detection of psychosis improved, for instance… "

Second, *the competitive tender controlled the change from top-down, without replacing clinical decision-making*. The competitive tender forced the change issue by de-commissioning previous services, controlling and accelerating its pace, and informing its overall organization (e.g. calling for composite partnerships with NHS trusts, voluntary organizations and private firms). At the same time, the competitive tender did not design the new service, which providers had to implement. Rather, the commissioning highlighted key outcomes, while the service requirements were relatively open to the 'free' interpretation and creativity of the providers. The possibility for professional groups to control the nature of the new service appeared to prevent stronger forms of resistance as (i) professionals used their expertise to inform the proposals and (ii) managers

could control the sustainability of the new model according to their organizational and financial parameters. In one of the observed meetings, it was noted:

"This commissioning did not demand specific requirements, for instance 'we want this, this and that'. We demanded specific outcomes, for instance 'we want to improve this, this and that' – you tell us how you can achieve that. Once providers agreed on these outcomes, they were free to model the new services according to their possibilities."

Third, the commissioning of the new 0-25 service mobilised a complex network of actors, which had different and significant motivation to support the change. These involved:

> ➢ CCG groups, which operated outside of NHS trusts' boundaries (and routines), and connected with multiple other contexts (e.g. non-mental health care, acute, primary care, social care).

> ➢ NHS providers, with established processes and routines of care, but also emergent awareness of their limitations.

> ➢ Patients, carers and patient groups who increasingly expressed their concerns about established services; and (iv) voluntary and private sector organizations, who brought their own distinctive understanding of and interests in change during the commissioning process.

This resonates with evidence that rapid radical changes are enabled by "institutional entrepreneurs" rather than established players in the field. It is often suggested that actors closer to operations may be too embedded in their established routines and practices to recognise or act upon the opportunity for change (Battilana et al., 2012, 2013). Radical change is often accelerated by actors who are less absorbed by current practices and/or less constrained by social influences, for example:

> ➢ Influential actors in the field in terms of reputation and/or resource control, who can use their social position and influence to mandate change.

> ➢ Marginalised actors who, on the contrary, are so overwhelmed by established practices and routines they are willing to "fight for" radical change

> ➢ External actors coming from different industrial contexts, who can bring their "esoteric" visions to the new environment and mobilise their social network to create influence.

It was interesting to observe how the commissioning of the new 0-25 service represented a way for NHS providers to expand, share or lose their jurisdictions. A traditional barrier to change (especially in the NHS and especially when integrated care is proposed) is professional groups' concern they will lose large chunks of decision-making to managers or other professional groups (Currie et al., 2012; Llewellyn, 2001; Radaelli et al., 2017).

Professionals also resist radical change to defend their autonomy. In this regard, the 0-25 service was an eventful change, as the two main providers – BCH and BSMHFT – faced ambivalent scenarios as they faced an opportunity to increase their jurisdictions to (respectively) adult and children mental health care, as well as the risk of "losing it all". Noticeably, the providers were not risk averse, as they decided not to collaborate (which would have reduced the potential gains and the losses), but instead to go their separate ways.

2.2.1 Acceptance of 'case for change'

Expanding the first point, we analysed if and how the different stakeholders accepted the case for change, and whether they shared a common interpretation of the change. Stakeholders'

scepticism (or outright rebellion) against the proposed change could become an important barrier to innovation, especially when the reasons for change are perceived to be unrelated to professional interests (e.g. cost saving).

Interestingly, there was no major controversy over the case for change. Informants agreed on the existence of important clinical reasons for a change, as well as on the perceived lack of patient satisfaction with existing services. Earlier CLAHRC-related research provided evidence of significant gaps in the provision of mental health services in transition ages (16-18 and 14-18), and highlighted areas in which the provision of services overlapped between CAMHS and acute services. And a noted above, the quality of service provision in the transition years (16-18) became a cause of concern for the CCGs, who highlighted the following issues:

➢ High disengagement rate of the 16-18 year old cohort of patients leading to re-presentation at a later age with entrenched mental health problems.

➢ Young people unable to access service after leaving CAMHS.

➢ A lack of seamless provision for 16–18 year olds for multiple services.

➢ High waiting lists.

➢ CAMHS and community services holding cases beyond the commissioned age.

➢ Reports of inappropriate admissions of 16-17 year olds into medical or adult services.

➢ Dissatisfaction amongst referring agencies and families trying to access services.

These problems were recognised by virtually all informants. Patient disengagement in the transition ages was given as a major reason for change:

"There were several really clearly documented reasons. We'd got a gap in services for people who were transitioning out of children's services, so 16, 17-year-olds did not become eligible for adult services until they reach 18… We tried to put bridged services into place, [but] there was still this inherent difficulty around the transition…"

Patient groups complimented the CCGs on their receptivity to patient needs in this respect:

"This is an example of CCGs listening very carefully to the feedback from service users, stakeholder groups, carers; and responding to the concerns that they've raised."

This appreciation extended to the recognition that NHS trusts should engage more actors in their service provision, in order to achieve more integrated care in the community. The contribution of voluntary sector and (more cautiously) private firms was recognised as missing from the previous provision of mental health services:

"[The engagement of voluntary and private sectors] is becoming more and more relevant, I believe. They really all do bring something else [to the NHS]. Private firms bring this very commercial attitude, this attitude of "you want it, you get it". And [voluntary firms] are great at meeting hard-to-reach groups. Very engagement focused. Very much thinking across the whole system, to the early intervention piece, not the bedded bit"

Economic motives were not highlighted as the driving force for change. On the contrary, there were clear expectations that no cost saving would follow. This clarification appeared to appease concerns that the reconfiguration hid different, non-professional, interests.

2.2.2 Acceptance of CCG Leadership

The second issue in our analysis was to understand if the stakeholders perceived CCGs as legitimate enablers of change. We asked: did stakeholders accept that CCGs should lead change, or instead did they demand a more bottom-up approach?

CCG informants agreed that a bottom-up approach could be preferable, if providers found some spontaneous or managed way to agree on a whole-system solution. CCGs reportedly tried to engage the existing providers in such conversations, asking them to propose a new 'vision' for the future. Earlier attempts to bring together these providers, however, were argued to be ineffective – hence the competitive tender was deemed necessary to overcome the inertia. As one informant commented:

"The service was poor and the waiting lists were long, something up to two years in some cases, and the service certainly wasn't equipped around early intervention support at the time. It was more 'rescue and support' in the sense of children been identified as having serious problems before they went to do CAMHS. We worked for two or three years, worked with the existing providers struggling to get them to improve their services… It became very apparent that that wasn't a workable solution… "

Delays and problems between providers to find a shared solution were also reported by representatives of the providers. Interestingly, several informants reported that local initiatives to address specific issues were indeed in place, and significant progresses could have been made if that route was followed. However, they did recognise two limitations, i.e. (i) solutions were local, while there was a perceived need for a more systemic solution, and (ii) progress was slow, especially since collaboration only occurred at the operational level, and not facilitated by strategic levels of collaborating organizations:

As a result, the opportunity for CCGs to introduce a tendering approach was not vilified by the providers which, on the contrary, recognised the need for a strong actor to accelerate change. This awareness often met with an appreciation for the commitment and determination of the individual commissioners.

Overall, the interviews did not reveal significant issues with "why" the service was redesigned, and "who" managed the change. Greater criticism was instead linked with "how" the commissioning was organized, i.e. with the use of competitive tendering processes.

2.2.3 Acceptance of competitive tendering

The choice of competitive tendering, in place of a more collaborative process, was arguably the key concern of informants. As noted above, the selection of a competitive tendering approach was often deemed necessary due to (i) a need for rapid and radical change in service delivery (ii) delays in earlier attempts towards collaboration between the providers. In general terms, almost everybody agreed that competitive tendering did in fact accelerate a radical change in services, and overcome inertia.

At the same time, the competitive nature raised concerns of relational damage between the providers, in terms of: interrupting established relationships between the parties which were already engaged in some service reconfiguration at local level; delays and long-term damage to future collaborations and the perception that the resulting partnerships were not the best possible as they separated (according to the informants) strong players from each other.

In the latter regard, the commissioning of the 0-25 services faced a conundrum related to the partnership between BCH and BSMFHT – generally perceived as the strongest players in the field. Informants suggested that a partnership between these two players (plus voluntary and private organizations) could be preferable compared to a configuration where each "strong"

player represented a powerful force around which newer or smaller organizations gravitated. Most informants acknowledged that the commissioners did not antagonise possibility for such a collaboration, which broke for different strategic reasons:

"We would have perhaps preferred the providers to work together. These organizations are like chalk and cheese really, but they do not have completely different philosophies of work. So originally, we thought that they planned to put in a joint bid for this… Well we tried for about three years to get them to do it and they wouldn't or couldn't do it, there was no incentive for them to do it. So we, with commissioning we don't want to be going out to tender at the drop of a hat, but if you've got an orphan service that nobody wants to provide, no one will provide it even when you're giving them money you've got to go out to tender because it's the only way you're going to get somebody"

A reason for the separation was apparently the reciprocal perception that the CCGs did not appreciate the other organization, and thus that they would better work alone. This suggests that CCGs' message of collaboration was not straightforwardly accepted by providers. More generally, some provider representatives complained that there had been no fair chance to revise the service without going straight to a competitive tender:

"We chose not to partner with the existing provider of [a service] because we had been told by a number of commissioners that [this service] was the principal cause of concern, so would you partner with the people we're told is the greatest concern? "

Another commented:

"My understanding, having spoken to the senior officers in the trust, in the CCG, is that the trust had been told over a number of years that GPs weren't happy and it's well-known that there were problems with the service. But there was no opportunity [to meet and discuss]. There was no formal meeting between the CCG and us to say "we're unhappy and therefore want to consider a service that is 0-25". My understanding is there was no discussion with the [other provider either]. So in relation to thinking how did we suddenly get into a tender process, there had not been a formal dialogue between commissioner and provider. A meeting took place when the two chief execs of the providers met with the accountable officer for the commissioning organization and we were told we're really unhappy and therefore we're going to tender the service. Now that's not giving the provider an opportunity, it's not allowing the discussion. And I'll be frank with you; from that point onwards there have been difficult relations between providers and commissioners…."

Along with concerns about the (lack of) communication with CCGs prior to the competitive tender – the one issue which informants really disagreed on, the informants also acknowledged problems with communication across providers. The very nature of a competitive tender is such that communication and collaboration between the providers "shut down" and resulted in a number of "missed opportunities". Communication across the partnerships could not be mediated anymore by the CCGs, which had to remain independent. Finally, there was no possibility to improve the final solution by hybridising the different proposals:

"I think tendering can be quite good in terms of creating rapid service transformation, but it's also a pretty blunt tool, and it can cause quite a lot of relational damage, particularly in a collaborative environment like the NHS. We had providers who had very different skill sets [so it could be anticipated that] one would be very good at doing one thing and the other [at doing] something else. [It would have been ideal to find a solution that hybridised the strengths and removed the weaknesses, but that's not how competitive tenders work]"

As such, while the competitive tendering allowed choosing a better solution (compared to status quo), it did not necessarily identify the best solution conceivable by combining skills and experiences available in the territory.

2.2.4 Understanding and acceptance of the 'grand vision'

Informants provided ambivalent views on another key element of the competitive tender, i.e. the intentional lack of detail regarding the expected service. The service specification delivered by the CCGs was intentionally open-ended to allow greater freedom of action and creativity from providers. More generally, the CCGs did not intend to "micro-manage" what the new service should include. Rather, it defined a "grand vision" with minimum requirements, and then left the providers with key decisions about the new configuration.

The lack of detail was explained in different ways: the 0-25 service was an unprecedented service in the NHS, so the commissioning process involved an element of learning-by doing; open-ended specifications could facilitate the local creativity from the providers, which were most expert about what could be done and open-ended specifications reduced the perception of CCG intrusions or "unrealistic expectations".

"This commissioning was about being different, and the service is different, the type of service, the expectations in terms of delivering in terms of outcomes are different, so those things are quite different... More and more CCGs are trying to commission like this. It is evidence-based and that's quite important… But in terms of the actual commissioning, it is quite different from a CCG perspective. The CCGs are typically pressured through a range of expectations to be able to almost be on top of everything and micromanage. It feels that the system is pushing people down that route all the time, and then there's the culture and history behind all of this, around contracts and finance and business intelligence, which is all about that minutiae. [With this commissioning] we said: we don't really want to do it like that. I think CCGs can get a bit anxious because they're not getting that sort of information that they used to get, and it becomes almost like we're not in control, or we don't know what's going on, type of thing. [This commissioning wanted to be] a process that allows the innovation and development and transformation that we are required to have as well; that we're required to have now, but also that we need… We have set a broad set of criteria and minimum requirements [and then let the providers] be free to create the solution [that best fit their own vision]"

On the one hand, such relative freedom of action was usually appreciated, as it (i) allowed providers to control solution based on their perception of needs and possibilities; (ii) put CCGs at arm's length, reducing the risk of creating controversies about "unrealistic expectations" or "intrusion". Furthermore, informants usually argued that providers were culturally inclined to be independent in their clinical and managerial jurisdictions:

"The new way of commissioning was less telling and it was more collaborative. I think that is a new way of working in Birmingham, and the relationship that has grown between FTB and the commissioners is quite a healthy one. People are not afraid to challenge. That has been really positive. I think everyone involved learnt a lot…."

On the other hand, informants were not fully content with the open-endedness of the service requirement, as it (i) delegated most of the creative effort to the providers, and thus required significant time and resource; (ii) generated uncertainty on what the CCG (and related panels) would eventually appreciate; and (iii) possibly pushed competitors to promise more than they can handle in order to win the tender.

The competitive tender was partly blamed for this uncertainty, as the informants complained about the lack of interactions (with CCGs and with rivals) to acquire more information about the service specification. Interactions did indeed occur through meetings and ad-hoc conversations, but had to happen before providers worked on their proposals.

Following which, several informants called for new mechanisms that could clarify some "nitty gritty" details, before and during the competitive process, in order to minimise the risk of re-negotiating core elements of the service and flag up key directions that providers should take to impress the commissioners.

Providers especially called for more time and more interaction to discuss details before the tendering process begins:

"This commissioning was more about outcomes [than service components]. It's such a massive change, because it was everything. When the service specification was developed, that was probably the hardest bit of it: how specific to get about things in there? Trying to get that balance right was really difficult, working on the KPI's and all that side of things, within it. That took a lot of brainpower and thinking through. The other main difficulty was when it comes to the nitty gritty of which bits are in scope and which bits aren't and there were often times where there'd be slight disagreements through misunderstandings of what [providers] did and how they would be impacted on if you took away "x" amount of money out of them"…."

The research did not find extensive evidence of discontent among informants about the 'grand vision' proposed by the commissioners. As noted earlier, providers had bought into the idea that the service had to be somehow redesigned, and expanded toward prevention and community care. Some informants (especially those residing in acute organizations) contested the implications of this vision, arguing that it was not inclusive enough of several actors who engage with mental health work without being part of mental health organizations.

Concerns of "retrenched" specialist services emerged across some interviews:

"There's a larger health system which does mental health work. This whole process should have recognised that they commission lots of mental health support that isn't badged CAMHS money, so what the commissioners have done is taken all of the money which they think is CAMHS and put it all together. And it fails to recognise that there is a whole healthcare system that needs to be CAMHS-skilled, or mental health skilled. And what this has done is drive an enormous wedge between the specialist CAMHS, and the rest of the healthcare system. So the point at which I felt I really wanted to do something about this was when I'd seen a patient who'd been discharged by CAMHS about six months before in my clinic. So I listened to this family, and it was really complicated psychology/psychiatry type difficulties. And so I rang up the single point of access in the CAMHS service and said, I've met this child, he was discharged about six months ago, but really, the problems are very significant. And the nice person at the end of the phone said: unfortunately, he doesn't meet our thresholds. And I said, oh dear. And he said, don't worry, it doesn't matter, because what you need to do is refer to [a community provider]….. so what we've got is a system where the specialist services are so retrenched, they just throw out endless referrals, and they're doing it at the moment, to other people, but there is no access at all to the expertise. So they've retrenched into a fortress and there is no access. Access for the whole flipping healthcare system is rubbish. And it's worse than it was before, and it was bad before…"

2.2.5 Role of patient and public involvement

The nature and extent of patient and public involvement (PPI) represented the most positive and consistent feedback from the informants. Such feedback emphasised previous services had failed to incorporate patient voice, hence leading to numerous patients and carers disengaging from the pathway. On the contrary, the 0-25 commissioning was very effective in this area, as both CCGs and the providers embedded patient groups in their decisions, in order to deliver better service specifications and service proposals.

Throughout the commissioning process, two distinct roles played by patients and carers were highlighted. On the one hand, patient involvement *legitimised* the change. We noted earlier how radical changes are often facilitated by the presence of dis-embedded and marginalised actors who identify the need for (opportunity for) change earlier than actors that are caught in the day-to-day routines. CCGs and providers gave patients a special role in the complex network of stakeholders mobilised by the 0-25 service, with the purpose of legitimising key decisions made in service specifications or in the proposals.

Patients were legitimised as service experts, and not just customers. By providing explicit and formal roles – e.g. "experts by experience" – CCGs and providers regarded patients as individuals with enough experience with the service to add valuable insight into the development of service specifications and proposals. More than engaging patients with customer satisfaction exercises (e.g. to legitimise decisions made by somebody else), both CCGs and providers incorporated patients in the decision-making process (e.g. using 'experts by experience' during the evaluation of proposals, or involving young patients in the development of PAUSE). Feedback, in this regard, was overwhelmingly positive:

"*Credit to CCGs, they created a group of expert patients, or patients by experience, before the specification was written and then, in the process of tendering the specification, and they had young people evaluating the bids all along. Through the tender and mobilisation process, they invested in the capacity to support a group of young people to help design it…*"

Overall, we suggest that PPI represented a clear element of 'success' in the commissioning process. This 'success' is noticeable if compared with a wealth of NHS experiences in which PPI was not attempted at all, was inhibited by cultural and logistic issues, or was managed poorly. We suggest six main factors made this process satisfactory:

➢ *Continuous engagement*: CCGs and providers were careful to engage patients and carers throughout the commissioning process. The 0-25 commissioning: (i) unearthed patient voice from the very beginning, as earlier surveys and meetings provided the initial evidence that patients were not satisfied with the status quo and disengaged from the service during the transition ages; (ii) evolved patient voice into patient engagement during the development of service specifications (with a long pre-consultation process), service proposals (with providers gathering and formalizing patient groups in their support), evaluation (with the "experts by experience") and implementation.

➢ *Formal engagement*: as noted, CCGs and providers gave patients a specific role during the commissioning process (e.g. 'experts by experience') so that their responsibilities were not vague.

➢ *Practical engagement*: CCGs and providers engaged patient groups in specific and clear decisions, such as the evaluation of proposals or the development of PAUSE. Usually, patient voice is collected within vague frameworks, so much that it remains unclear when and how such patient voice is used by the providers. When this happens, patients typically become disillusioned with commissioning or innovation processes, and perhaps become antagonistic to them. On the contrary, patient engagement was embedded in clear and transparent processes, so that patients could evaluate the outcomes of their involvement.

➢ *Non-intrusiveness*: Patient engagement is often resisted by professionals, who express concerns that their own expertise is replaced by "unrealistic expectations" from and for patient groups. In the context of 0-25 commissioning, PPI never replaced the expert decision-making of professionals, but rather added to it.

➢ *Multiple channels of communication:* Patient engagement took different forms – from traditional customer surveys to workshops and meetings, from social media to face-to-face interactions.

➢ *Multiple uses of PPI:* Patient engagement appeared to have simultaneous: (i) *symbolic* value (i.e. communicate that providers had to develop patient-centred solutions); (ii) *empowerment* value (i.e. empower patients to engage with the change, and actively propose ideas); and (iii) *expert* value (i.e. gain insights from patients).

2.2.6 The role of evidence

It was evident in this study that evidence played an important role in shaping the commissioning of the 0-25 service. The local CCG used CLAHRC-based evidence, which highlighted transition gaps and patients' disengagement from the previous service, to inform the 'case for change'. Coupled with PPI, this evidence stimulated radical change 'here and now' – especially because it built upon and consolidated a perception that providers already had about "many problems" with the previous services.

Likewise, available evidence legitimised the decision to change the age of transition. For instance, the existing evidence argued transition at 16 was problematic for patients with psychosis, as 16-18 is often the period of first diagnosis. Evidence generally suggested that transition should be pushed back to 18, 21 or 25.

On the downside, providers could not rely on more operational knowledge about the design and implementation of 0-25 services – since no other experiences in the UK or internationally had introduced a 0-25 service. CCGs and providers gathered information from similar services (e.g. 0-18 or 14-25 services), but remained a first-mover regarding the specific 0-25 service. This position met ambivalent, but mostly positive reactions from the informants. The possibility to be first-movers created uncertainty ("will we do it right?") but most importantly represented a positive challenge and an opportunity to be creative and "think outside of the box".

Informants agreed that the commissioning could represent, at the very least, a learning process that could help them as well as the NHS to deliver better care for young patients in the transition ages. Informants agreed that "somebody had to take the first step" and doing so would allow the NHS to "learn from mistakes" and gradually achieve superior services and performances:

"*Have we got it right, will the model evolve in the direction that we wanted it to – or even if it does no - it will be an important learning process. We will continue to evolve and adapt the model. There are advantages and disadvantages that there isn't a model sitting out there. There's something quite interesting about leading the way, someone has to go first don't they?*"

Following which, service specifications and proposals were mostly built around peer-reviewed knowledge (regarding diagnostic and therapeutic choices), but also experiential knowledge regarding the operations and organization of the service). This knowledge included: (i) data and experiences from the current provision; (ii) the triangulation of data and experiences with adult and children providers, as well as voluntary organizations and private firms; and (iii) the engagement of patients and experts.

Overall, our findings reveal that this commissioning was unlike several other procurement processes, where the innovation is known (e.g. a new drug) and piloted (e.g. in other NHS trusts or catchment areas; or internationally), and providers are asked to replicate it in their context and for their customers. Here, the commissioners dealt with a new service design, which was unprecedented and thus likely to generate mistakes. This has the potential to create significant benefits for the system, i.e. produce as 'first movers' early scientific and operational evidence that could inform other providers, and hopefully support the diffusion of the model.

2.3 Final considerations

It was not the purpose of this study to evaluate whether the commissioned 0-25 service is a 'success' or the 'best solution' for Birmingham. Analysis focused only on the earlier stages of the commissioning process, i.e. development of the service specification and procurement to Forward Thinking Birmingham.

The informants did not discuss in great length the perceived 'fairness' of the commissioning process; however the findings do highlight the main elements of satisfaction and dissatisfaction

with the commissioning process. In the first regard, we highlight three main aspects: firstly, the informants generally agreed with the 'case for change' and with strong CCG leadership in the face of inertia and collaborative problems; secondly, the nature and extent of patient and public involvement was very appreciated by most informants, who recognised the need to embed patient voice and actively worked to incorporate patients as experts in their own processes, and thirdly, the 0-25 service was generally perceived as a "first-mover" experience, and thus the opportunity to generate learning points that go beyond Birmingham, and could inform second movers in the NHS.

In the latter regard, the findings highlight that informants expressed some discontent with the competitive tender approach, i.e. they understood why CCGs "had to do it", but also preferred more collaborative approaches. Informants also appreciated a commissioning based on outcomes rather than service requirements, but asked for more time and more interactions to discuss some 'nitty gritty' detail before the tender.

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Chapter 3: Initial interviews with stakeholders
Cathy Street, Yvonne Anderson, Jane Sedgewick and Fiona Warner Gale

3.1 Summary

FTB began to roll out its services on 1st October 2015, however, with the agreement of the commissioners of the evaluation, it was agreed to delay the commencement of evaluation interviews until later in 2016, to allow for a phased going 'live' of services between October 2015- April 2016. Thirty eight interviews were then completed in the period November 2016 - end of February 2017 with an aim of capturing baseline date about the early set up and first six months operationalisation of the new FTB model, the inputs/resources needed and also the early establishment of agency partnerships.

Interviewees included staff from: PAUSE; Beacon Access Centre; FTB community Hubs; CYP IAPT; staff in the ADHD and LD pathways, EIP; infant mental health; staff from Birmingham City Council/local authority looked after children's services, 18+ leaving care services and the Youth Offending Team. A wide range of voluntary and community sector (VCS) providers were also represented. These included: Open Door, Place2Be, Anawim, Beyond the Horizon, Barnardos, Lateef, Ripple Cic, Future Health, Acacia Family Support, Pattigift, St Basil's, Malachi Community Trust, Remploy West Midlands, Birmingham LGBT and Resources for Autism.

Interviewees were identified via FTB senior staff and were invited for interview via email. A semi-structured topic guide was used; some interviews were face-to-face, however, the majority were by telephone; data were analysed using Thematic Analysis.

Following these baseline interviews, a further fifteen interviews were taken, to address certain groups or parts of FTB under-represented in the initial cohort of interviewees. These included: schools, staff responsible for service user participation in FTB, practitioners developing the new community Eating Disorder Service (EDS), in-patient provision for under-18s and psychological therapies; the Primary Mental Health Worker (PMHW) team, urgent care/crisis team and home treatment and the police. Unfortunately despite repeated invitations, no interviews were possible with representatives from the Priory, a key partner in the model for in-patient provision.

3.1.1 Issues raised

The interviews revealed a wide range of issues and themes which form the basis of this chapter. They are briefly summarised since it is acknowledged that these data were collected at an early stage in the roll out of FTB. However, it is salient to note that many of the issues raised in the baseline interviews emerged again and indeed, persisted throughout the evaluation namely:

➢ Acknowledgement of the need for change and strong support **for the new model, in particular, its emphasis on 'no wrong door' and accessibility/self-referral routes** – countered, however, by serious concerns about staffing capacity, knowledge, expertise and skill mix, by whether and how FTB would be able to manage likely demand.

➢ Support for the **extended age range** – though again concerns about what this might mean in terms of increased demand and also high levels of complex cases.

➢ The **integration of mental health practitioners** from Child and Adolescent Mental Health Services (CAMHS) and mental health practitioners from adult mental health services (AMHS) in the community hubs, also the co-location of some specialities such as MST with CAMHS was viewed very positively across the groups interviewed – although they were anxious about how each group would be supported and skilled up to work across the 0-25 age range.

- The **partnership working with Voluntary and Community Sector (VCS) partners**, a very prominent and innovative element of the successful bid to provide a new mental health service in Birmingham – but where from the start disquiet and disillusionment with what this looked like in reality now that FTB had won the tender were apparent, with complaints of poor communication, limited involvement in planning (despite extensive attendance at early consultation events) and insufficient funding allocations.

- Positive views about the potential for **more integrated work around expectant mothers and young parents** and working with parents and young children together.

3.2 Implementation and early mobilization of FTB

In many of the interviews, broad support for the new FTB model was evident. Interviewees highlighted the value of:

- The extended age range (especially its potential to improve transitional care).

- The service configuration of the local hubs and in particular, the model of adult and child and young people's practitioners working alongside one another (whilst it was acknowledged that joint working was still at a very early stage, it was felt that the hub arrangement would facilitate this partnership working as the service became more established).

- The involvement of VCS partners - described as a rich and diverse resource in Birmingham - and the shift away from thinking that only the NHS could deliver mental health support to children, young people and their families.

- The PAUSE Centre and how this could provide early help in an accessible and non-stigmatising way – a way of really 'reaching out' to the local population that hopefully may support the engagement of those who might not feel comfortable to access more 'traditional' mental health services.

- The potential of the model (via its many partners) to offer step-up and step-down avenues of support and support through key transition points and again to reach groups who traditionally had not engaged with the previous providers of mental health services, e.g. young homeless people.

- The potential for more integrated work around expectant mothers/young parents – especially the possibility of addressing parental mental health alongside parenting needs.

- 24-hour provision and the potential for much stronger join up of services across the city, promoting easier access for those needing help and support.

- The development of the EDS which reported it had been successful in attracting both CAMHS and AMHS staff (although struggling to recruit medics which had impacted on the team's capacity) and that the team was growing together and felt comfortable to work across the whole age range of FTB; it was suggested that already the work of the team was making a real difference in terms of waiting times and reducing crisis presentations to A&E. It also highlighted plans to develop self-referrals routes and the possibility of being open on Saturdays.

A number of those interviewed reported systems in development to help improve the targeting of services and saw the potential for more proactive identification of high use or repeated users of

mental health services; they were also hopeful that the new model would allow a more systematic approach to follow up.

They reported that the open days and staff away days had helped the mobilization process, also that the involvement of children and young people, parents and carers, had been quite extensive and influential in the development of the service (noting that they hoped that this would continue). The holding of regular operational meetings in the early days of mobilization (e.g. involving all the Hubs) and the sharing of good practice were described as building "good service connectivity and support in the workforce"; one interviewee highlighted the opportunities to see different perspectives and that this felt collaborative working approach was a welcome development in Birmingham.

Several interviewees welcomed the dedicated staff roles – e.g. a dedicated lead for CYP IAPT (which was previously part of a wider job role). In addition, various aspects of provision that have been specifically commissioned by FTB – e.g. the project at Acacia Family Support and the e-learning and other materials commissioned from Ripple CiC, were viewed positively.

The work of the crisis team based at Parkview was described as settling down and becoming more structured after what was described as a "very tricky start". The team was reported as being much clearer about what they can and can't provide and to be developing good working relationships with the Hubs – although it was also noted that the team could find it difficult to get hold of clinicians to hand back cases. An issue of inappropriate referrals from the Rapid Assessment Intervention and Discharge (RAID) provision in local Birmingham A&Es (that was, apparently being dealt with) was also raise. One gap highlighted in this initial round of interviews was that FTB has no provision for crisis beds; the crisis team suggested that something similar to the EIP respite beds warranted consideration.

At a practical level, governance and complaints processes reported to be in place.

3.3 Areas of concern about the early development of FTB

3.3.1 FTB staffing and skill mix

A number of interviewees raised concerns about staffing and the skill mix and highlighted that there were gaps/vacancies and recruitment difficulties within FTB, especially of senior staff and of medics/psychiatrists (which it was acknowledged, was a national problem, not one specific to FTB).

Interviewees expressed anxieties that planned staffing levels were too low for what needs to be a larger service catering for a bigger client group. They were also worried about staff knowledge, experience and skills to work with children and young people and/or with the older age range and about fragmentation of provision overall. Plans to develop and build workforce capacity and to upskill the workforce to work across the 0-25 age range were noted to be unclear and a collaborative approach to developing pathways and agreeing the staffing/resourcing of these was described as 'largely lacking.'

Identified gaps included need for more psychiatric skills, work with adults and building capacity in the service to share and develop skills across the FTB workforce. It was also highlighted that language and diversity issues within the local population of children, young people and families, needed to be addressed in developing the FTB workforce.

3.3.2 Capacity of the service

A number of those interviewed expressed anxieties about whether the capacity of the service would be sufficient to deal with an expected high level of cases as a result of making the service more accessible, including creating avenues for self-referral. Extending the age range upwards

was recognized as likely to increase the numbers of complex and/or high risk cases and made the planning for crisis care even more critical (e.g. with regard to higher prevalence of suicidal ideation/suicide risk in older young people).

Getting service capacity and the balance of provision right was seen to be crucial in ensuring that early intervention and preventative work could be delivered. A number of interviewees suggested that already at an early stage in operationalising FTB, both the volume and complexity of referrals had been much higher than expected and had led to a sense of staff feeling overwhelmed. This included a much higher footfall at PAUSE (around 500 per month and growing as the service getting known about) than originally expected.

Interviewees reported that caseloads had already exceeded planned levels in a number of parts of FTB, including the Crisis Team and Home Treatment and that there were already growing waiting lists in a number of the community Hubs. There were concerns emerging about low staff morale, high rates of staff sickness and that experienced staff had already left the service or were actively looking for jobs – for example, one described Band 8 staff as feeling:

"anxious, overloaded and undervalued"

*A*nother mentioned that a number of psychotherapists were noted to have left since they "*could not see a future in FTB for psychotherapy"* and one medic reported that their team/hub should have five consultants but was currently operating with two. As a consequence, they were having to rely heavily on locums and psychiatry trainees which made building the service and providing continuity of care highly challenging. Furthermore, the lack of secretarial/PA support for FTB clinicians was adding to work pressures since staff now had do much of their admin work themselves - the end result of which, according to this interviewee, was that GPs and other referrers were getting significantly less letters about their patients than previously, a situation which obviously posed issues of safety and risk.

It was also pointed out, with regard to the loss of higher band posts, that this raised serious questions about clinical leadership of the FTB service since this could not be expected from junior/lower banded staff.

These concerns had, so a number of interviewees reported, been raised with FTB senior management but their response had only fuelled staff concerns. It seemed (to many staff working in FTB) that more junior staff at lower bands were being recruited to try and patch in the gaps – this only serving to heighten pressure on the remaining senior staff. There were also rumours of cuts to the overall proposed workforce establishment (although none of those interviewed could provide anything to substantiate this clearly widely held worry).

In addition to overall service capacity, interviewees also raised concerns about management of the different service interfaces within FTB:

> The move away from a tiered system, whilst strongly welcomed, was felt to need more work re: clarifying where people fit in the new system and in particular, who should be seen in PAUSE. Promoting PAUSE to more outlying communities given its city centre location, was also suggested in order to ensure this part of FTB was understood and seen as relevant and available to all children and young people.

> Some frustrations were expressed that staff felt that post the initial consultations about the new model, FTB senior management had not properly involved its workforce in helping to shape the service and that there were few opportunities for all staff to meet together to reflect, discuss or make suggestions for how to address some of the difficulties that were emerging.

> Communication between community services and inpatient provision was noted to need

improvement in order to ensure timely and robust discharge planning. (one interviewee suggested that the impact of higher bed use was yet to be properly assed in terms of what this meant for the model overall). Likewise a number of the pathways, including those where inpatient care was needed, were felt to be insufficiently developed and to have unrealistic timeframes. The need for better care co-ordinater roles, able to actively manage children and young people through a pathway, was suggested.

3.3.3 Communication and engagement with VCS partners

Various interviewees described feeling unclear about the operation of the new FTB service and complained that there was a lack of detail about how they (specific VCS providers) would link to FTB. It was also apparent that some agencies had been expecting to be commissioned to offer services having been identified in the FTB tender response and then found that this was not the case. Understanding who and what was being commissioned was described as difficult since as one VCS interviewee described:

"Comms and updates from FTB about its implementation seem to have come to a grinding halt"

A number suggested that FTB was not capitalizing on the skills and experience of many local VCS partners. From their perspective, this constituted a critical missed opportunity to draw on local knowledge, existing networks and things that were established and worked well, and crucially, to build capacity. In their opinion, there was also a significant risk of duplicating provision and thus wasting scarce resources.

Some VCS interviewees expressed the view that the new FTB model did not actually look that different to what had gone before and that the model was not sufficiently tailored to the needs of specific groups in Birmingham – e.g. those on the edge of or leaving care or young homeless people. It was suggested there was a need for more outreach work to be built into the model since this style of intervention was often needed for engaging with such groups of young people.

In terms of the planned partnership working between FTB and VCS, an early conclusion from the baseline interviews was this required considerable development; some interviewees indicated that they did not feel equal partners but that their agencies were:

"Being used to mop up FTB's waiting lists"

3.3.4 Inconsistent responses to children, young people and families

A number of those interviewed noted concerns about inconsistencies in response and that there needed to be "transparent and explicit" criteria. For example, some interviewees reported experiences of some young people being accepted and offered a service, whereas others going to PAUSE with very similar difficulties had been turned away.

Several VCS interviewees expressed concerns about children and young people being 'passed around' due to capacity overload in the service. Others were concerned that there was limited information about what or where young people were being signposted to and/or a lack of feedback from FTB to referrers as to how a child or young person would be supported/what would be offered. However, it should be noted that some interviewees reported that information sharing about what was planned had recently improved after what many viewed as a "*rocky start.*"

3.3.5 Loss of areas of provision that used to work well

In a similar vein to some of the comments noted in Chapter 2 about the commissioning and procurement process, in the baseline interviews, a number of people talked about the loss of

arrangements that had been well-established and previously worked well. For example, before FTB, it was reported that the Home Treatment team had worked well with the Parkview inpatient unit in discharge planning; the presence of the HT team on the ward had now largely disappeared. Planning of admissions was also much more disrupted due to a lack of continuity of mental health staff/consultants in the community.

3.3.6   Use of agency staff and role of Beacon

Some interviewees questioned the role of Beacon, in particular, its apparent reliance on agency staff who, they believed, were not clinicians with the requisite skills or experience to offer triage.

They highlighted the risks this posed of children and young people not being picked up or appropriately referred on for specialist mental health assessment and treatment. In one interview, examples of inappropriate referrals and referrals where no safeguarding work had been undertaken, were reported.

Beacon's data management system and the promise of being able to track a child or young person's journey through FTB in order to optimize timing, frequency and duration of interventions was welcomed. At the time of these interviews, however, it was too early to assess how well this would work in practice.

3.3.7 Data management systems and information sharing

Recording systems within FTB were widely acknowledged to be still evolving. However, in many cases, these were described as needing significantly more development and standardization since not all parts of FTB were using the same systems or recording in a consistent way). Some interviewees highlighted difficulties access old patient data/records and others reported feeling unsure about data quality. Computers were also described as running "slower and slower" leading to delays being able to write up care notes and with the IT department apparently advising (in response to staff complaints) that the computers in use across FTB were not designed for multiple users and so were getting 'clogged up.'

3.3.8 Service infrastructure

Whilst working in a portacabin was viewed as fine and largely to be expected in the NHS, some interviewees highlighted that FTB's infrastructure/provision of clinic and office space needed attention – that the noise levels in some portacabins made it difficult, for example, to have sensitive conversations over the phone, including those about safeguarding concerns. Some staff were also reported to be sharing phones, having been told it was too expensive to provide more.

Chapter 4: Impact evaluation - distilling the outcomes in relation to the core aims of the service
Andrew Thompson, Rachel Upthegrove, Max Birchwood

4.1 Summary

1. Five core questions were distilled and agreed with commissioners which would enable FTB to understand whether it is meeting the basic requirements of an early intervention approach to youth mental health, consistent with the principles of the service. These were derived from parallel work we have undertaken in first episode psychosis and early intervention teams and work demonstrating congruent logic with wider youth mental health.

2. Commissioners requested that the balance of the evaluation focused on qualitative elements of the service structure and function, hence the impact evaluation was restricted to routinely collected data; however we were given the opportunity to shape the architecture of the data collected to enable these questions to be answered, including high level service indices (DNA, waiting times..), individual-level outcome data. The architecture we gave to FTB/Beacon to answer these questions unfortunately was not realised so we had to rely on unprocessed anonymized 'data dumps' from the Informatics Team. We had to clean these data and analyse them; there was considerable missing data.

3. The quality of the data was such that none of the core questions could be answered - this is important as it means that FTB do not know if they are meeting the basic requirements of the service specification laid out in the service specification.

4. Nevertheless, we were able to record the high level of referrals to FTB within the first year (23,247) which was mainly from GPs (45%). 7261 (31.2%) patients were offered and attended an FTB appointment and 767 (3.3%) did not attend. This suggests a low DNA rate but appears rather low and in conflict with other data collected by FTB. It also conflicts with some of the data gathered through the focus groups and interviews with young people (see Chapter 7).

5. The delays from referral to first appointment booked was a mean (delay) of 51.6 days, then a further 5 days until the appointment (total 55 days), with considerable variability. The average time from referral to discharge in those who were offered appointments and attended was 124.8 days; this suggests on average 2 months of treatment time.

6. FTB are not able to track and understand the outcomes of those individuals who were not offered an appointment (46.5%) and then 'signposted' to a charitable or other VCS service for young people (72% of this group). This sit uneasily with the foundations of the new service, it is, however, congruent with reports from partners of a high level of unplanned 'signposting'.

7. No individual level outcomes are being collected or available to us - as such, we do not have any data suggesting interventions are correctly applied or bringing positive outcomes/improvements in mental health or wellbeing of those seen in the service.

8. There were no trends suggesting that the service improved over the first year.

9. Admissions and in particular out of area placements are unchanged and remain high (36 OOA in July 2017). This suggests that the home treatment and admission/discharge are operating less than optimally and/or insufficient beds, though we were not asked to focus on the acute pathway (but note that this has been the subject of a separate piece of modeling work by Mental Health Strategies).

4.2 Aims

In this element of the evaluation, following discussions with the commissioners, it was agreed that the evaluation would address the following questions as they relate to the mental health needs of young people seeking help and the early intervention approach taken by the service:

Question 1: Is 0-25 transforming access and equality of access to interventions for those that need it?

Question 2 - What are the pathways to care, patient flows and duration of untreated mental health difficulty, including: time to first assessment following first help-seeking contact and time to first assessment following receipt of referral?

Question 3 – To what degree is 0-25 successful in maximizing engagement of individuals and their families and delivering interventions, following access to an initial assessment?

Question 4 – Is the 0-25 service transforming recovery and resilience such that further service use is reduced?

Question 5 –To what degree is 0-25 making use of established and emerging indicated prevention strategies (early identification of emerging mental health disorders), within the service and in linked community settings?

4.3 Methodology

The original evaluation proposal set out a design for the collection data on all cases accessing the service with monthly data examined over 3 epochs in the delivery of the new service: 0-6 months; 6-12 months; and 12-18 months, comprised of high-level service and routinely collected individual level data.

The service data was to cover service indices such as DNA, community attendance, admission, occupied bed days, readmission rates, A&E attendance, Place of Safety, home treatment contacts and individual level data, was to including a clear coding of diagnosis and HoNOS care cluster and NICE approved interventions. Standard clinical outcome measures such as the HONOS/HONOSCa, WEMWBS, SDQ and ESQ were also requested.

Unfortunately, outcome measure data proved to be largely lacking and it appears that across FTB, completion of outcome measures was (and remains) patchy; what data that were available, were not of a high enough standard to do any formal or meaningful data analysis.

To try and gather at least some individual outcome data, the evaluation team then suggested FTB collect more specific and detailed patient and carer data on a subset of patients (1 in 10) coming through the service hubs collected using tablets devices. Again this proved impossible during the current implementation of the service. The evaluation team believes that there are plans to consider this system in the future.

4.4 Data provided by FTB

Data on some of the service data originally requested was received but a number of the requested items were missing. In the first set of data received (1st April to 31st December 2016) there was initially a considerable amount of missing data with regard to outcome of referrals and so it was difficult to evaluate pathways within the service. Key variables had data missing in up to 70% of cases: for example, DNA rates for assessment or first contact were impossible to report with any accuracy, and as this a key impact, hence engagement will remain unclear; first

appointment attendance outcome was initially missing in 8372 out of 12442 cases. Some of this has subsequently been rectified but the missing data rate for outcome of what happened to an individual referral remains at around 20% and higher for some variables. Data has been made available up until the 30th June 2017.

For these reasons and given the quality of the data, this chapter presents figures for the whole period of the evaluation (1st of April 2016 to 30th June 2017); this is followed by some data split into two separate time periods (the first and last 6 months) to look at overall trends in areas where this is possible rather than the proposed 3 time periods. This is with the caveat that there is a considerable amount of missing data.

The specific questions asked of the service comprise the final sections of the chapter.

The evaluation team have been able to access data for the period 1st April 2016 to the 30th June 2017 to be able to report referral, basic demographic information including gender and ethnicity, appointment offered, DNA, postcode source and discharge (e.g. signpost).

4.5 Overall analysis of service data

Data analyses for the period 1st April 2016- 30th June 2017. For data that was missing we have coded the outcome as "appointment not offered not discharged" as we are not sure if these individuals were discharged from the service and their data not recorded, or the data was missing. This was the case for 4403 patients (18.9% of the sample).

4.5.1 Information on referrals

23247 referrals received were received over the 15-month period. There is no detail on how many patients this equated to (i.e. more than one referral for individual patient may have been received in the 15-month period). 52.5% of all referrals to the service were female.

Figure 1: Referrals by gender
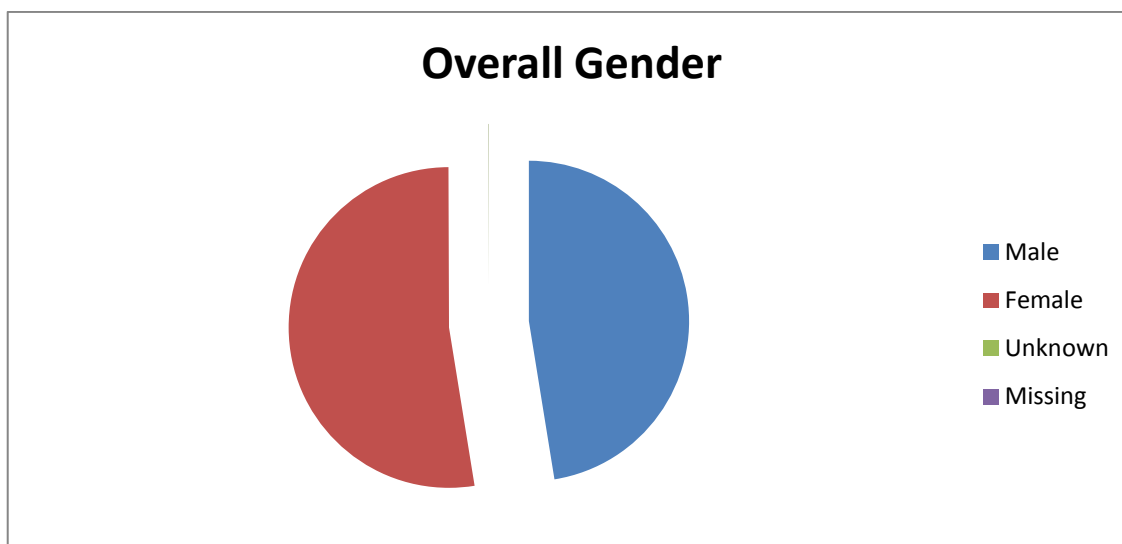
4.5.2 Ethnicity

Information on ethnicity was missing or not stated for 55.1% so these results should be

interpreted with this major caveat. Of those where ethnicity was recorded 62% were white, 19% Asian and 9% Black.

Figure 2: FTB referrals by ethnicity

Overall Ethnicity - Not Stated/Missing Removed
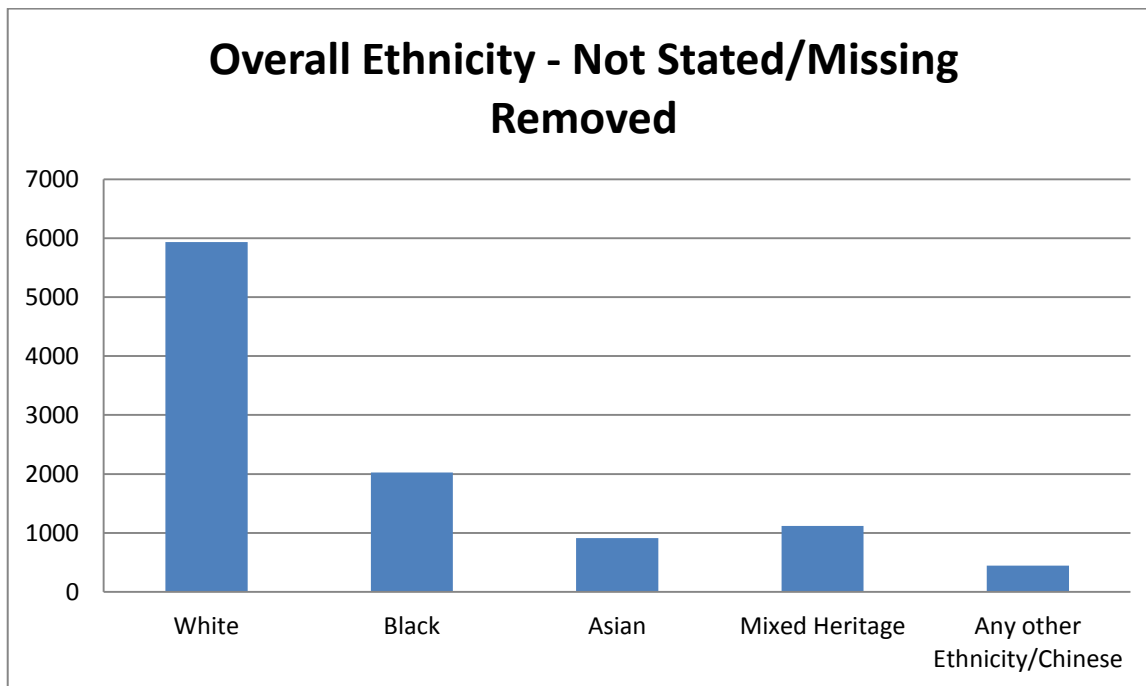
4.5.3 Age of referrals
The highest number of referrals fall in the 12-16 age group, followed by those aged 17-20. Referrals of those aged 11 and under are considerably lower.

Figure 3: FTB referrals by age

Overall Breakdown of Age
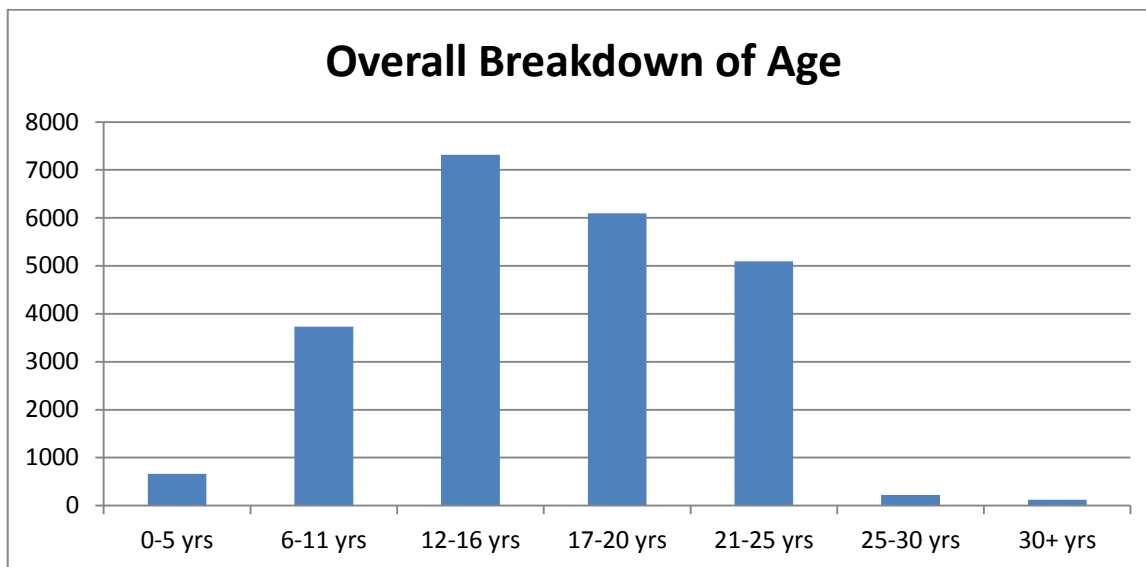
4.5.4 Referral Source

The highest referral source was from General Practitioner (GP) referrals (45.2%). There were a number of other referral sources but none accounted for more than 10% of the total referrals. Self-referrals were relatively low at 7.4%, as were A&E Referrals at 1% (suggesting possible inaccuracy in recording).

Figure 4: Referrals by source
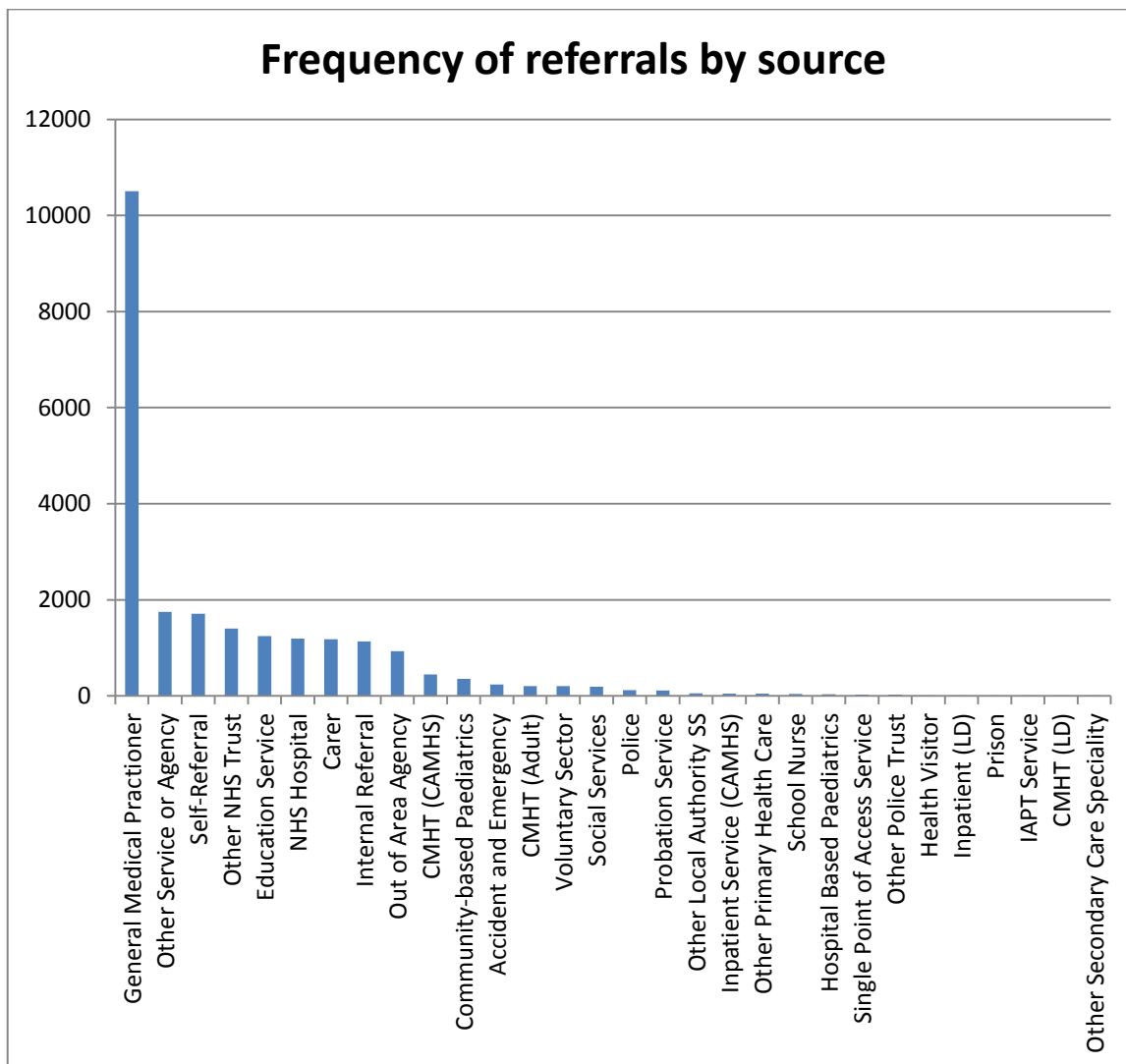
Figure 5: Outcome by referral source
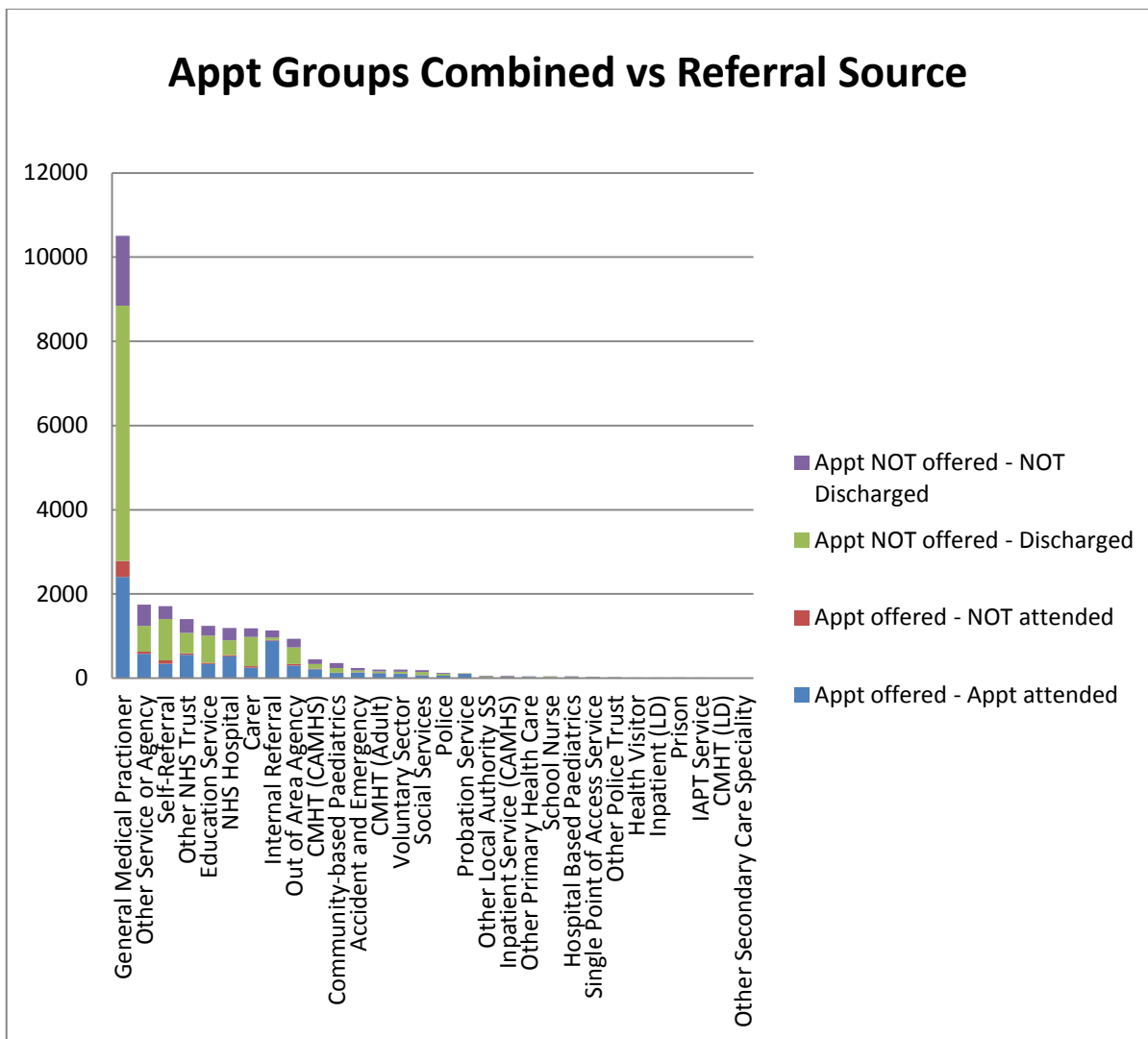
4.5.5 Outcome of referrals

Of 23247 referrals, 7261 (31.2%) patients were offered and attended an FTB appointment and 767 (3.3%) did not attend an FTB appointment. This appears rather low and in conflict with other data collected by FTB.

Table 1: Overall breakdown of appointment groups

Grouping	Frequency	Percent	Age at Referral	AgeatRef Std	Age range
Appt offered - Appt attended	7261	31.2	16.93	5.13	0-34
Appt offered - NOT attended	767	3.3	17.61	4.93	2-32
Appt NOT offered - Discharged	10816	46.5	15.38	5.30	0-74
Appt NOT offered - NOT Discharged	4403	18.9	16.72	5.41	0-34
Total	23247	100.0			

As stated above there was around 20% of patients where the outcome of the referral is not clear. The recording of outcome did improve over time during the evaluation.

4.5.6 Service delay

The delays from referral to first appointment booked was a mean (delay) of 51.6 days; then a further 5 days until the appointment

Average time to discharge in those who were offered appointments and attended was 124.8 days.

Table 2: Delays in service[1]

Delay Coding		N	Minimum	Maximum	Mean (days)	Std. Deviation	Data Error	Missing
Appt offered - Appt attended	Total							
	Service Delay	7189	0	475	51.58	48.70	72	0
	Appt Delay	5906	0	338	5.08	22.02	1	1354
	Total Appt Delay	5872	0	419	47.82	45.54	66	1323
	Overall Delay	1565	4	458	124.82	98.08	5	5691
Appt offered - NOT attended	Total							
	Service Delay	763	1	282	52.23	44.38	4	0
	Appt Delay	n/a	n/a	n/a	n/a	n/a	0	767
	Total Appt Delay	n/a	n/a	n/a	n/a	n/a	0	767
	Overall Delay	766	11	467	92.84	89.44	1	0
Appt NOT offered - Discharged	Total							
	Service Delay	n/a	n/a	n/a	n/a	n/a	0	10816
	Appt Delay	n/a	n/a	n/a	n/a	n/a	0	10816
	Total Appt Delay	n/a	n/a	n/a	n/a	n/a	0	10816
	Overall Delay	0	468	36.16	52.976	72.349	30	0

[1]Service Delay = from first referral received to first appointment booked.

Appt Delay = Appointment Booked to appointment attended
Total Appt Delay = First referral received to appointment booked.
Overall Delay = First referral received to discharge date.

4.5.7 Discharge destination and 'signposting'.

Of all referrals, 7832 were signposted to voluntary and community services at first contact (72.4% of all referrals not offered an appointment). There is no detail on which voluntary or community service they were referred to or outcome attendance thereafter. There were a variety of discharge destinations for those who attended appointments with the service. For those who DNA'd appointments with the service, voluntary and community services (VCS) were the most common discharge destination (266 or 42.3% of those with known discharge destinations).

Figure 6: Discharge outcomes - discharged
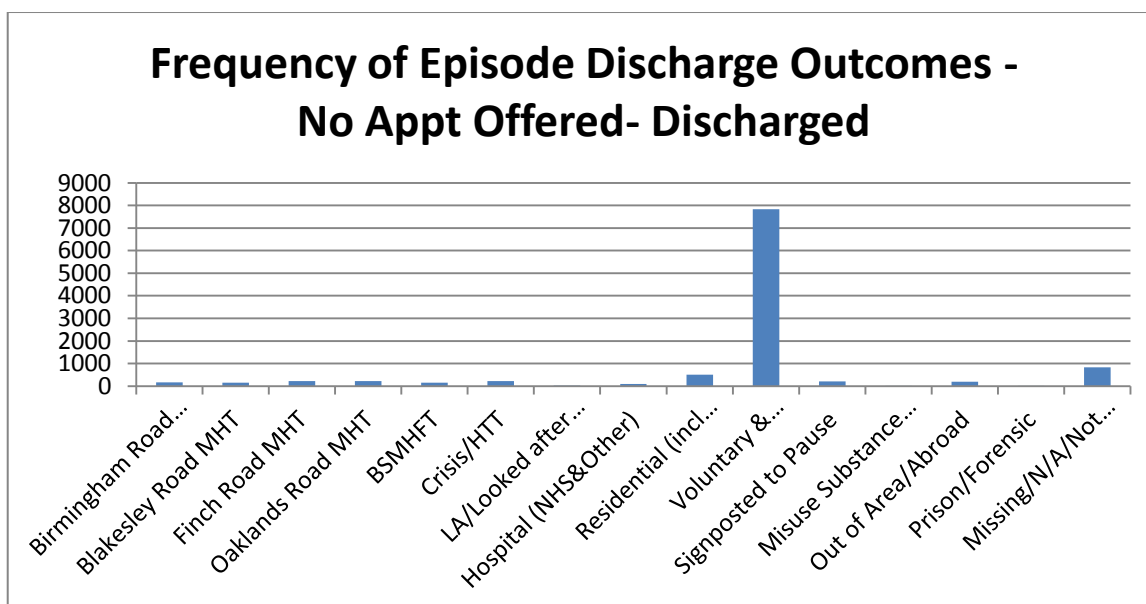
Figure 7: Appointment not offered
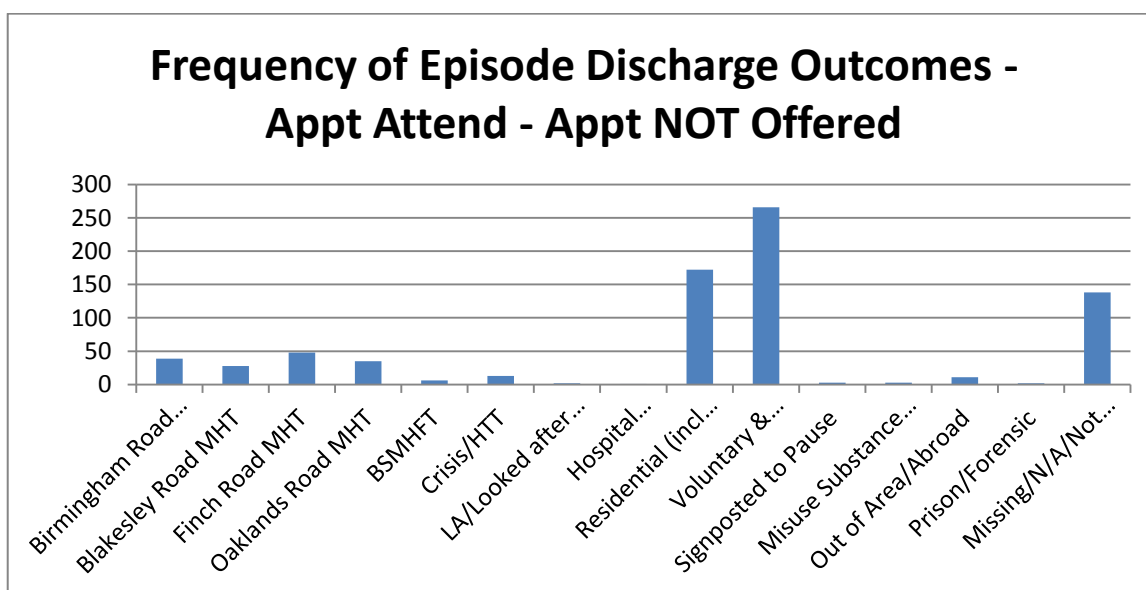
Figure 8: Appointment attended

Frequency of Episode Discharge Outcomes - Appt offered - Appt attended
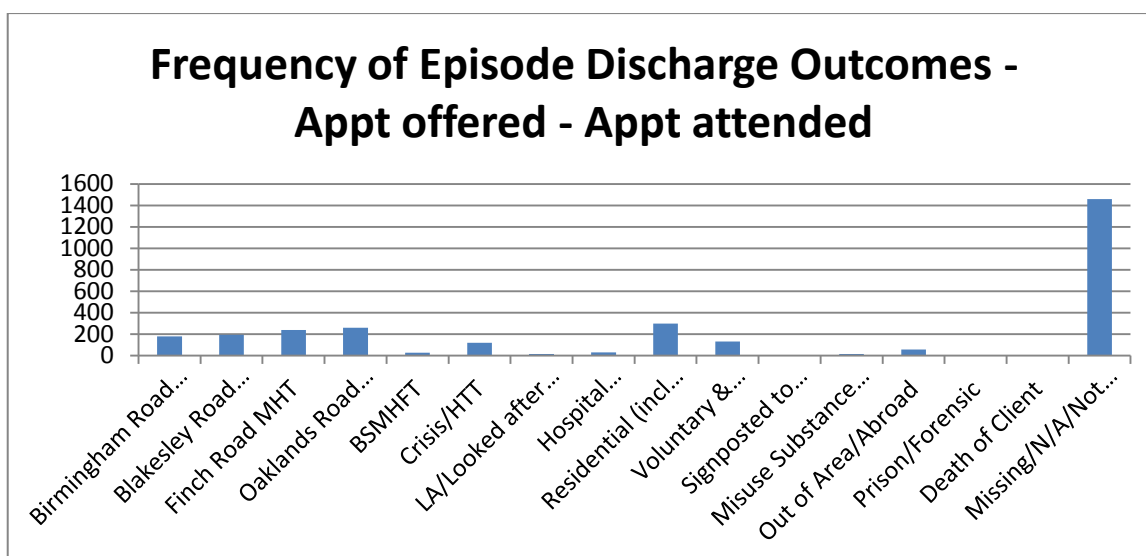
4.5.8 Outcome of referral by source

Of 10508 GP referrals, (22.9%) were offered and attended appointment. This was similar to that of self-referrals (20.2%). These data are shown in Figure 9.

4.5.9 Reason for DNAs

Of the 23247 referrals, 767 patients were offered appointments and did not attend (3.3%). The reasons recorded for the DNA's are shown in Figure 10.

4.5.10 Priority of appointments

Around 11% of appointments that were attended were identified as "crisis" priority and around 50% of the DNA appointments were classified as routine as opposed to 36% of the attended appointments. These data are shown in Figure 11.

4.5.11 Referrals by broad postcode

There is a wide variety in postcode of referrals with B31 and B29 being the highest, with over 1200 referrals each, other postcodes had single figure levels of referrals.

We were not able to investigate whether there was a relationship between the deprivation index of an area and referral rate. We were also not able to investigate expected referral rates per postcode given the distribution of people aged under 25.

There results should be interpreted with these caveats and are therefore not weighted for population or deprivation.

Figure 9: Appointments by referral source

Figure 9: Appointments by referral source
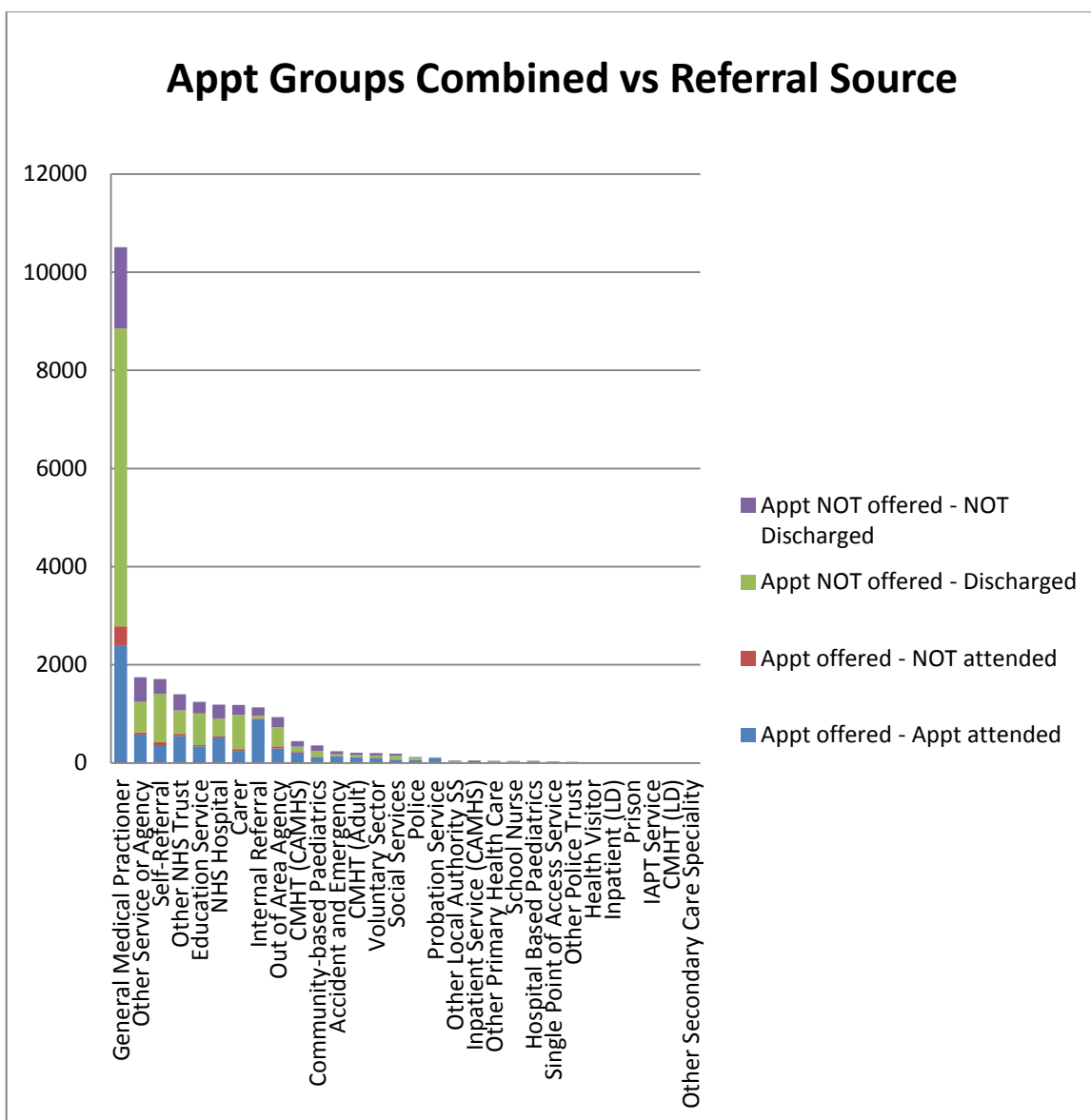
Figure 10: Outcomes for DNAs

Pie Chart of Outcomes for Appt Offered - Not Attended

- 10% Cancel - By client
- 9% Cancel - Health Prov
- 29% Confirmed
- 29% DNA - No warning
- 1% To be attended
- 0% To be attended - Mobile
- 22% Unable to contact patient
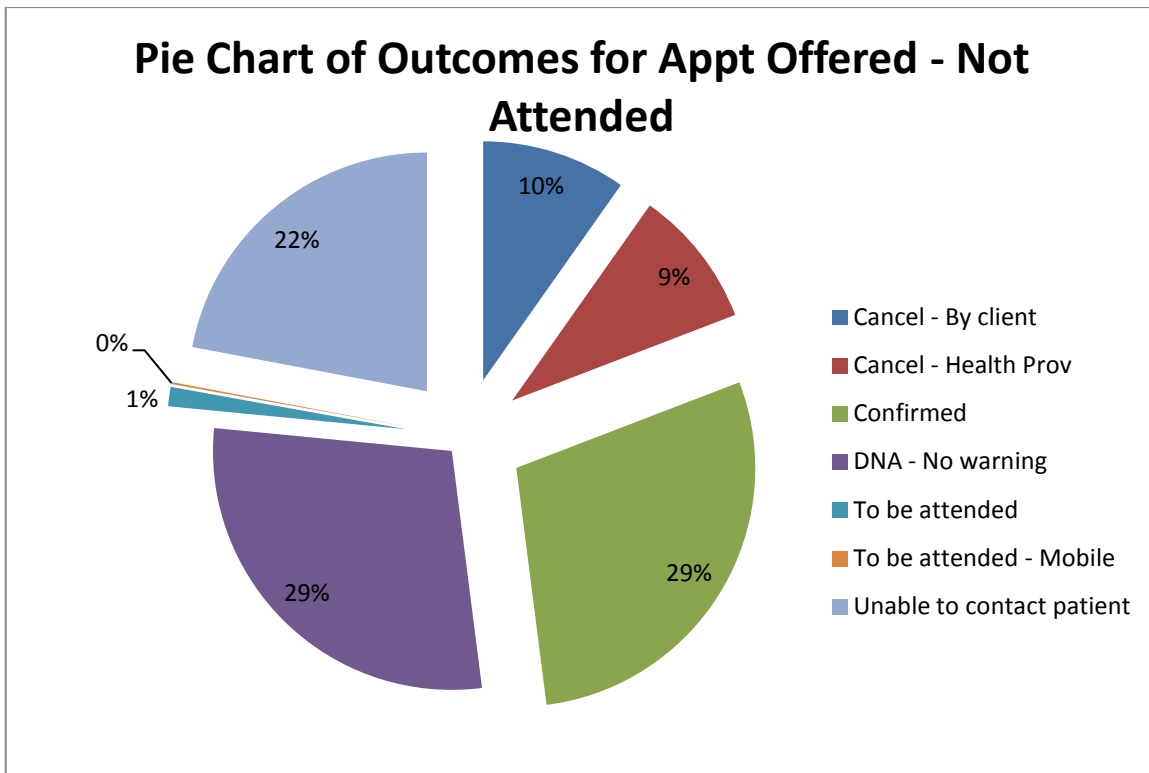
Figure 11: Priority of appointments

Pie Chart of Priority of Appointments Attended

- 1% Awaiting Further Information
- 11% Crisis
- 36% Normal
- 0% Query ED
- 1% Query EI
- 1% Query Perinatal
- 36% Routine
- 35% To be Assessed
- 0% Unknown
- 15% Urgent
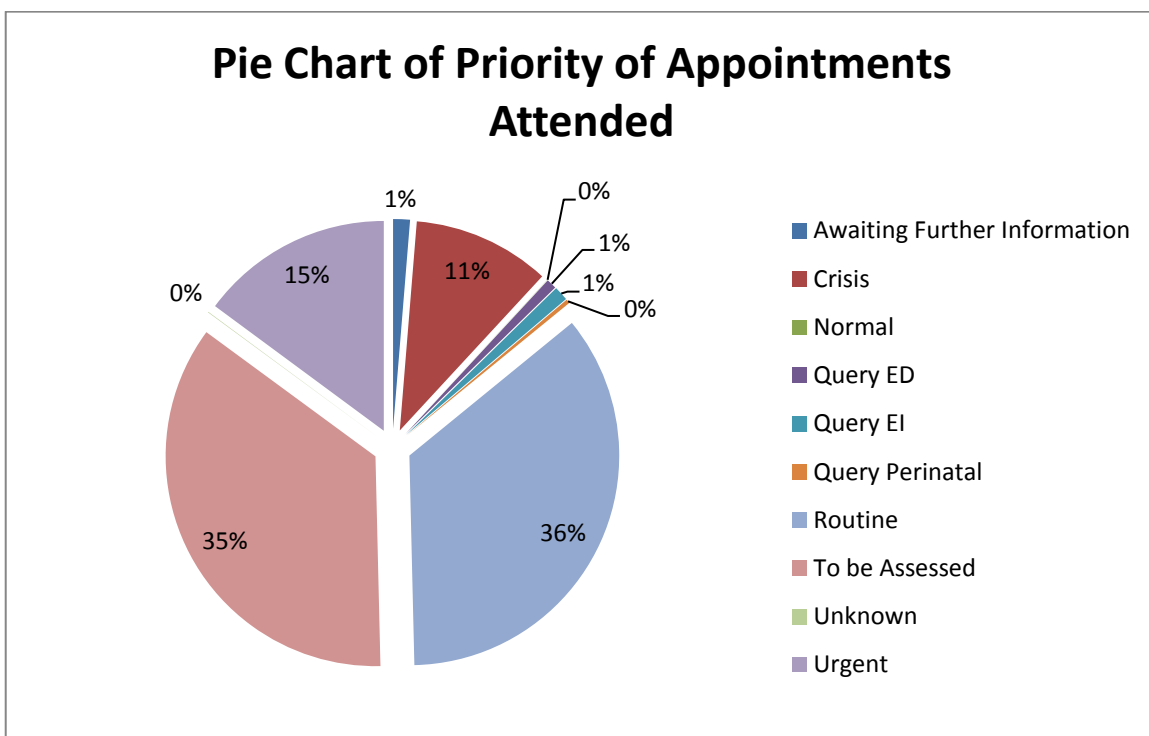
Figure 12: Priority of appointments not attended

Pie Chart of Priority of Appts NOT Attended

- 7% — Awaiting Further Information
- 5% — Crisis
- 1% — Query ED
- 1% — Query EI
- 48% — Routine
- 29% — To be Assessed
- 9% — Urgent
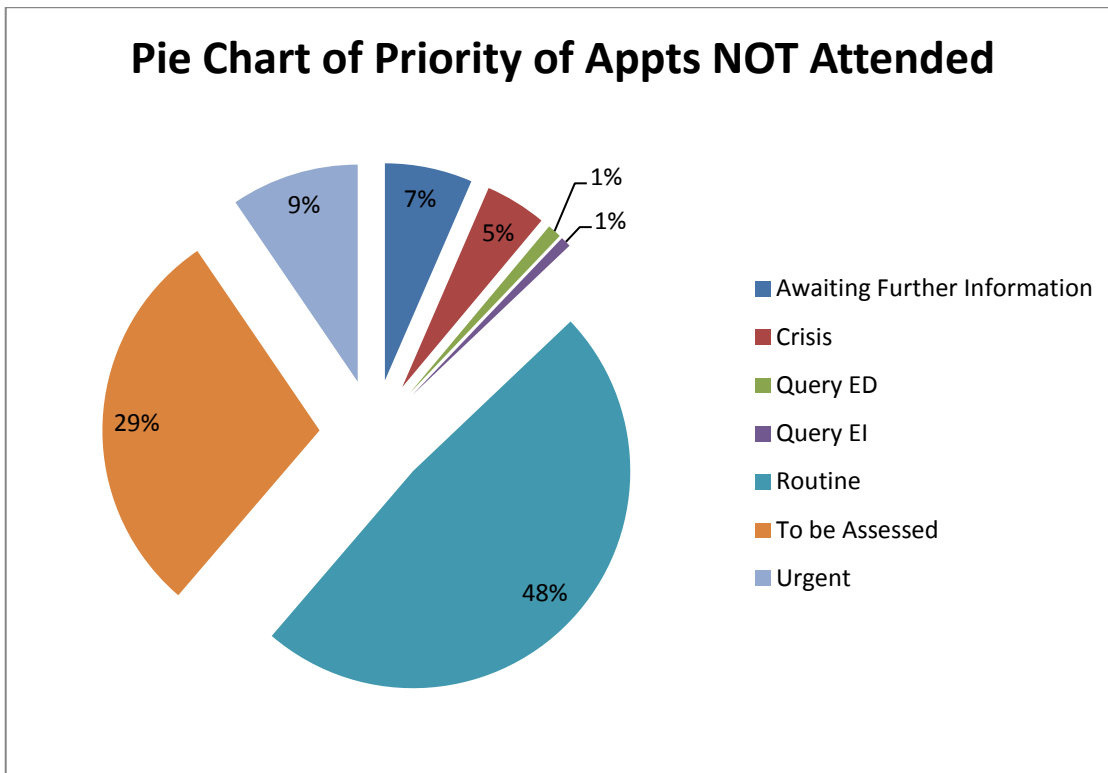
Figure 13: Referrals by broad postcode

Appt Groups Combined vs Postcode

- Appt offered - Appt attended
- Appt offered - NOT attended
- Appt NOT offered - Discharged
- Appt NOT offered - NOT Discharged
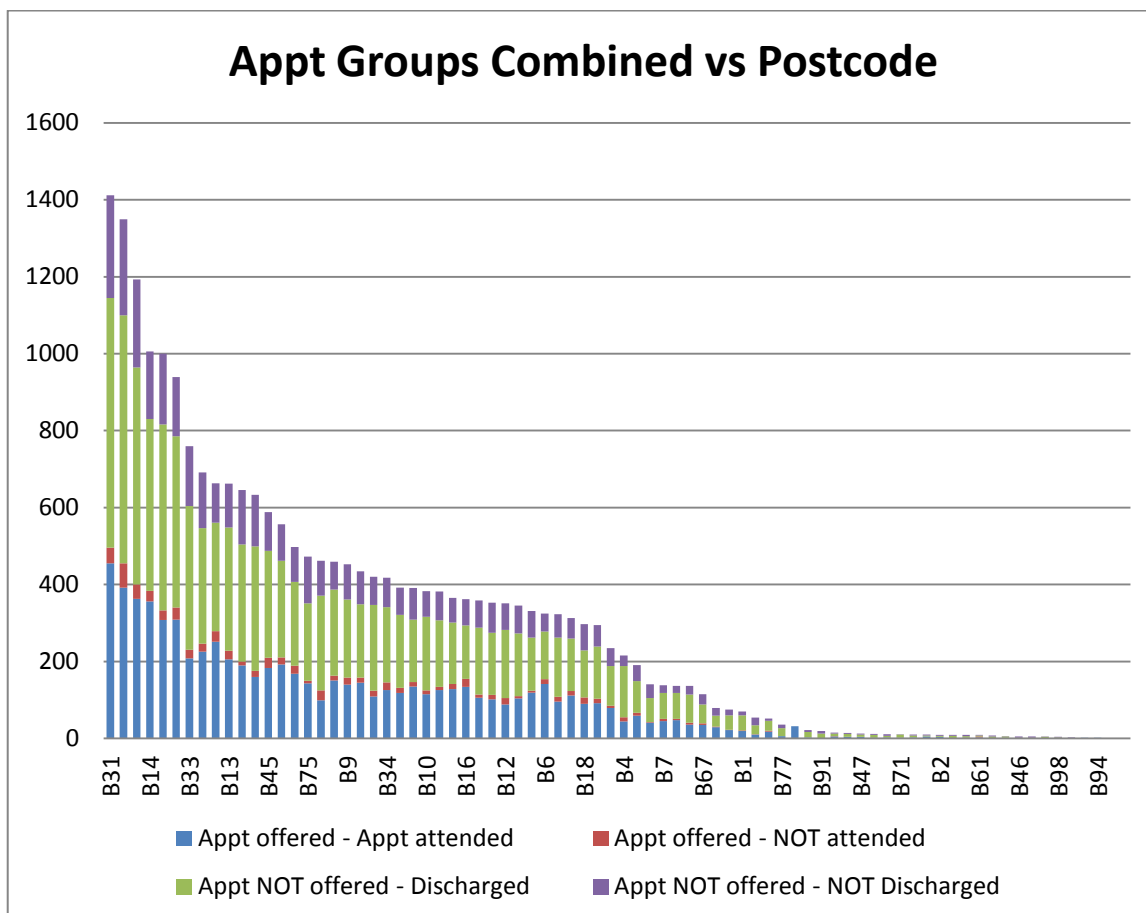
4.5.12 Incidents, Complaints and Hospital admissions

Complaints received between the 1st of April 2016 and 30th June 2017 = 17
Serious Incidents 1st of April 2016 and 30th June 2017 =17
No further breakdown of incidents or details was available

Figure 14: Serious incidents and complaints
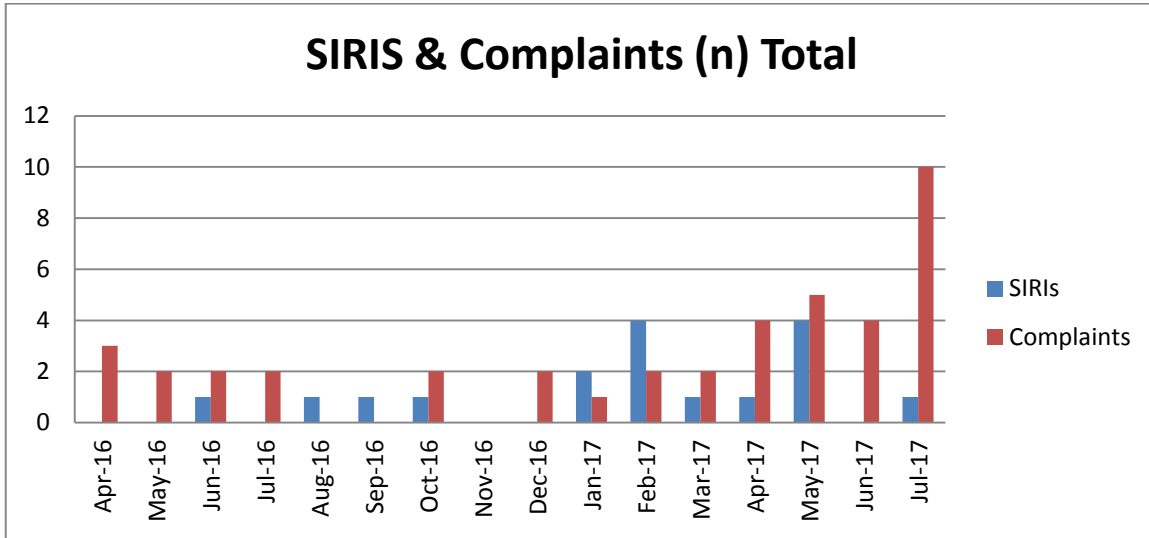
4.5.13 Hospital admissions
Admissions between 1st April 2017- 30th June 2017 – total admissions 727, average 48 (per month range 27-94); total occupied bed days 22054; average months occupied bed days 1470
Out of area placement (range 7-45, average 24)

Figure 15: Total inpatient admissions
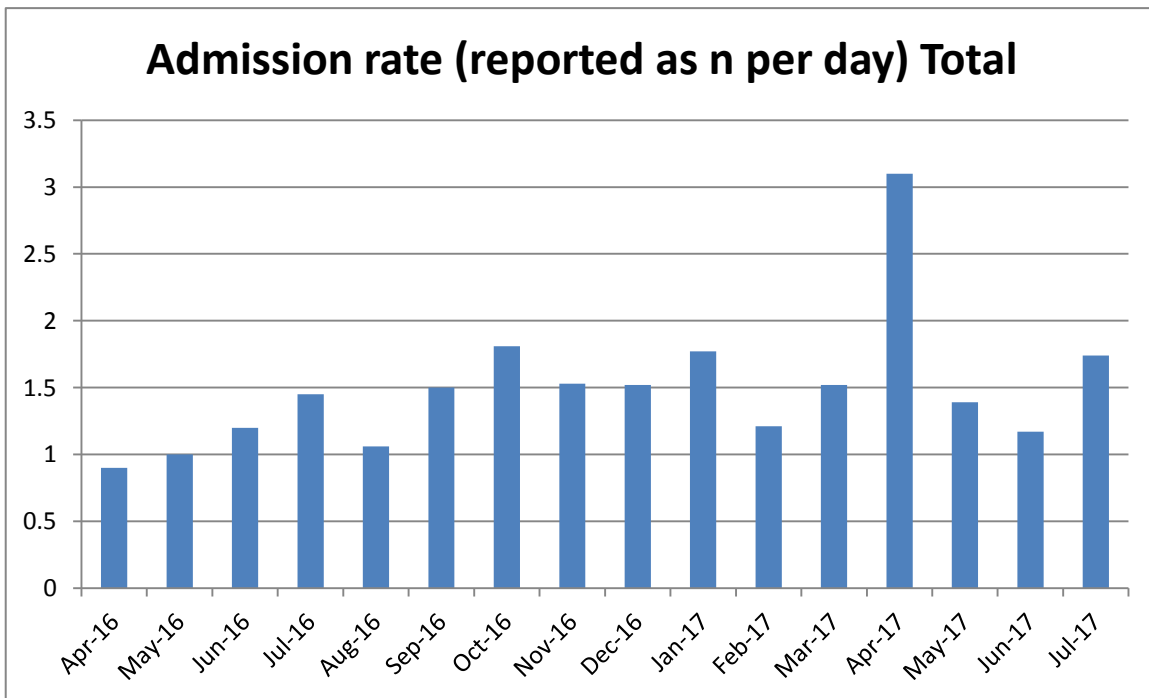
Figure 16: Out of area placements in inpatient provision

Out of Area Placements Total

(Bar chart showing Out of Area Placements Total by month:)
- Apr-16: 7
- May-16: 17
- Jun-16: 22
- Jul-16: 19
- Aug-16: 16
- Sep-16: 31
- Oct-16: 28
- Nov-16: 17
- Dec-16: 27
- Jan-17: 14
- Feb-17: 17
- Mar-17: 22
- Apr-17: 45
- May-17: 23
- Jun-17: 16
- Jul-17: 36
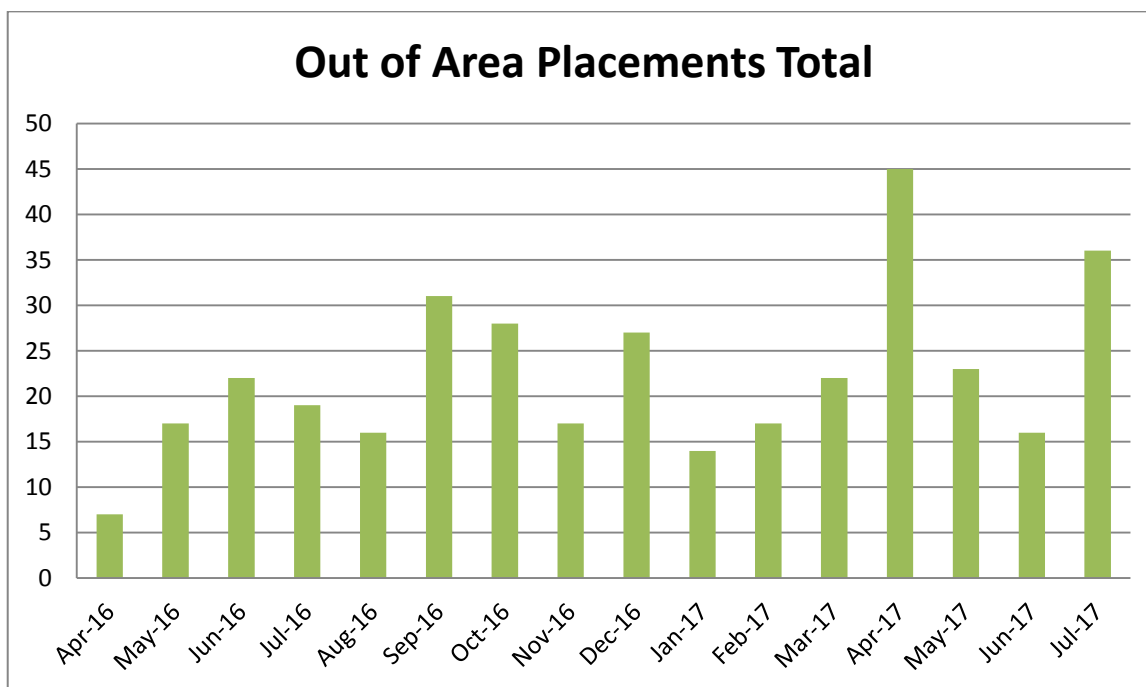
4.6 Data divided into 2 time periods to examine change over time as the service mobilized.

The data was divided into two equal 6-month periods to look at the first and most recent 6 months of service activity:

➢ Time period 1 - 1st April 2016 to 31st October 2017

➢ Time period 2 - 1st January 2017 to 30th June 2017

Overall there were 9,254 referrals the first 6 months of the service and 10,772 referrals in the 6-month period, a sizeable increase of 16%, suggesting the rate of referral is increasing. Apart from this, were no trends across the first year of operation suggesting that there was improvement in the service performance or populations served (Full analyses shown in Appendix 1).

4.6.10 Incidents, Complaints and Hospital admissions

Table 19: Complaints and serious incidents

	Complaints	Serious Incidents
Time period 1	9	3
Time period 2	11	11
Total	20	14

There was an increase in reported serious incidents in the second time period; the number of complaints was similar.

There was no further information available about the serious incidents to explore this finding further.

4.6.11 Hospital admissions

Table 20: Inpatient admissions

	Admissions	Average stay (n days)	Average monthly admissions rate (n per day)	Average out of area placement (n days)
Time period 1	217	36.2	1.19	18.7
Time period 2	306	51	1.69	26.5
Total	523			

There was an increase in both admission rate and numbers of out of area placements between the two time periods but considerable variability on a monthly basis.

4.7 What this data tells us about the recent and current operation of FTB

The gaps in data, and in particular, the lack of individual outcomes data, makes it difficult for the evaluation to draw conclusions about how well or otherwise FTB is delivering a mental health service for children and young people that delivers improved clinical outcomes, within an early intervention framework. Below we provide responses to the questions it was agreed that the impact evaluation would focus on:

4.7.1: Is the new 0-25 model transforming access and equality of access to interventions for those that need it?

Given the data available we are unable to unable to answer this question. There is clearly a difference in referral rates by large postcode denominations are but we were unable to access individual postcode to examine if areas with higher levels of deprivation have differential referral rates. There is some suggestion this is the case. There are some postcode referral changes over the two time periods but this would need further investigation.

4.7.2: What are the pathways to care, patient flows and duration of untreated mental health difficulty, including: time to first assessment following first help-seeking contact and time to first assessment following receipt of referral?

With the data we have at present we can only give very tentative answers to this. We are, for example not able to distinguish new referrals from re-referrals.

The time to first assessment is relatively long, at around 50 days mean, but has reduced very slightly.

In understanding pathways to care (as well as considering the demand facing FTB), there is also the question of children and young people seen in PAUSE but where referral data is not entered onto CareNotes or RIO but instead goes onto the Children's Society database MOSAIC (on the basis that their needs do not warrant creation of an NHS record – e.g. a drop in visit for general advice). Currently this largely sits outside of the main activity and outcomes data collected by FTB and although the Children's Society report all PAUSE activity on a monthly basis to FTB, it is recognized these data can easily missed since they do not fall fit easily with NHS reporting categories such as 'referrals to treatment.'

To date, the evaluation team has not been able to undertake any detailed analysis of PAUSE data but one conclusion is that further investigation is needed, to ensure all contacts with FTB are reflected in their outcomes/activity data

In particular, FTB are not able to track and understand the outcomes of those individuals who are not offered an appointment (46.5%) and then 'signposted' to a charitable or other VCS service for young people (72% of this group). This sit uneasily with the foundations of the new service.

4.7.3: To what degree is 0-25 successful in maximizing engagement of individuals and their families and delivering interventions, following access to an initial assessment?

Given the data we have we are unable to answer this question. We are aware that the DNA rates are relatively low and have reduced in the last 6 month of service operation. The data also suggest that people are being discharge from the service faster but it is not clear whether this is due to service pressure or improved outcomes.

Data gathered through the focus groups and interviews have highlighted concerns about FTB's use of CAPA and long delays post a 'Choice' appointment and being seen for a treatment appointment, also concerns about shortages of clinicians within FTB causing blockages in individual assessments. Consistent with this, the VCS and other partners have highlighted high and increasing levels of signposting out from FTB following triage via the Access Centre and have questioned whether all of these are appropriate (see 6.4.5). There have also been repeated reports of high staff turnover and changes of young people's care co-ordinators, with staff departures sometimes resulting in children or young people going back on to a waiting list. It is not clear to what extent these and other 'internal waiting times' may be reflected in the activity data provided to the evaluation team by FTB.

In addition, we requested FTB workforce (current establishment) data in order to review the capacity of the service and to provide some assessment of whether the capacity is adequate to meet both the level of demand (numbers of referrals) and the complexity of need presented by children and young people. Unfortunately we did not receive these data.

4.7.4: Is the 0-25 service transforming recovery and resilience such that further service use is reduced?

Given the data currently available, we are unable to unable to answer this question. There is clearly a high level of need in the population given the very high numbers of referrals made to the service (23247 in 15 months). However, the lack of individual clinical outcomes data is a significant deficit here since without this information, it is impossible to report on any changes (improvements or deterioration) in the mental health and wellbeing of those receiving treatment and care from FTB.

4.7.5: To what degree is 0-25 making use of established and emerging indicated prevention strategies (early identification of emerging mental health disorders), within the service and linked community settings?

Given the data available we are unable to unable to answer this question as we do not have

specific data from these services. We have no evidence that FTB is making use of the latest developments in recognizing those young people at very high risk for e.g. Psychosis, bipolar disorder or eating disorders.

4.7.6: General limitations of the data

As stated above we have been unable to answer most of our initial questions with the data currently available from FTB. We have also noted the quality of the data was very variable, especially at the start of the evaluation when there was an appreciable amount of missing data.

Chapter 5: Key issues from the first stakeholder focus groups
Cathy Street, Yvonne Anderson, Jane Sedgewick and Fiona Warner Gale

5.1 Overview

Two rounds of focus groups for FTB staff and partners were convened in 2017, the first round running in June (six groups) and the second in September (four groups).

The groups covered a range of staff across FTB from the following teams and services: crisis service, home treatment, A&E, PAUSE and Access Centre/Beacon, Primary Mental Health Workers (PMHW), Eating Disorder Service (EDS), Learning Disability (LD), Under 5s services and FTB's community hubs. Two groups were specifically for staff working in voluntary and community sector (VCS) services across Birmingham, both those commissioned by FTB for specific provision and those not commissioned but often referring to, and taking referrals from FTB. Numbers of attendees at the groups ranged between 4 -10 participants per group, with a total of 56 stakeholders in the first round and 29 stakeholders in the second round of groups.

The groups were run in a variety of local venues across Birmingham including the Oaklands and Birmingham Road FTB Hubs, Parkview, St Basil's and the Bennett Hill offices of the Rape and Sexual Violence Project (RSVP).

Participants in the focus groups were self-selecting, through an open email invitation. A semi-structured topic guide was used to guide the conversations which explored participant views about how and to what extent the FTB service model was:

➢ Meeting local needs

➢ Engaging children, young people, parents and carers in a responsive way

➢ Developing partnership working

➢ Addressing some of the areas of concern that had affected the previous service arrangements such as long waiting times, poor access by some groups of the local population, high waiting lists for 16-18 year-olds with ADHD, high DNA rates, poor patient experience and dissatisfaction within referring agencies such as primary care (issues noted in the Birmingham Case for Change document dated November 2013).

The topic guide for the second round of focus groups included a summary of findings from the first series of focus groups. The purpose of these follow-up focus groups was to share initial findings, to check out accuracy, and to further consider the impact of the implementation of the 0-25 mental health service some four months later/nearly a year post the service first going live in October 2015.

Participants in the second series of focus groups were also asked for their recommendations as to how FTB should develop going forwards, in particular exploring the following areas/issues which were prominent in the first services of focus groups:

➢ Improving access to specialist help/treatment and reducing waiting times

➢ Developing capacity and the FTB Workforce

➢ Data and information

➢ Partnership working.

The focus groups were audio recorded and transcribed in full and/or full observer notes were taken. Data were analysed using Thematic Analysis in order to identify emerging themes and

sub-themes. The key themes identified are described below. Direct excerpts have been used for purposes of illustration, with any material that could identify participants being removed to protect confidentiality.

5.2 First series of focus groups – what was identified as working well

5.2.1 Transforming access to support

Participants highlighted that those aged under 16 now have a 24 hour crisis service that they never had before. The crisis and home treatment teams are led by senior clinicians and provide a swifter response. It was suggested that signposting had improved, that the skill sets of the staff are higher than before and that clinical delivery is better. Young people are also able to self-refer.

The crisis service was described as responsive and containing, covering acute provision, risk management and signposting, all within an average 72 hours. Signposting or onward referral can include home treatment, the emphasis of which is to prevent admissions through intensive support over up to 6 weeks. All of this is new for the age group 16-18.

Having access to a crisis service was recognized as very positive and did not happen before for those with eating disorders. Evening work and home visits have made a lot of difference to the patient experience. The service is more outward facing and in particular, staff in the Eating Disorder Service (EDS) and LD service, have found it better to work with the young clients in their family unit. Home visiting is beneficial but it takes more time: practitioners cannot see people back to back as they did in 9-5 clinics. A good marker of the benefits of the new ways of working is that there are reportedly fewer eating disorder crisis cases now and fewer DNAs.

The inpatient unit takes local and non-local referrals. In the past twelve months, participants reported that local admissions had reduced whereas the non-local had not, indicating that the new service is working. (The picture for under-18s is different) They thought there were also fewer A&E presentations. It was also suggested that:

> ➢ FTB is improving access by using **more and better triage** – although it was also highlighted that there is low capacity generally, for instance psychological therapy has a high number of locum staff and is therefore less stable, has less continuity and, in the opinion of a number of participants, is not as good as it was before. **Outreach** elements of FTB were also thought to be working well (if not yet widely known about).

> ➢ Within FTB, there is more **joint working** with other teams and no more internal referrals since these have been replaced by the integrated hubs.

> ➢ FTB's ways of working are more **collaborative:** the whole family, whether parent, step-parent or sibling, can receive a service which is more joined up than in the past; having FTB's own beds to refer into is better than before and there is funding for a specialist perinatal service that is very timely. Access for young parents also described as "vastly improved."

> ➢ There is positive change as a result of **PAUSE and the alternative access route** who, participants thought, work really well with the EDS and LD team. The PMHW model is new since FTB and involves consultation, simple intervention, or if complex a referral to a hub. (Though in reality PMHWs hold complex cases because, it was reported, hubs are up to and beyond capacity).

The Access Centre has been central to the new model FTB being able to meet local need. For the EDS, Access is now making appropriate referrals – but EDS can also filter by triage. EDS has someone available all day, a duty worker and telephone triage. With a caseload of 190 (90 more than expected) the duty system is important and helps compliance with standards on waiting times of five days for urgent and two weeks for routine referrals.

The LD service reported putting in a lot of work to build relationships with Access, again finding it challenging at first, with inappropriate referrals and signposting, but having worked through this, described now feeling confident that the right people are receiving a service.

Staff reported more crossover skill sharing and joint working, based on the understanding that not everyone needs to cover the whole age range but it is important to keep up to date and understand the issues.

In terms of communicating about the new model and promoting access, a variety of stakeholders reported that the early set-up phases had looked:

 "*very promising with lots of consultation with the local population, good and frequent newsletters, an engaging website and easier referral pathways…. The old system was rigid and this looks more flexible"* (VCS partner)

However, it was concluded that some of this initial promise appeared to be waning, with communication dropping off (e.g. it was reported that the newsletters had stopped) and concerns emerging about long waiting times, higher thresholds, service capacity overall and more signposting out (discussed later in the chapter).

5.2.2 Self-referral and PAUSE drop-in centre

Good feedback across services for PAUSE drop-in service was noted; people like its informality and the staff are seen as engaging well with clients. Self-referral, including via online avenues, was thought to be an excellent innovation – with more young people now coming forward, e.g., from situations where there is domestic violence and this has widened the scope of the service appropriately.

However, it was also pointed out that there is a balance to be struck between low level support and high level need. At the time of these focus groups, PAUSE reported no particular pattern to presentations, with each day being different. It was also noted that service users can't see the same person each time at PAUSE as it is drop-in and there are no booked appointments (which most people were thought to be happy with).

Furthermore, an important suggestion at this point in the evaluation was that one PAUSE was not enough and that another is needed to meet all the need/demand. It was also highlighted that neither PAUSE or the Access Centre (which operates 8am – 8pm weekdays and 10am -3pm on Saturday and Sunday) are intervention services and dealing with all the need and demand means the teams have had to learn to be more resilient.

Additionally, a number of participants suggested that more information about what PAUSE does was needed (e.g. some suggested that young people thought it was for crises only) with one stakeholder commenting:

"it could be very good if it had a tighter focus, was clearer what it did or could not do, offered home visits since not every young person is OK coming into the city centre and ensured its staff were trained and experienced…"   (VCS stakeholder)

5.2.3 Team cohesion and working together

A contributor from Worcester reported that it was strange at first to do the same job in different service. In some ways there had not been much change and workers were still using local systems, specifically in the EDS. The main link and interface had been with Access and other than that there has been no appreciable change other than meeting new people at training. Participants suggested that now everyone was FTB, staff in EDS had stopped viewing others as '*you are Birmingham, you are Worcester*' ; however, there were still some niggles, such as knowing which training was mandatory and access to training records continued to be difficult.

Partnership working is discussed more fully later in this chapter and while it has taken time to become embedded, some participants view it as a positive aspect of the new model. One long

term CAMHS professional felt that the positive aspect for them of the partnership model was that they were now more confident in approaching other organisations and creative in setting up new partnerships. An example was given of FTB under 5s, Birmingham City University and the Multiple Births Foundation forming a new partnership with the aim of promoting collaborative research and good practice. This person felt there is an opportunity to '*go out and create*' rather than sit back and wait for others – partnership is more proactive and outward facing.

In one sector staff feel they have really developed as a team, whereby those with adult training have learned skills for working with under 16s and those qualified in children's working have developed their expertise with older young people and adults. Teams were full of praise for the Access Centre:

"really helpful, always on the end of the phone and parents are so grateful to have a response and feel reassured."

One contributor asked *"Where did those people go before?"*

5.3 Concerns and challenges

The initial round of focus groups revealed an array of concerns and challenges, some of which, it must be acknowledged, were likely to be the result of the large-scale change to the service model required to implement FTB. However, over and above this, the concerns and challenges identified by these stakeholders raise some fundamental questions about the following interconnected issues:

- ➢ FTB service capacity and whether this is adequate to meet demand
- ➢ FTB staffing/workforce, including recruitment, retention, capacity building (training and development to work with the extended 0-25 age range), supporting staff morale through a period of change – and fundamentally, leadership of the FTB workforce
- ➢ The interfaces between teams and systems
- ➢ IT systems and data/information sharing processes.

Successful delivery of the FTB model is also predicated on extensive and innovative partnership working with VCS providers and serious concerns about the reality of this emerged in the focus groups. Finally at a practical level, questions were raised about the working environment of FTB premises - both in terms of providing the resources and space mental health staff need in order to do their jobs, but also, its appropriateness for the 0-25 client group.

These and a number of other challenges or concerns are explained further in the remainder of this section and in 5.4 where we discuss the implementation of the FTB model to date.

5.3.1 PMHW and working with the Access Centre

Initially Access wasn't involved in the work with schools– the PMHW team had an administration post to keep data and track activity, but recent changes to how FTB operates now means that all referrals have to go via Access so the PMHW team are unable to track and monitor the data. The PMHW model is simply: visit the school, do a consultation, offer a Choice appointment and that comprises the referral.

The team's issue with going via Access is that the referral might not come back to the right place – if triaged it might go by a different route. A number of the PMHWs who took part in the evaluation focus groups suggested that it did not appear that Access fully understood what the team did, nor did Access realise the triage is done before the referral and they don't need to triage again.

A conflict between the two systems was also explained, namely the PMHW team allocates geographically to save time on travel and so that one worker is known by a group of schools. However Access allocates to next available diary slot across the whole geography.

5.3.2 Lack of strategic partnership with VCS

At the beginning of negotiations about FTB – about 20 months ago, the VCS, led by the Children's Society, were involved in the strategic approach. From the start, however, some conflicts of interest were suspected in that each voluntary organisation, of which there were many, was asked to provide a schedule of all they could offer. This was felt to be a potential breach of practice regarding commercial sensitivity, since the Children's Society had access to this information and was also likely to bid for work itself. Respondents from the VCS feel that partnership working was not well understood by FTB particularly at the beginning, when it was clear that public sector colleagues were unaware of issues around commercial sensitivity. One stakeholder commented:

"many (in the VCS) felt 'courted' at the bidding stage and then left out…. Promises were made that have not been realised… partners feel hurt and let down; that makes it difficult to trust FTB going forwards…. We need transparency and clear plans…. information seems to be a 'one way street', it only goes IN to FTB…."

VCS colleagues questioned what is defined as partnership in FTB; people working in community and voluntary settings are well accustomed to working collaboratively and offering joint services in which there is mutual respect and valuing of each other's contribution. Some indicated they felt that this was not the model being adopted across FTB, where there was always a lead agency, which is always public or private sector and where in their words, 'the medical model' prevails.

5.3.3 Mobilisation, commissioning and partnership working with VCS agencies

"FTB is nowhere near a partnership model…. Discrepancies emerged as a result of the bidding process… it was a muddle at the start but maybe now it's getting to a point where the internal debates are over and FTB can sort this (partnership working) out…" (VCS stakeholder)

Overall, the VCS as represented in the focus groups presented a stance of not really feeling part of FTB, despite good working relationships with individual practitioners. Contributors stated that during the first year of operation the focus was on TUPE and FTB had made it clear that there was an 18 month mobilisation phase to move all existing workers into the new system. Then the mobilisation of the VCS had been expected – but so far this had not happened. It was apparent in this first round of focus groups that there was a great deal of confusion and the VCS was by no means fully commissioned, although individual organisations had acquired bits of work (and where there was uncertainty in the focus group about the fairness of the processes involved).

VCS contributors reported that they had attended a large number of meetings about FTB. Several participants suggested that possibly, there had been a positive shift within FTB away from only seeing them as working with people when they are well or only having minor problems (citing as evidence some of the small subcontracts that had been commissioned), however, the majority view was that the VCS role was seen as more of a support than a partnership model. Furthermore, although most were not properly commissioned or integrated within the FTB system, staff from VCS agencies reported having to hold complex cases where there is no capacity to hand them on to specialists and that this is done mostly without recognition.

It was noted that only was £500k had been made available in the FTB model for all VCS provision – for some this has led to a degree of cynicism:

"the penny began to drop – this is not about commissioning the VCS…"

Nor is it 'real' partnership:

"FTB view it (partnership) as a subcontracting arrangement which they have pursued in a very ad hoc fashion driven by crises and gaps… it's not been proactively planned on the basis of understanding their local population or the skills practitioners in the VCS can offer….this situation is one enormous missed opportunity to draw on existing skills, build local knowledge and capacity, optimise scarce resources and work together rather than competitively…."

5.4 The FTB Model and its implementation

5.4.1 Interfaces – between teams and systems

For crisis and home treatment staff, at the time of the first round of focus groups in June 2017, it was acknowledged that it was still early days. While they were aware of a wide range of partner organisations, not all partners in FTB are directly relevant to them and their main interface is with Beacon and the Priory. With Beacon the partnership was said to be very successful regarding bed management, which involves managing entry and exit criteria as well as highly complex inpatient care. Initially there were issues with Beacon and the service was felt to be '*all talk and no action'*. That has changed; the bed management is robust as a result and the partnership is working.

Staff agreed that Beacon tends to be pulled in many directions. The focus has to be to reduce admissions. However, the home treatment team specifically reported that it did not yet have effective partnership working with agencies outside NHS. Community based organisations would be very useful links for the crisis team but they have never yet all sat round the table and it was reported that as a consequence, there was very little mutual awareness.

Partnership was described as a large and complex issue for PAUSE and Access, with many elements. Good communication between PAUSE and the Access Centre was noted but relationships with the crisis service were said to be rocky and not so close with the community hubs. PAUSE is an early intervention service so it is frustrating when the staff cannot get a service from the community hubs. Early intervention staff recognised, however, that the hubs were experiencing capacity and staffing issues. While this is understandable it does not help children, young people and their families/carers

Staff said that making these complex arrangements work is about building relationships and one person described it as '*You scratch my back I scratch yours'*.

Some of the difficulties in getting partnerships to work may be caused by an initial lack of understanding about what services are set up to provide: PAUSE is a signposting and triage service that takes any referral or drop-in within the age group 0-25. PAUSE staff report that some young people feel they are in crisis on a daily basis and some GPs send young people to PAUSE who they believe to be in crisis. In these cases PAUSE provides telephone triage with the young person, followed up with a risk assessment that may warrant referral to the crisis team, although often staff find their view of what constitutes 'crisis' differs from that of referring professionals.

Overall, staff stated it was hard to know what each of the partner organisations are doing and what is their involvement with FTB. They were aware of building relationships with Priory around inpatient beds and have recently become more aware of the Children's Society but feel very much that partnership is still a work in progress.

5.4.2 Discrepancies in age range and integration issues

Clinically the services across the geography are integrated and the important change is the upper age boundary of the service. However, one discrepancy is that the LD service only goes up to age 19; families were informed by FTB that services will be offered up to 25 and now they are disappointed. This has also created a transition problem and causes confusion: if the child has mild LD they can receive a service to age 25, but if moderate to severe, the cut-off is 19.

From the PMHW view, the major partnerships are with and around schools, where they provide the service up to A level. A worker for colleges and higher education has also recently been recruited. As with other services and teams, the pre and perinatal services reported having many partnerships – internal, external, some well established, some new. They felt that any

sense of partnership in the first nine months had been challenging since the situation had been fluid, with some organisations having funding removed and others springing up.

In terms of teams integrating, this has been slow since they are stretched already and have no spare capacity to go to another MDT meeting. Across the hubs, some do not yet have joint MDTs while in at least one hub there is a 0-25 MDT that has been integrated.

Psychotherapy in the old CAMHS used to see children up to age 16 but now the service has had official confirmation from their professional body that they are able to offer therapy to the whole age range 0-25. The therapy used (STTP) is recommended by NICE, it can be offered up to age 25 and is a 28 week treatment. While this is new and exciting, it was described as stretching capacity through increased referrals, especially for under 5s, in a very small team.

The level of engagement in partnership working depends, as one person put it '*on where you sit*', so that some people's role involves attending cross agency meetings and they get to know what is happening, while others who are based in one team or one location have to wait for it to filter down and that does not always work well.

5.4.3   Delays in the pathway after referral from the Access Centre

While anyone can make a referral to Access, when feeding back to the community hubs, many of the stakeholders reported that it was difficult to get to the right person. PAUSE and Access staff reported that they felt stuck in the middle of Crisis and Rapid Assessment Interface and Discharge (RAID) interface, described as a "very complex partnership": for those over 18 the referral will be to whereas those aged 17 and under are referred to crisis team. Furthermore, RAID can refer directly to Crisis.

As the FTB services have become better known, demand has increased and practitioners reported there was now a waiting time of a few months. While waiting for an appointment, assessment or treatment, young people and/or families sometimes turn up at PAUSE or Access where they get low level skills in self help and general support and advice.

5.4.4 Interface between Home Treatment and CMHTs
Crisis and home treatment staff raised the question of what will happen when young people reach   the age 25 transition point. Before FTB, it used to be that the age 18 transition point, while unsatisfactory in many ways, provided a '*stop and think'* opportunity. They were unsure if this would be the case at age 25 and highlighted that work on managing this exit point from the service was needed.

5.4.4   Implementation of CAPA

A number of stakeholders asked about the new model and whether FTB's CAPA is the 'real 'CAPA or whether it has been adapted so much it is no longer CAPA. Staff were unsure how to check that out and whether it is even an issue.

5.4.5   Reduced capacity of staff

Staff reported that parents find the service more accessible '*which is wonderful but we need to be able to meet the need'*. It is exciting for young people and parents to self-refer and drop in to PAUSE – however, they expressed concerns as to whether FTB service capacity was sufficient to meet demand and suggested that the sheer scale, scope and complexity of FTB had not adequately been taken into account.

It was reported that PAUSE see the majority of young people on the same day, in rare cases the next day. If more formal support is needed this can be a challenge: how much can PAUSE support someone who is waiting for a Choice appointment – by definition they need more than PAUSE is set up to offer but they may have to wait two months or more. PAUSE staff noted they felt frustrated they couldn't help more in that waiting time. It was also noted that parents are not

happy with these waiting times and PAUSE and Access often get the brunt of the complaints.

5.4.6 Staffing - difficulties in recruitment and retention

Prior to FTB in AMHS there were 21 CMHTs, now there are four for the whole age range, so as one contributor put it, '*who did the maths*?'

A prominent view was that the proportion of locums was significantly too high and staff told of one psychologist covering a whole CMHT, which is not sufficient to meet demand.

Problems with staff retention and increasing demand were highlighted. In the first month of the new model, five child psychotherapists resigned, apparently because they felt the new model was not going to work. That service is still not back up to the capacity it had as a CAMH service. Posts have reportedly gone from that team and across psychology and family therapy. High rates of staff sickness across the service (e.g. two psychotherapists noted to have been off sick for the past seven weeks) were a further concern.

Stakeholders emphasised how problematic recruitment and retention all leads to less continuity of care; they gave examples of very vulnerable perinatal mothers seeing a different psychiatrist for each appointment and of vulnerable children from deprived areas, including those with autism, seeing about six different psychiatrists. It was also pointed out that because psychiatrists in the under fives service were having to do all their own administration, letters are taking three weeks in the system and up to six weeks to get to patient.

Recruitment problems were seen as exacerbating the pressures on existing staff, not least in terms of the need to try and see more children and families and to keep the waiting lists as much under control as possible. Stakeholders cited an example of six posts being advertised, with four people being shortlisted and two then turning up for interview, of which one was an internal candidate. Such a poor response was described as a common scenario; one suggested reason was that the less than desirable working conditions of being housed in a Portacabin are not appealing to potential applicants.

However, it was also acknowledged that FTB is an entirely new concept, the first of its kind. There is no reference point, no benchmark. The service is under constant scrutiny and is an easy target for criticism that could damage reputation. Dealing with all of this requires the staff to be resilient. Some staff cannot deal with the change or the pressure and they have left.

5.4.7 Staff support and morale

This was noted as a concern in a number of different ways, including the challenges posed by 'agile working':

➢ The increased demand experienced by staff in PAUSE and the Access Centre has required these teams to be resilient otherwise they would be in danger of burn out. Furthermore, young people come in with expectation of help and if the team cannot help them, it makes them feel guilty.

➢ In another area of the service, staff all agreed with this contributor: '*I can't get a car parking space so I'm late for appointments, I have to carry bags everywhere as I have no storage of my own. It all adds unnecessary time.*' The same group reported having to buy their own stationery, paper and books of stamps. They reported no basics, from a lack of administrative support to no toilet rolls.

5.4.8 Data and IT systems

A range of complaints about FTB's IT provision were noted and these included:

➢ Delays and time required to log into the system

➢ A lack of essential hardware such as laptops, docking stations etc and access to adequate desk space on which to work/use IT

➢ Incompatible case management systems, including inconsistencies and confusion over the use of CareNotes and RIO.

IT was described as 'slow and dire' across FTB, with 30 minutes taken to log into essential systems. Staff were unanimous in their frustration with the time wasting and feeling that information-sharing was worse than before FTB. They feel the system can't cope and expressed fears for the lack of continuity of care.

According to those interviewed, many staff in FTB do not have the necessary laptops, docking stations and dongles. Furthermore, tablets were reported not to have full functionality and the set-up prevents practitioners from logging any impromptu consultations or accessing information when off-site. Added to these issues, the north of the city has very poor connectivity, so the tablets often just do not work.

The consensus was that remote working was not yet fully enabled. One contributor reported a case in which they received no feedback after making a referral for psychological therapy, saying '*we have no clue what happened and no records.*' Such gaps in data systems pose obvious risks to the safe and necessary sharing of information about client care within FTB.

Overall, communication and information-sharing were reported as ad hoc at best. Integration with BWCH and Woodbourne was reported as happening on a daily basis and seemed to work well although staff have differing levels of access to case files via electronic records and some clinical information-sharing has to be done face to face or by phone.

5.4.9 Multiple non-integrated systems

The two management systems being used variously are RIO and CareNotes. Where CareNotes was used within the 'main' bits of FTB, it was felt to be good and comprehensive, however, the following difficulties were outlined in the focus groups:

➢ Access to CareNotes was reported as being possible for 'privileged partners' whereas a sub-contracted voluntary organisation would not have same easy access

➢ While BWCH uses CareNotes, BST uses RIO; across FTB some have access to RIO while others do not, depending on the service

➢ One team reported not having access to other teams' CareNotes and the same with RIO; they reported that there were about 10 licences across the service

➢ Staff describe the system as piecemeal and were not aware of plans to integrate or to select one common system

➢ Even within CareNotes it was reported there were two different versions in use.

A further complication was noted, namely that in addition to CareNotes and RIO, PAUSE uses another system, Mosaic. This is not a health system and PAUSE use it on the basis that many of the young people they see do not necessarily have a diagnosable condition and as such, there is no need to create an NHS case record/their case notes do not always need to be entered on CareNotes. Finally, stakeholders reported lots of manual transfer between systems – creating inconvenience, delay and information security issues.

In essence what all of the above translates into is a situation wherein a young person could be seen in one part of FTB and this would not be easily identifiable by other areas of the service – with one participant giving the following example - a young person seen at A&E, would possibly be 'street triaged' and the home treatment team would not automatically know or be able to readily access any information about what had happened/the care offered.

5.4.10 Working conditions and Infrastructure

In the opinion of the stakeholders consulted, at this time point, they viewed the infra-structure for FTB as not fit for purpose. They described FTB teams as having exactly the same space and facilities as they did when it was just a CAMH service – but now of course, they served the

extended age range, 0-25. The PMHW team also reported losing clinical rooms in GP surgeries, further increasing the pressure on FTB clinic space.[1]

It was also suggested that there were fewer resources than before, for example, when the service 'went agile' basic assets such as desks were lost. In some cases equipment just disappeared; in the case of scales going missing in the EDS, this was equipment vital to patient care.

Stakeholders acknowledged that being creative and finding 'workarounds' to these difficulties could have masked some problems and thus FTB management might not be aware of them. However, it was also apparent that this situation required attention – for example, one practitioner described a safeguarding issue which came through on a Friday afternoon. No desk or computer was available as all were fully occupied and so the practitioner ended up having to wait for several hours, until 7pm, in order to write up the incident.

5.4.11 Service environment suitability for purpose.

A negative and unforeseen aspect of the widened age range described by the focus group participants concerned shared waiting rooms. A general view was that these do not cater for the needs of different age groups. For example, staff reported younger children asking to have their toys returned. More worryingly it was reported that very complex and sometimes agitated adults sit in the same space as young children whose own complex needs may stem from violence at the hands of adults.

One contributor stated it was not uncommon to find in waiting rooms 'five year olds with grown men who are ranting and raving'. Furthermore it was noted by staff from the LD service that a paedophile had been in reception with children present. These situations are very hard for administration staff. Mixed waiting areas were noted to be less of an issue for EDS.

According to those in the focus groups this was not a new issue:

'*We were discussing things like how to separate access for adults and children right back at the blue sky thinking days – it is all documented. So why are we here talking about it now?*'

Staff reinforced their deep commitment to the work and saw that the solutions were there in the room. For example the kit and facilities for adults and children are completely different in clinical rooms; those designed for adults are not appropriate or comfortable for children. One solution noted was that the under 5s service was planning a pop-up clinic for babies and infants – they will carry all the equipment around in bags, as one commented:

"*more boxes to carry around!*"

Contributors were also aware that the participation lead has been working on waiting areas but no one was sure how that is feeding in to decision-making. As one staff member remarked:

 'it *will be a sad thing if in twelve months time we are here saying the same thing'*.

They went on to say that FTB could be a bit defensive and prone to fire-fighting. The organisation needs to open up. Opportunities were there at the beginning and missed.

5.4.12 Changes to working practice – work with RAID (Rapid Assessment Interface and Discharge)

The aspiration is for a young person to receive a seamless service regardless of the provider and this was likened to the use of an ATM: the machine may be owned by one particular bank, but it can be freely used by customers of a range of other banks.

Currently FTB works with RAID on a model of 'trusted assessment'. Stakeholder suggested that this needed to be reviewed, since sometimes there was disagreement with the RAID

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[1] Some plans for extended evening and Saturday morning sessions were reported, e.g. by the Eating Disorders Service, which may alleviate some space pressures.

assessment. RAID works with young people aged over 16; previously the entire pathway was based in BST and the change to the new model has led to some incidents and complaints. Reportedly, these are known and being addressed, since it is agreed that improvement is needed.

Staff acknowledged that moving from one well established service model to another very new one was bound to have initial problems and challenges. A major change had been that in BST crisis and home treatment were integrated in one service, whereas in the new model they are separate and clearly differentiated.

5.4.13 Service user engagement

Stakeholders noted that here was now a participation lead working with partner agency the Children's Society. It was thought that this had led to more user involvement in service design and staff recruitment.

PAUSE and Access work with young people on various parts of the system, keeping young people involved in all elements of the service. Some young people participating have never actually used the service – pre or post FTB. In the past year they have received only two pieces of negative feedback.

EDS staff expressed the view that it was too early to report on the feedback about their service without analysing data. Informal feedback shows, however, that the community based EDS was having a very positive effect and contributing to a reduction in admissions.

Less positively, both the EDS and the LD service noted that staff had heard adults saying 'I want to go back to my old CMHT'. Several parents have complained about internal waits, for example for NDT (though NDT was thought to be 'brilliant', the service was viewed as being inadequately resourced).

5.4.14 A gap in offer for under 14s

Stakeholders highlighted a gap in the offer for under 14s in that in Birmingham there is no counselling service for this age group. Young people in the 14-25 age group are reasonably well covered by Living Well Consortium, IAPT and Open Door, but now Open Door is becoming burdened and a waiting list is growing.

Chapter 6: Issues identified in second round of focus groups

Cathy Street, Yvonne Anderson, Jane Sedgewick and Fiona Warner-Gale

6.1 What's working well?

6.1.1 Transforming Access to Support

Improved access to services has been described in a number of areas of the FTB model, including support into schools, through the Primary Mental Health Worker (PMHW) team; access via the Access Centre and self-referral; the development of the PAUSE drop-in centre and the ability to get a swift response to crisis. Home treatment support and provision for under 5s, including work with young mums (via a specifically commissioned project at Acacia) was also positively commented on by some stakeholders.

Participants acknowledged that access to support for children and young people through PAUSE and the self-referral avenues meant that they had a number of different options to ask for help, including online:

"It's different, what they have done is they run self-referrals, so they accept self-referrals that are new, and they open on a Saturday and a Sunday, and they are open until 8 o'clock at night - so in terms of increasing access, yes that has been achieved" (Parkview participant)

"PAUSE - Pause is a massive success…I think it would be hard to improve Pause…even the staff are a successful part of FTB - I don't think they anticipated that it is that much of a success - but I think it's where is it based which is smack bang in the city centre - the fact that you can just drop in at any given time - it's almost like they need another one of those in the south" (Oaklands Hub participant)

A number of participants highlighted that the PMHW model has been valued in schools, and has made a significant impact on prevention and early identification of problems, as well as keeping problems from escalating further and ensuring access to the right part of the service, at the right time. From the cases that PMHWs have supported through their consultation model, only around 25% have required further engagement from CAMHS. The PMHW model is felt to be highly effective in picking up CYP with emerging problems quickly:

"…the young people that [PMHW] see in the school, they are getting a Rolls Royce service, because they are being seen very quickly, picked up very quickly…" (Birmingham Road Hub participant)

"Primary Mental Health Workers and the Schools Link Project, which is one of the elements of the service that's been working really well. The Schools Link Project was in 2015 a pilot that was funded by NHS England and DFES and then from that pilot they developed the project and the project was going into schools, working directly with the wellbeing champion within the schools, seeing young people in the school for initial triaging assessment choice – and then offering them intervention so therapeutic intervention or bringing them into the system, if they needed to be brought into the system really quickly that project has been working, as I say really well…" (Oaklands Hub participant)

"This year – [PMHW] did 500 consultations, so we keep a record of every consultation because we need to know the outcome. So we did 500 consultations and of the 500 consultations that we did only 133 of those ended up in a referral into the system opened on care notes so …we have got PMHW's out there and they have only done 133 choice [Assessment appointments]." (Birmingham Road Hub participant)

Unfortunately it was noted in the second round of focus groups that there were plans for the PMHW team to move into the hub teams, so the model will not operate as it has previously and its current efficient way of working may be compromised.

6.1.2   Team cohesion and working together

Participants highlighted that there was strong team cohesion and resilience gained through working together. This was especially evident in the home treatment and crisis teams, however, it was also reported across participants from the elements of the service that were represented in the focus groups.

There was a strong sense of shared values amongst particularly the substantive staff on the ground, and whilst it was reflected that working in the FTB model was becoming increasingly stressful (due to ongoing staffing shortages, increased demand, infrastructure issues etc), it was evident that FTB staff recognised a need to support one another and to provide the best quality service that they could:

"…we value colleagues – they trying to do their best and work as a team… team relationships mean that staff keep the service as safe as the absolutely can"

(Oaklands participant)

6.1.3   Improvements in Communication

Communication has been an issue repeatedly raised through the evaluation of FTB – from senior management to other levels of FTB, across FTB frontline staff/services and between FTB and the VCS and other partners. Participants in the second round of evaluation focus groups reported that certain developments had begun to improve over time, albeit slowly. Clinicians who felt that they weren't fully involved in early planning, described now starting to be included.

It was noted that some improvement in communication within the in-patient settings, and across access, crisis teams and community settings had been evident in recent months. However, some difficulties have arisen in communication with older age group services such as PASS or the HEX consortium:

"… it has got a lot better [in the in-patient setting] and I think that the communication has got a lot better between us but also because it has got better as we have become more familiar with the client group."

(Parkview participant)

The focus group participants also suggested that there had been a gradual, although limited improvement in communicating the FTB model to wider stakeholder groups. For example, they felt that staff in A&E departments were much more conversant with the urgent care pathway, and children and young people seemed to be more aware of their ability to self-refer.

6.2   Delivering improved interventions for high risk groups

6.2.1 Crisis support and Home treatment

Participants highlighted that being able to access the service in extended hours had made a big difference to the way support could be provided in response to urgent mental health need. It was felt in general that this approach was a positive approach to preventing deterioration, and that having an Urgent Care pathway had enabled a preventative response in these situations:

"… the 24 hour provision, the access to crisis, was a way of potentially dealing with long standing problems or poor access, and getting in there when there is a crisis and but also I

guess providing access might prevent some deterioration and then the urgent care pathway is now working well and it says here - likewise the home treatment team and primary mental health work teams have been putting on training to prevent mental health problems from escalating.”

<div align="right">(Parkview participant)</div>

6.2.2   In-patient services for 18 – 25year olds

Participants highlighted that they felt in-patient services had improved significantly since the beginning of FTB for older age groups. They reported that their service users in the 18-25 age group were having a much better experience than previously on adult mental health wards:

“[In-patient settings]…looking at the model I think it works and I think if you talk to some of the 18- 25's that come into the inpatient beds they will say yes it is much better than us having to go into a mainstream adult ward.”

<div align="right">(Parkview participant)</div>

However, some issues around delayed discharges and availability of step-down services, the result of delays in obtaining DST (Decision Support Tool – for continuing care needs) assessments on discharge, were mentioned:

“In-patient admissions for over 18s have lengthened due to the waiting list for DST assessments, staff to come and do these (over 18s). They can’t often be discharged due to their circumstances.”

<div align="right">(Parkview participant)</div>

With regard to younger people, stakeholder views were not so positive; in particular, concerns were noted about the high number of out of area placements still occurring for the under-16 age group which participants linked to the closure of local in-patient provision for under 16s:

6.3   Areas of concerns and challenges facing delivery of FTB

6.3.1   Change in PMHW Team Function

Concerns were expressed regarding the proposed change in function of the Primary Mental Health Team, with them becoming part of the Hubs, rather than out in schools. Participants from two of the focus groups suggested that they felt the current PMHW model worked well and offered a preventative service, minimising the number of children and young people that required higher levels of intervention and building capacity in frontline staff. This move could also have an impact on the speed of response to children and young people with emerging mental health needs:

“PMHW model working well but altering this to embed into main teams - will this help prevention or bring more into the service? … Yes that’s right [when the PMHWs join the hubs], it does mean that they will be waiting longer because in the schools we can do the consultation with those young people and we can offer them a choice next week, they go through the access centre and I’m not sure what the waiting time is at the moment.”

<div align="right">(Birmingham Road Hub participant)</div>

6.3.2   Partnership working with VCS agencies

Participants expressed ongoing concerns about the engagement of the VCS with FTB on a number of levels, a situation made more difficult by a general reduction in the VCS due to Birmingham City Council funding cuts. They noted that:

➢ The original intentions of the FTB model regarding partnership working with the VCS have not been implemented as expected; the confusion about who was commissioned and why, the disillusionment and damage to trust (between FTB and VCS providers) caused by this situation and prominent in the earlier focus groups was reiterated.

> ➤ A focus on crisis management within FTB was also seen to have significantly altered plans for partnership working and the delivery of early intervention:

It was reported that high and increasing levels of FTB signposting out to VCS partners, often inappropriately, was creating significant pressures on some VCS services. Participants suggested such signposting probably reflected attempts within FTB to manage under-capacity/increased demands and the resultant growing waiting lists in the community hubs. Open Door counselling service, for example, described itself as swamped with referrals from FTB, meaning that it now had a waiting list of around 450 young people, much bigger than usual and which:

"makes a nonsense of Open Door being an early intervention service."

And Resources for Autism reported a waiting list of over 1500 and that since it was expecting to lose about 30% of its budget due to Birmingham City Council cutbacks in the next financial year, this was likely to result in a big service gap (especially since there is a large population of children and young people in Birmingham with autism and little provision for those aged 18+).

Overall, it was felt that there had been a specific impact on children and young people under 14 years as low level interventions for problems such as anxiety, were not available, with FTB largely focusing on the crisis management aspects of the pathway, rather than prevention:

"…there are certain things where the service starts to operate in a sort of crisis management way and I think that the original model, the Forward Thinking Model was about intervention, was about working with the voluntary sector – lost us a big chunk of that voluntary sector partnership ….. then the partnership hasn't worked as smoothly as we envisaged it would. But again a large part of the model was about doing early intervention work but when you're doing crisis work you can't do that and it feels like that's what we have shifted to do now."

(Birmingham Road Hub participant)

6.4 The FTB Model and its implementation

Participants expressed concerns about a number of aspects of the FTB model and challenges around the way it was working. As described earlier in the first round of focus groups, and an ongoing concern, was a **gap in offer for under 14s**; participants felt that the transformation had a focused on older age groups, especially the extended age range element of the model to add 18-25 year olds.

A widely held view was that preventative and early intervention services weren't available or as, with the VCS partnership working, had not been adequately included in the FTB model (both capacity and demand planning and adequate resourcing) during implementation phase.

Many of the following issues were also raised in the first round of focus groups and as much as possible, the following sections follow the same order as Chapter 5 in order to provide a sequential view of developments over summer 2017. However, some new areas of concern emerged and are included at points throughout this summary.

6.4.1 Interfaces – between teams and systems

Participants described many continuing interface issues and a feeling that each part of the FTB pathway was working in a silo. They attributed some of this to a lack of communication between teams, also remote and agile working. Inadequate data and IT systems meant that teams weren't able to communicate regarding services users moving from one team to another or to easily access notes to ascertain what work had been done already.

They reported that these issues resulted in delays and bottlenecks in the system, and sometimes uncertainty about what was happening to young people once they were moved to another part of the pathway, for example if they moved from early intervention to a community hub:

"We can't move anyone on from early intervention, back down to CMHT…"

"We are getting better information from the Access Centre, from crisis…. but when some of our clients go to the PASS or the HEX consortium or BMHFT then we are uncertain what happens to the clients."   (Parkview participant)

6.4.2   Delays in the pathway after referral from the Access Centre

Participants described delays in support being provided to children and young people once they had been referred or had engaged with FTB through Access or Crisis teams. They expressed the view that whilst there had been significant improvements in the 'new investments' - Access, Crisis and Home Treatment, services beyond that were straining at the seams, and weren't able to respond quickly.

In addition, there had been reductions in the ability to undertake assessments properly due to time constraints and the push to get people flowing through the system quickly. As described previously, silo working was seen to cause blockages in discharging or moving on young people users when it was appropriate to do so.

Some participants felt that a lot of effort had been put into the new parts of the pathway, but the capacity in the original teams was greatly compromised, with children and young people having to wait up to 9 months for a Choice appointment, which was significantly more than before the FTB model was implemented. The following excerpt from one focus group illustrates participant concerns on this issue:

P1: We've got the front doors - but it's like you've got that increased access

P2:...with minimum staffing at the back - that is an analogy to use that would fit

P3: And there's no communication through, there's no 1 process to communicate

Facilitator: So have you got any thoughts on improving those front doors to FTB?

P1: They don't need improving, it's the back door

P2: The front doors are great, it's having a good service

P3: It's the [service] at the back which needs addressing

*(*Oakland Hub participants*)*

Interface between Home Treatment and CMHTs
Participants from the Home Treatment Teams described particular issues around the interface between their team and the adult mental health teams (CMHTs). Problems around service users not being picked up by the CMHTs means that they return to the Home Treatment Team and their problems can become more acute:

"Home treatment is working well, the care is good, but when they need to move to CMHT there is a problem as they don't get picked up, they come bouncing back."
                                                                        (Parkview participant)

6.4.3 Implementation of CAPA

Participants in three of the focus groups run in September 2017 expressed major reservations about the implementation of the Choice and Partnership Approach (CAPA) within FTB:

➢ Some of the issues were related to the lack of capacity and staff vacancies compromising the application of the model, and delays in being able to offer partnership appointments after Choice assessments (interventions).

➢ Other issues related to concerns about the incorrect application of the CAPA approach and a lack of access to data, with participants feeling that it wasn't working well because of this.

The comments below, from the focus groups run at Oaklands and Birmingham Road hubs, provide a clear illustration of these difficulties:

"I think that the other challenge that we have with CAPA at the moment, because there aren't enough clinicians in the hubs to see young people once they have been offered a choice or once they have been through a choice assessment the choice clinicians end up holding those cases so if there is a crisis the Choice clinician ends up with a caseload and it's not supposed to work that way."

(Birmingham Hub participant)

"CAPA does work this is not CAPA – CAPA is alright, it was working fine – CAPA is invest in your team, get your communications right, get your systems clear, know your data, know your capacity and it's not a clinical model it's a capacity and demand model that works – if you mess with the figures and disregard the model then you're not doing CAPA."

(Oaklands Hub participant)

"…it is supposed to work with the right amount of people on the ground in the first place and we haven't got that – so all of those things again come back to your staff retention and come back to your capacity come back to allocating to agency staff and we just end up doing the crisis work and picking it up."

(Birmingham Hub participant)

6.4.4 Agile working compromising staff time

Participants described the move toward more agile working and sharing of workspaces as a real challenge for them. They noted the following reasons:

➢ Often they were unable to find an actual space (desk) to work on writing up their case notes, or to do their administration work.

➢ It was frequently very difficult to get time on a shared workspace and/or to log on to the data system. They described situations where they have been held up by waiting to get time on the computer, sometimes having to work after hours to be able to upload notes.

➢ Whilst they had been provided with laptops, these did not work remotely.

"Agile working is not working- you come into work and spend a lot of time just walking around looking for a desk."

(Birmingham Road Hub participant)

6.4.5 Reduced capacity of staff

Participants from all four focus groups described serious concerns about the lack of staff capacity and in one group (with VCS partners) concerns about the level of staff experience and skills within FTB were also emphasized (where it was suggested that staff inexperience was a key factor in the poor quality or inappropriate referrals and high levels of signposting VCS partners were experiencing).

A variety of issues were highlighted, particularly around the increase in demands through the extended age range; the use of locum and agency staff due to high volumes of staff vacancies and the through-put and attrition of staff.

Participants in one group expressed concerns about the safety of the service, and the lack of stability because of the transient nature of the staff teams and the ability to achieve consistency because of this.

Many participants described feeling stressed and under pressure, and unable to meet the demands of the service. A number of staff described working long and extra hours to ensure that children and young people were getting the help they needed and in order to maintain a safe service. The following are illustrative of the many comments noted on this issue:

"Adding the older age group has opened the floodgates. Hubs are inundated with work. Staffing can't meet demand, locums just move on. Mobility of the staff group is making consistency difficult."

(Parkview participant)

"…it is just massive and the workforce just isn't there to cope with the demand and for the reasons that you mentioned, because we are using agency - they come in, they don't like it - they can get the same money somewhere else, you know it is observations, why am I stressing myself out here?"

(Parkview participant)

"It's not safe, so we are dependent on one another – the good will of our fellow colleagues…It's survival mode."

(Oaklands Hub participant)

In addition, participants identified gaps in skills and capabilities in working with under 18s; this was reported to be contributing to problems within FTB of young people being subject to prolonged in-patient stays or delayed discharges:

"…there is a real lack of staff with under 18s skills – (in Home Treatment) this has a massive impact. Agency staff are not able to cope with children and young people, so they are kept in hospital – because these staff are worried that they are missing things…"

(Parkview participant)

6.4.6 Staffing - difficulties in recruitment and retention

Participants described specific issues around staff recruitment and retention, and reported that at the time of these focus groups (September 2017), over 80 vacancies existed across FTB with posts being cut and a reliance on locums and agency staff.

On top of this, it was reported many permanent staff were leaving and locums often moved on quickly. Recruitment was described as getting more difficult, especially in the Hubs and CMHTs and there were also issues in the Crisis and Home Treatment Teams, currently also comprised of a high number of agency staff.

Participants felt that staff couldn't be retained because they were experiencing a lot of stress and workloads were large. Whilst they acknowledged the positive effects of PAUSE and the Access Centre in improving access to mental health care and support, undoubtedly this had seriously impacted on the ability of the FTB workforce to meet the demand:

"…although access has improved, we can't keep up with the increased referrals."

(Birmingham Hub participant)

Specific feedback from one locum working in FTB suggested that there is a lack of induction to the service, only a generic induction to the Trust, and this makes locums feel very unsafe in their work. This participant also outlined that locums have no one to go to with questions and they have to work out processes for themselves:

"…the service feels unsafe, there are no stable teams, not enough capacity and non-collaborative management – it's very stressful."

(Oaklands Hub participant)

6.4.7 Shortages of medical staff

In the second round of focus groups, a very specific concern with regard to FTB emerged, namely that the current workforce has insufficient medical staff and that this is having a seriously detrimental impact in a number of areas, not least in the management of complex and often high risk cases. Participants noted hearing regularly about problems discharging service users from the in-patient settings to CMHTs which was thought to be due to the lack of medical staff, as well as interface issues with CMHTs (e.g. the information sharing limitations noted earlier).

Delayed discharges, apart from blocking highly costly in-patient beds that other young people need admission to, was also seen to be compromising the capacity of other parts of FTB, as illustrated by the following:

"…I mean the times it gets quite stressful in Home Treatment you will normally find that 9 times out of 10 it is a medic issue, lack of medics, lack of substantive medics - it makes a huge massive difference to our home treatment and the crisis team because home treatment is a medical model and if you haven't got a medic to discharge people they just keep piling up and piling up they just keep coming - because in an average, on an average day at home treatment we get about 6 referrals on a good day, on a Friday I would say that we were probably pushed to about a 9 or a 10 in a day that we would get - and if you have got no medics discharging, how many is that already for the week that you've just accumulated, you know, 6 Monday to Friday and then 9 on a Friday - 30 that you have just accumulated so if you don't have a medic that has been discharging 30 throughout the week…"

(Parkview participant)

Another example of the risks posed by the inadequacy of FTB medical cover was also outlined in one of the focus groups. This involved a patient being discharged who had not been provided with a prescription for his medication, leaving staff in the hubs then having to rectify this.

There was also concern about the increasing severity of need amongst the older age group served by FTB and the service's capacity to meet these demands. Some staff were of the view that quality of assessment was being compromised:

"…sometimes I do feel whether we are really meeting up to the challenge or the demands of them really because every week the average for me is 4- 7 urgent assessments and we don't have enough staff or clinic resources to meet them." (Oaklands Hub participant)

Another participant described having to regularly open up new clinics to try and manage the demands, noting that the current way that CAPA is being used to organize staff roles was leaving big gaps in cover and a further participant commented:

"Nurses in the crisis team are pulled out – they are doing shorter assessments to get the work done and often staying late."

<div align="right">(Parkview participant)</div>

6.4.8   Staff support and morale

Participants reported morale within FTB as low, that many staff feel unsupported (although within team support is seen as good) and suggested that there is an urgent need to improve leadership support across FTB. Many perceive that a 'stripping out' of the management layer within FTB has taken place and that poor or no communication about this, alongside the employment of staff across a number of Trusts and different organisations, has led to uncertainty amongst the staff group and a lack of understanding about what FTB is or aspires to be going forwards.

Some staff described a reduction in the capacity and quality of the service and that this was jeopardizing the development of a strong service culture. Unrealistic demands and pressures on staff and what some described as a 'dumbing down' of the service in order to maximize throughout of children and young people, were further impediments to building morale and the building of a confident workforce:

"I think morale is so low that what I've noticed is a lot of staff talk and talk and talk about this and nothing gets done… But as well as that, staff are being monitored about their contacts and then unrealistic demands put on them about caseload numbers and then requests to rag rate your caseloads and then report on this and then put it on the CareNotes and then do this…."

<div align="right">(Oaklands Hub participant)</div>

6.4.9   Data and IT systems

Participants outlined ongoing concerns with the data systems, especially sharing of notes. This was felt to be a contractual issue that remains unresolved. Particular issues exist around gaining information on new admissions and staff not being able to identify if a service user had been seen before, what medication they were on and the potential levels of risk. As an example of the difficulties this could cause, staff described a situation concerning a young person who posed a particular level of risk that would have required two staff to go out to him, however, because notes could not be accessed, only one staff member was sent.

Four months on from the first round of focus groups and nearly a year post FTB going live, participants reported that some notes remain on the old system (RIO) whilst others are on CareNotes; the use of two different types of CareNotes in different parts of FTB (which do not allow communication with one another) also persists. Such incompatibility of recording systems was seen as risky in that young people presenting to FTB requiring admission are likely to have complex needs and carry a certain risk, which staff are unable to anticipate.

Feedback also suggested that the recording systems within FTB do not capture all of the relevant information about how the teams work and are not felt to be helping waiting list management.

With regard to FTB's IT provision, participants outlined that this remains a major concern. They described still being unable to log on remotely and therefore not able to update notes, also that the range of incompatible IT systems across the service meant that communication was impaired when young people move between services (thus posing a risk when information about a young person's history or progress cannot be accessed/isn't known).

Concerns were also expressed that due to the data collection for the service being outsourced to Beacon, who only report on the KPIs agreed for FTB, some activity is not being captured. Lastly, participants highlighted that it would be useful to have IT tools to do assessments, as currently they have to handwrite and enter in the results later, so findings cannot be shared across teams in real time. The laptops they have were described as not fully functioning to enable this.

6.4.10 Working conditions and Infrastructure

The previous round of focus groups identified some significant deficits in the working conditions provided for FTB staff (e.g. enough physical space, a desk, access to computer or tablet fully enabled to run the required data systems). In the subsequent focus groups it was confirmed that many of these problems persist and have contributed to a growing and increasingly widespread feeling across the FTB staff group that the whole system is unstable and unsafe.

Furthermore the diversity in working practices arising from a number of employers, policies and systems, was recognized as introducing a lack of confidence in the infrastructure and the effectiveness of the service being provided. The perceived lack of senior management to support staff on the ground was seen as adding to this concern.

6.4.11 Environment suitability for purpose

The impact of the extended age range on FTB being able to deliver age appropriate and welcoming environments within which to see a broad range of children continues to be a source of concern. The focus group participants explained that the Hubs don't provide opportunities for segmented clinics, so there continues to be a mix of younger children having to wait alongside young people in the upper age-group, who are often presenting with complex and serve presentations. Similarly, clinic rooms are not at fitted out for young children because they are shared and there is nowhere to store tools and resources required for clinical work.

The difficulties caused by cramped premises also continue, with staff reporting that it is often difficult to find rooms for sessions, meetings and supervision. Agile working still means that participants may have to hang around waiting for a desk to become vacant, with many now resorting to storing the resources they require for work in their cars. On top of this, and compounding the frustrations caused by the slow and inaccessible IT provision, participants described having to work with a downsized admin team, who often didn't know how to find staff due to the agile working approach - sometimes meaning messages were being missed.

6.4.12 Leadership and management

In the second round of focus groups, the issue of leadership and senior management support within FTB emerged as an important theme. Participants talked about the apparent reduction of key managers and leaders across FTB and suggested this had led to on-going difficulties around communication, integration of teams and the interfaces between different parts of the pathway. VCS partner agencies attributed a lack of transparent and supportive senior leadership to the confusion they experienced as to what FTB model was now aiming to deliver and where their agencies now sat in developing the service.

In particular, participants felt the lack of senior management and clear leadership within FTB had created considerable uncertainty around what had happened, or would happen, as a result of reporting serious concerns. They noted that a number of IR1s/serious incidents had been reported over the last 12 months, which they had not yet received feedback on. In addition, VCS partners described having to escalate matters to the highest levels due to difficulties gaining any feedback whatsoever from FTB about concerns they had raised.

Chapter 7: Views and experiences of children, young people, parents and carers using FTB

7.1 Overview of data collected

The views and experiences of 27 children, young people and 3 parents of carers were collected via a number of different avenues/seven different settings. Some young people had direct experience of using FTB within the last year/were currently in the service whilst others had had no contact or experience of using mental health services.

Interviews or focus groups included:

> ➢ Three individual and/or small group interviews with young people and keyworkers at one Birmingham VCS provider who extended an open invitation to young people using its services to meet the evaluation team.

> ➢ Five young people and three parents/carers shared their views via evaluator drop in visits to two of FTB's community hubs, accompanying the FTB participation lead as he did his regular monthly visits to collect Friends and Family feedback.

> ➢ One focus group with 4 students at Birmingham City University (BCU) where the Health and Wellbeing team had circulated an invitation to students to share their experiences of FTB and their suggestions for what they wanted from mental health services in the future.

> ➢ Follow-up interviews with 3 further students from BCU.

> ➢ Focus groups at two Birmingham schools, attended by a total of 11 pupils. Invitations to pupils, their parents/carers and to school staff were facilitated by senior staff at the schools (e.g. the head of pastoral care), following introductions to the evaluation team facilitated by the Birmingham Education Partnership (BEP).

> ➢ One interview with a young person using one of the hubs and a member of the PAUSE hub squad.

In addition, two other Birmingham secondary schools, who initially offered to host focus groups but who then encountered problems with staff availability to support the group, canvassed their staff for views about working with FTB; these are summarised at the end of the chapter along with a summary of young people's feedback about PAUSE.

It should be noted that some of the young people and/or parents and carers or the staff supporting them, raised some serious concerns about the care they had been offered by FTB and these have already been raised with the Clinical Director of FTB in order for them to be investigated and addressed.

7.2 Awareness and understanding of FTB

Across the different groups, there was very mixed awareness of FTB with some young people indicating that they had no idea what Forward Thinking Birmingham was or what it did. Several suggested that they thought it was just a name change and that services looked just as they did before (although they had not used them). Two young people who had used BSMHFT previously and now FTB, also indicated that they did not see much to have changed.

Three young people reported that they hadn't heard of FTB before they were referred there by their GP and some mentioned they had heard of FTB via information disseminated in their

school, college or university or via the VCS service they were using. Some young people and parents also reported that they had looked at the FTB website – this was mainly those young people who were transferred to FTB from BSMHFT and some young people who had dropped into PAUSE for some general advice.

With regard to understanding of the service, young people talked about it being somewhere you could go for help, somewhere you could go to see a person you could talk to about your worries. They were less clear about the different parts of FTB, (where they were, what they offered, who worked there etc) in particular the community Hubs; PAUSE seemed to be the most widely understood service, with strong support for the drop-in facility it offered.

A number of those interviewed or who took part in a focus group had used the FTB crisis and or Home Treatment provision and it was apparent that they understood what these offered and the referral routes to them. In a number of cases, it appeared that young people had accessed these services whilst on a waiting list for an appointment in one of the community hubs.

7.3 What children, young people, parents and carers like about the model

PAUSE and the ability to drop-in, including at the weekend, was highlighted as something young people would find very helpful. Amongst those who had used PAUSE, there were positive views about its welcoming environment and helpful, accessible staff:

"*it's a safe space with great staff…*"

However, two young people expressed the view that perhaps the atmosphere was "too happy", that it could feel a bit "forced and artificial", especially for those young people who might be feeling "low or sad".

With regard to PAUSE, getting into the city centre was noted to be difficult for some people and when the recent development of Pop-Up PAUSE (at the Lighthouse) was mentioned by the evaluator, there was strong support for this – and a request for more PAUSEs around the city. One young person commented:

"*having a drop-in is really important but you've got to have them across the city… having to travel a long way or to somewhere you don't know, could make your situation worse, it would definitely put you off…*"

In terms of other parts of FTB, when these were explained to the different groups of interviewees, there was agreement that:

➢ The Access Centre sounded a helpful way in to the service – but it shouldn't replace the chance to see someone face-to-face.

➢ Having staff in hubs who could work with younger children and with young adults sounded a good idea – although several people pointed out that the needs of younger children could be very different to those of older adolescents and the environment of the service and skills/knowledge of the staff needed to take this into account

➢ Going up to the age of 25 was good in terms of being able to go to a young person focused service while you were in education and higher education.

One young person who had used the FTB home treatment team reported that the team was good – staff were friendly and approachable, would liaise with school or college and joint planning had made this young person feel involved. A slight downside was that staff often changed:

"You see different people but you get used to that… it helps that it's in your own home so a familiar setting… it feels like they make time for you…"

And another, who had used various parts of FTB commented that overall:

"it feels less clinical (than a previous service used), it feels warm and welcoming…"

A further young person noted:

" the communication is rubbish but overall, the service is generally very good… it's helping loads of people but it could help so many more… it's a shame it's let down by basic things…" (to which they were referring to the waiting times and information problems discussed in Section 7.4).

There were also highly positive reports of FTB workers being flexible and showing high levels of commitment to supporting young people:

"my support worker… not sure of their title… was willing to travel to me and have meetings in his car outside my accommodation when my anxiety and depression were extremely bad and I was unable to travel…. When I was struggling so much, to have someone go so far above and beyond had me feeling extremely supported…. He even posted prescriptions to me when I told him it would be too much to travel…."

Another young person also highlighted the good follow up they had received:

"my psychologist was brilliant, really good at following up things to make sure they happened and being there for me when I was in crisis…"

However, unfortunately alongside this highly positive feedback, this young person had experienced two members of FTB staff leaving, with no handovers or introductions to their replacements and that they had only found out about one staff departure when the university Health and Wellbeing Team range FTB on the young person's behalf.

Other positive feedback was provided by one parent who commented:

"The doctor listened and he knew the best options… the appointments and input from the EI team really were good… seeing someone regularly is so important in terms of therapy working…"

7.4 Areas of concern

A variety of issues and concerns were raised of which the three which were most prominent were:

- ➢ Long waiting times to get an appointment in a Hub.

- ➢ Repeated changes of staff and poor continuity of care.

- ➢ Poor and delayed information about what was planned including referral letters which gave little or no information about who a young person would see and for what reason.

A number of concerns about the attitude of FTB staff in the Hubs and their confidence to work with young people were also raised. Several young people complained that they had only been offered six sessions of counselling or other therapies and had wanted longer-term help and some highlighted dissatisfaction with prescribing of medication; more detail on these issues is provided below. Likewise some provided information which suggested that the quality and

flexibility of care may be being compromised as FTB has come under, it seems, more pressure since Summer 2017 – for example, one young person described a highly positive experience of support from the crisis/home treatment team at the start of the year and then more recently:

"they were lovely and supportive (when YP discharged from hospital)…. On the second occasion, they didn't talk to me.. they just prescribed meds and discharged me after 2 days.."

Two of the young people interviewed also reported that they had made formal complaints such was their level of dissatisfaction with the service they had received – and at the time of interview, they had not had a response or any acknowledgement that their complaints had been received or was receiving attention.

7.4.1 Waiting times

Whilst those using FTB reported that the actual initial referral process seemed quite quick and straightforward, waiting times after this were a source of widespread dissatisfaction especially since a common complaint was of receiving no information as to what would happen next. This was possibly the biggest issue with some of the young people/parents and carers reporting that they had waited for over 6 months to be transferred from BSMHFT to FTB (with it seemed no handover) and others had waited in excess of 3 months to be seen in a Hub and often had to chase up appointments:

"my mum had to ring repeatedly and so did my school and GP and still nothing happened…"

In addition to chasing up appointments themselves, it was reported that quite often, GPs and staff in schools/colleges and VCS agencies had made repeated attempts to contact FTB to try and find out when a child or young person might be seen and when, often finding it difficult to talk to anyone with knowledge of the referral. Getting the time and date of any appointments confirmed was also generally problematic:

"communication is shocking, you have to chase and chase… on occasion, I've gone in to PAUSE and got them to try and ring Finch Road (Hub)… they never seem to put things on the system or even book rooms… simple things to fix…."

In addition, young people/parents and carers talked of attending for an appointment at a Hub only to be told that the person they were meant to be seeing had left and that they would have to return another time to see someone else, then receiving no letter to confirm the new arrangements, leading to further chasing.

Two young people reported that they had experienced this process happening several times (i.e. several departures of staff resulting in being returned to the waiting list on more than one occasion). Paperwork being lost or not being transferred (e.g. from one Hub to another) had also been given as reasons for some young people being told they would have to wait for an appointment having been seen once for what sounded like an initial assessment (the purpose of these appointments was not clear to the young people). One commented:

"they told me they don't have the space or the staff so it may not be until next year (when they would be offered an appointment)…"

A common experience, it seemed (reported independently by 4 young people from 3 different settings), was for young people being told that they had missed appointments (to be seen in a Hub) and therefore would now have to wait for an appointment. The young people concerned were all adamant they had not received any appointment letters, suggesting that this was not an isolated incident related to one specific hub. One young person also described being told that he would be sent a new appointment and then receiving a letter saying that he had been discharged from the service. Another, at the time of interview, had just experienced their care

worker leaving and had heard nothing from FTB for over 2 months, despite her mother phoning the service regularly:

"Workers leave, that's the problem…. They don't have people who can take over so you just end up waiting a long time…"

In talking about waiting times, young people acknowledged that they expected to wait a short while for a service since they understood that NHS services were, as one described, very busy. However, they emphasized that if young people were feeling very unwell (the example was given of feeling suicidal), then FTB should be able to respond quickly. One parent noted:

"under the old system, if you needed an urgent appointment you could phone up first thing in the morning and something would be organized…. Now if you ring up, it seems they don't know you at all…"

Young people from one of the school focus groups also talked about how long they felt you should have to wait; they thought that 2 months was definitely too long (based on their experience) and that 1 week should be what a service should aim for in terms of a first assessment at least. One of the group suggested:

"if you make a request at the start of the week than you really should be able to get an appointment that week… advice over the phone is not enough, it's not the same…"

Both young people and parents/carers highlighted that young people should not have to reach a crisis or be very unwell before FTB offered them help. One parent highlighted that even at that point, it seemed nothing happened; they went on to describe trying to support a young person who was threatening to kill himself by ringing the crisis team:

"… all weekend and even after a visit nothing happened and we were left in the same situation.."

With regard to problems with FTB crisis provision, one young person reported waiting for over a month for a response from the crisis team; the young person then received a series of visits at home, each time by a different person who did not seem fully informed of the young person's situation. During this period, they dropped into PAUSE regularly for support and eventually they were signposted for counselling.

Another young person, also in contact with the crisis team, described a similar experience of different staff visiting and commented:

"it felt like they were reading from a script… they didn't listen to me, or if they did they didn't seem to take it in… they seemed to have standard advice and an answer for everything even though it didn't fit with me…. It felt fake, they didn't really care…."

A third young person reported the crisis team visiting on days when the young person had told them they would be at college; this young person had also experienced crisis team visits being promised which then did not happen. They also described several occasions when following a presentation at A&E/referral to the crisis team, they had been discharged without a visit taking place or any contact from the team. The family of this young person was now reported to be paying for private counselling.

Using PAUSE while waiting for an appointment in a Hub or other FTB team was mentioned frequently; being open at the weekends (when FTB Hubs are not) was also very helpful:

"it's my 'life saver'…. Being able to turn up whenever you have a problem makes me feel safer…

 However, whilst what PAUSE offered was viewed positively, one young person noted:

"it's being used as a 'fill in service' to try and cover the gaps in other parts of FTB….

7.4.2 Staff turnover

There was a general view across the different groups of children, young people, parents and carers that FTB did not have enough staff and this was why people had to wait so long for an appointment – various comments were noted as to how difficult it was to see a doctor or the same person twice.

A frequent complaint was of children and young people constantly having to re-tell their stories, one things that the FTB model highlighted it would eradicate with its approach of 'no wrong door' and joined up approaches to service delivery. One young person and their mother noted that in psychiatry continuity and trust are crucial; they had experienced very short notice of the clinician they had been seeing being deployed and no information as to who would replace them.

These informants also highlighted a practical problem in the booking of appointments, namely that because clinicians were unable to put their follow up appointments onto the system, families could not be told at the end of an appointment the timing of the next appointment and instead, they would have to wait for a letter. A change of staff within this could be, as this young person and parent found:

 "disastrous, you can just get dropped off the system…"

As described in the previous section, children and young people clearly attributed the delays and long waits for appointments to staff turnover and vacancies. They also reported that it had impacted on their experience of care and treatment, with a number describing establishing a relationship with a temporary member of staff only to have them leave, often with no warning or handover to anyone else. Two young people, when talking about the impact of repeated staff changes also said this made communication difficult but what was worse was the lack of follow through:

"they should not make promises and then not keep them…"

7.4.3 Information

Problems with information, as noted earlier, included the referral letters young people and families had received which seemed to provide only very limited details as to who a young person might be seeing at an appointment.

Letters were also described as arriving late or in clumps or not at all, leaving young people, parents and others to chase FTB. Conversely, examples were also given of letters being sent to a young person's home address containing sensitive information and when the young person had expressly asked for this not to happen.

Once in the service, it seemed that children, young people and parents were generally more satisfied with the information provided although there were some complaints noted about a lack of diagnosis (one young person described getting a diagnosis due to their "sheer determination and persistence"). However, with the exception of one young person being supported by the home treatment team, and one young person who had previously been seen by BSMHFT, none of the young people or parents/carers in current contact with FTB who were interviewed appeared to have a care plan, and indeed, most did not seem to know what this was. (The young person with previous experience of BSMHFT described being given a care plan that was out of date, including details of what staff were involved and missing important recent events).

Other problems with information identified through the interviews and focus groups included what information was given when young people were signposted elsewhere:

"I was given a load of stuff about wellbeing places that didn't seem right for my needs"

"they referred me on to Resources for Autism and I don't have Autism…."

"the (FTB) website only seems to have things about anxiety and depression… information about the therapeutic services seems to be missing…."

And a number of those interviewed called for FTB to provide more advice and information about other sources of local support that they could access whilst on a Hub waiting list, including online resources, and also about what would happen when they reached 25 and needed to move on from FTB.

7.4.4   Attitude of staff and listening to young people

As described earlier, some young people made complaints about FTB staff 'reading from a script' or not really listening to young people and this theme emerged across all of the different settings from where young people were invited to take part in the evaluation (that is, 2 hubs, 2 schools, 1 VCS project, 1 university and PAUSE).

Comments from young people included a quite widespread view that FTB staff had a 'one size fits all approach' to young people's difficulties, that they 'lumped young people together', they made assumptions and seemed keen to get young people out of the service. In the opinion of some of those interviewed, some members of staff seemed to be dismissive of young people's concerns or did not appear to believe them. One stated:

"they seem to twist your words… if you ask when you might be discharged that then becomes ' oh you don't want treatment then'…. It makes it hard to talk to them, to trust them…"

Another concluded:

"they seem to have standardized advice that they don't personalize to your needs…"

In addition to calling for FTB staff to improve what a number of young people called their 'bedside manner', it was also suggested that:

"they need to think about who they are dealing with…. Recognize that they are different… and that how a young person presents may be very different to how they really are on the 'inside'…"

One of the young people who reported that they had lodged a formal complaint explained what had led to this; she described feeling that FTB staff were laughing at her and that she was told that she couldn't be experiencing the symptoms she described. With experience of using mental health services for some years, this young person described the response of FTB staff as:

"the worst ever…"

A further young person commented that staff had told her she couldn't be depressed because she had put on her make-up and one noted they were:

"worried about how younger more vulnerable people (than me) will feel if they are talked to in such a rude and dismissive way… I'm older and more resilient and it (how FTB staff talked to her) reduced me to tears…."

7.4.5   Prescribing

Some complaints were noted that the only things on offer in FTB were medication and referral out for counselling. However, possibly more worrying were reports of:

- Young people experiencing their prescriptions running out, or changes to prescribed medications not being recorded on the FTB system or communicated to the young person's GP.

- One young person experiencing serious side effects from their medication and phoning FTB repeatedly over a two week period trying to get advice from the clinician who had prescribed the medication.

7.4.6 Level of interventions and skill mix – is the balance right in FTB?

Several young people commented that FTB seemed to offer mainly low level interventions and that it didn't seem that well suited for dealing with young people who had complex issues. These comments seem to refer to the reliance on PAUSE as a way of offering young people support (especially when on a waiting list) and also the apparent high signposting out to counselling which some young people had not been expecting, thinking that they required some form of specialist assessment of their needs first (a view supported by a number of the VCS interviewees highlighting high levels of inappropriate referrals from FTB and/or referrals with little or no information as to the young person's needs).

Two of those interviewed put forward the view that FTB lacks staff experienced in working with LGBT and with gender issues. One commented that the only support for those young people going through gender transition seemed to be anti-depressants and they called for staff training and awareness raising about how to work with young people, especially those on waiting lists for gender assignment. Service sensitivity regarding the names by which young people wish to be known was also requested; ignoring this was described as highly distressing to young people.

One young person described attending for an appointment at their local Hub and being told that the person they were meant to see was not there; another two members of staff were called but they apparently only worked with adults and so the young person was told they would receive a new appointment on another day. This young person posed the question as to why the Hub only seemed to have staff who could work with older people?

7.5 Suggestions for how the service needs to develop

The young people, parents and carers who contributed to the evaluation put forward a range of suggestions for what they thought was needed to develop and improve FTB. Many of these are self-explanatory and so are simply listed below:

- Better communication about appointments, with patients able to choose how to receive this information and ideally, able to choose the scheduling of appointments to avoid clashes with other commitments.

- Much prompter scheduling of appointments and if a young person has to wait, information, advice and support to be available during that time.

- Referral paperwork to be specific about who the appointment is with and what will happen. The service should be more proactive in explaining what is being offered and where they need to go rather than expecting children, young people and their families to work this out.

- Staff training to work with children and young people and their families across all areas of FTB; this includes their engagement skills so that children and young people feel fully involved and not 'talked down to' or that they are 'under examination'.

➢ All children and young people should be provided with an up-to-date care plan which provides key contact details; if staff leave or are deployed, there should be advance warning of this and handover meetings that involve the child, young person and their family. This should also cover when young people are signposted out to other services.

➢ Case notes need to be kept up to date and if these need to be shared, e.g. if a young person moves hubs, then this should happen immediately so that young people are not put back on waiting lists because their paperwork has not been transferred.

➢ There should be options for longer-term help and treatment; six sessions of CBT or counselling may not be enough for some young people and it should be possible to extend this.

➢ There should be more PAUSE drop-ins across the city since many young people will find accessing the city centre PAUSE difficult – however, PAUSE must not be used to cover for shortages or long wait times to get into other part of FTB.

➢ FTB needs to ensure it offers advocacy support and also develop opportunities for peer support; it is also really important that young people are involved in helping to develop the service going forwards.

➢ FTB should develop and extend the support it can offer via schools, colleges and universities since these are places that young people use and which provide non-stigmatising environments.

➢ Making sure that the service is age appropriate is crucial – e.g. the waiting areas and clinics; it is important to recognize that younger children require different environments to adolescents and these need to be different again for young adults up to 25.

7.6 Feedback from other school staff and from staff in further education

One school canvassed its staff group for feedback about working with FTB when it proved impossible to find a time when the school could host a focus group. They highlighted the following:

➢ It was "fantastic when we had a PMHW in school, we could utilize their skills directly with our students and engage parents quickly"

➢ PAUSE was described as a brilliant resource and they had signposted parents to it

➢ In some cases where they had serious concerns, someone from FTB was able to speak to the member of staff and the young person on the phone; others noted that when they had called or emailed FTB, they had been quite supportive in providing the information requested.

Less positively, a prominent theme was that it was often hard to get feedback from FTB:

"hearing back from FTB is an issue. There is no feedback to us even if we submit the referral…. The initial phone conversation is sometimes used to dismiss the need for counselling when, over the phone it is less easy for a young person to admit there is a problem."

Other concerns noted included the long waiting times for initial assessments and the online referral process which staff found very time consuming (and also unhelpful that the document cannot be saved, with only a receipt acknowledgement sent back to the referrer). It was also

reported that the school had been told that there would be a package they could purchase from FTB at different levels but this had subsequently not materialized.

Interviews with representatives from two of Birmingham's universities, Birmingham City University (BCU) and the University of Birmingham highlighted high levels of complex mental health need amongst their student populations, also that these young people may have very particular needs as a result of being away from home living independently for the first time and/or may be international students and thus living in a country that is not familiar to them (likewise UK mental health services may also be very different to the services they may have used in their home countries).

The need for FTB to be able to respond appropriately and rapidly to students in crisis was emphasized, as was the need to think about how to deliver services to a group who may be out of the Birmingham areas/need linking into their local services during university vacations – especially in terms of ensuring safe monitoring/continuity for those on medication.

7.7 Feedback from young people using PAUSE

Feedback forms are regularly issued by PAUSE and some of the comments in the free text box included:

"the person who talked to me advised both me and my mum on how to control frustration and anger….. I felt relieved because I thought it would be horrible before I came but it actually helped me…"

"Liked the support workers and how I can try things to stop worrying…"

"The atmosphere is very calm and welcoming…"

Unfortunately data regarding the needs initially presented by these young people was not available although it is understood from an interview with senior staff from the Children's Society that an audit of the numbers of young people presenting to PAUSE suggests that around 70% are not known to the NHS/in contact with mental health services and that the numbers presenting to PAUSE with complex problems are quite low. However, undoubtedly young people in crisis and those on waiting lists for an appointment in a FTB hub, do frequently feature in the other 30% of young people seen in PAUSE.

Chapter 8: Progress in implementing the new FTB service model

8.1 What the findings tells us about FTB service delivery to date – learning from the interviews and focus groups

8.1.1 Improving access to mental health support and care

The findings from the interviews and focus groups indicate that overall, there have been some significant improvements in developing access to services for all age groups of children and young people, particularly through the self-referral pathway, PAUSE and the Access Centre, as well as the online portal for self-referral.

It was also suggested that the FTB model has lead to improvements for those requiring the most urgent care, through the Crisis and Home Treatment Teams, (although as the previous chapter described, information from some young people suggests this may have deteriorated over the course of 2017 as FTB has become more stretched and unable to keep up with demand) as well as for older age-groups requiring in-patient care (18-25 year olds).

The factors that are said to have enabled these developments are the investment in these specific elements, and the processes and environments that are in place.

The Primary Mental Health Work Team are seen to be providing important preventative and early interventions and support to children and young people in schools, and to the teaching staff working with them. The current model is felt to be very effective in managing a significant number of children and young people with emerging mental health needs, who otherwise may have accessed services further along the pathway. There is concern that the PMHW team is about to be amalgamated with the Hub teams, and that the current model could be compromised as a result.

Acacia Project for Young Mums, commissioned by FTB, appears to working very well in engaging with those young mothers who might otherwise not access services. With the recent decommissioning of the Family Nurse Partnership (FNP) programme in Birmingham, the outreach and home visiting support offered by Acacia is seen as providing something that is not offered anywhere else. Analysis of its referrals to date indicate that the service is working with a higher level of complexity than originally expected and the outcomes achieved suggest a model of early intervention and support that is achieving positive improvements in the confidence and resilience of the target client group.

8.1.2 Assessment of progress in addressing other priority areas identified in the Birmingham case for change

From the data gathered through the focus groups and interviews, it is possible to conclude that FTB has made headway in improving access to services as noted above. However, given the concerns about long waiting times and signposting out, it is much less clear whether the model is offering seamless provision for 16-18 year olds

It would seem likely from the reports of long waiting lists that these will include for condition specific services for 16-18 year olds such as ADHD.

Rates of DNAs have not been highlighted as a concern - but young people have talked of feeling that they no longer trust FTB and that they have disengaged with the service; we have also received reports of families paying for private counselling such is their level of dissatisfaction with the FTB offer of treatment.

Poor patient experience is suggested by the various concerns that have been reported to us outlined in the previous chapter. Obviously these data are based on a small number of young people but some issues were reported consistently across seven different settings and from young people not known to one another.

With regard to dissatisfaction within referring agencies i.e. primary care, interviews with GPs from some of the top referring GP practices have revealed a mixed picture of some improvements but also concerns, for example about information sharing (e.g. letters arriving very late and/or missing important information about medication or care), of GPs being 'dumped on' to prescribe rather than specialists taking responsibility for this and of concerns of insufficient monitoring of patients (of all ages) by specialist health service providers.

These interviewees have noted that possibly the crossover of care for those aged 16-18 is now easier with FTB although major changes or improvements are not yet evident and from their perspective, it does seem that whilst children and young people may be assessed quite quickly, they then seem to wait a long time for any treatment to start.

These interviewees have also encountered difficulties being able to identify and talk to the named consultants for young people they may have referred and confusion about signposting of young people to a wide range of different VCS services. One interviewee, working closely with the university sector also noted the loss of the previous much more tailored service for this client group and the need to explore with FTB how this might be addressed going forwards.

This interviewee also reported that Extended Share Care Agreements (ESCAs) very rarely arrived with young patients from FTB and that these are important in cases where for example the monitoring of lithium may be required. It was also noted that this GP practice had experienced FTB requesting 'holding prescriptions' for young people whilst they waited for an appointment to be arranged in FTB.

8.1.3 Barriers to Progress

Barriers to progress are seen to largely arise from the following key factors:

> The **lack of ability to recruit and retain substantive staff members**, compromising capacity and inducing raised levels of stress amongst the workforce, and feeling of increased risk and reduced safety within the service.

> Needing to run the services through a **high number of agency staff and locums**, who often move on quickly, therefore having an impact on consistency of approach and care.

> A perceived **lack of investment in the original community CAMH teams**, in terms of time and funding is leading to issues around capacity to meet demand, and in the application of the CAPA model, which with proper implementation, could help flow through the system.

> Concerns about the **paucity of provision for children under 14**, especially as there has been a reduction in the VCS, an increased demand on Hub teams, and an identified gap in support for newly emerging mental health needs in this group.

> The **reduced leadership and management capacity** affecting the ability to support staff through the change process and to bring the teams together to negotiate and agree processes and interfaces. This in turn is contributing to low staff morale and a difficulty in

working together on the development of the service culture to enable fit with the FTB model, and confidence in it.

- ➢ **Poor data collection and recording systems** that are difficult to access and don't provide a consolidation of the information required at a strategic, operational and clinical level, to support effective provision and review of services.

- ➢ The **overcrowded physical environment** within which clinical support is offered is not felt to be conducive to engagement with service users, especially in the younger age-groups.

8.1.4 Key factors to help mobilisation and identified gaps

Participants were able to offer very little in terms of solutions to the challenges they have highlighted. They felt that a focus on developing a skilled and substantive workforce is a priority, along with robust leadership and management of both the transformation and operationally would help overcome a number of the issues they identified.

In addition, they felt that a pathway for young people with Personality Disorder was a gap that needed consideration. Stakeholders in the second round of focus groups reported that they were working on developing one, which needs formalising, however, it needs liaison to be agreed along the pathway and between teams. The main concerns were that these young people are being managed in home treatment, but this can escalate and they can become in-patients. They also frequently attend A&E.

Participants suggested that PAUSE should be replicated in the South – on this basis, the recent introduction of Pop-Up PAUSE (one already at the Lighthouse and a further planned in Longbridge) are welcome developments.

An innovation staff would like to see in the future is a shared care record, for more automated booking whereby all diaries are viewable and time slots can be booked to suit the young person/family at the time of asking. People need to know exactly when they will be seen, not receiving the message "*the health exchange will contact you.*"

Chapter 9: Developing the service – evaluation conclusions and recommendations

9.1 Summary

As noted in Chapter 8, the findings from the interviews and focus groups indicated that overall, there have been improvements in developing access to mental health services for all age groups, particularly through the self-referral pathway, PAUSE and the Access Centre, as well as the online portal for self-referral. It is also suggested that the FTB model has brought some improvements for those requiring the most urgent care (following the substantial work done on the pathway during the evaluation time period), through the Crisis and Home Treatment Teams, as well as for older age-groups requiring in-patient care (18-25 year olds).

However, it is also clear that overall, the service has become overwhelmed with referrals due to the success of the Access and PAUSE structure and that while these structures are welcome changes, their function needs review. In addition, the capacity of those areas of FTB that sit 'behind' its 'front door', namely the community hubs needs urgent attention if they are to be able to offer the seamless, joined up care, in particular, for those with more complex needs requiring prompt access to specialist mental health assessments, treatment and care.

9.1.1 Activity and outcomes data

The evaluation data gathering has revealed significant limitations in the activity data collected by the services and crucially, a lack of individual patient outcome data which makes it impossible for the evaluation to draw any conclusions as to whether the interventions offered by FTB are bringing positive outcomes in mental health and wellbeing for those using the service.

In addition, FTB are not able to track and understand the outcomes of those individuals who are not offered an appointment (46.5%) and then 'signposted' to a charitable or other VCS service for young people (72% of this group).

The large amount of missing data, for example, has meant:

➢ Limitations in any analysis of referral rates by postcode to assess whether areas with higher levels of deprivation have differential referral rates into FTB.

➢ Difficulties in understanding the pathways to care, patient flows and duration of untreated mental health difficulty. The time to first assessment is relatively long, at around 50 days mean, however, from the data provided, it was not possible distinguish new referrals from re-referrals so this is only a partial picture.

Likewise, whilst it appears that DNA rates are relatively low and have reduced in the last 6 month of service operation, also that children and young people are being discharged from the service faster, it is not clear whether this is due to service pressure (and increased use of 'signposting' to the VCS – where respondents from that sector have highlighted concerns of greatly increased numbers of inappropriate referrals) or improved outcomes.

There have been repeated reports of high staff turnover and changes of young people's care co-ordinators, with staff departures sometimes resulting in children or young people going back on to a waiting list. Again, it is not clear to what extent these and other 'internal waiting times' may be reflected in the activity data provided to the evaluation team by FTB.

9.1.2 Issues raised by stakeholders

Through the 10 focus groups (85 participants at two time points), 53 baseline interviews with mental health professionals from across FTB and its partners, 3 focus groups and/or interviews with 27 children or young people and 3 parents or carers from 7 different settings, and follow-up interviews with a range of staff from primary care (including 3 GPs) and the education sector, a wide variety of issues were raised. Support for the FTB model, especially the extended age range, the integration of practitioners from children and young people's mental health services and adult mental health services in the Hubs and the proposed partnership working with VCS was apparent – but alongside this, right from the outset, concerns were raised that the level of demand facing FTB was far higher than expected and worries about the capacity (including the levels of skills and expertise in the FTB workforce) to be able to manage this.

Prominent areas of concern raised in the focus groups and interviews included:

➢ Communication and partnership working with the VCS, in particular, a strong sense that initial promises had not been realized, that VCS providers felt excluded from discussions about the development of FTB and then more latterly, were being subject to increasing numbers of what they viewed as inappropriate referrals (signposting on) and were being used to 'mop up' waiting lists in FTB, with no money or formal service agreements attached to this activity.

➢ Inconsistent responses to children, young people and families with long waiting times, and in particular, delays in the pathway after referral from the Access centre.

➢ Compounding this, a lack of communication and information was frequently raised, with worries about children and young people being 'passed around' the system or escalating into crisis because of a failure to intervene early. High staff turnover within FTB was seen as adversely impacting on the continuity of care.

➢ The loss of provision that used to work well and a sense that well established professional networks had also been unnecessarily and unhelpfully disrupted. Across FTB, a range of service interface issues were described, often the result of initial limited understanding as to who was meant to do what within FTB.

➢ A range of issues to do with staffing, including recruitment and retention difficulties, recruitment of staff at lower bands/the loss of senior staff - all resulting in low staff morale and high vacancy and sickness rates.

➢ The use of locums was viewed as too high and a number of interviewees described CAPA being wrongly used, that planned caseloads had been exceeded/were unmanageable and that the ability to offer preventative work and early intervention had been seriously compromised in attempts to manage demand.

➢ Shortages of medical staff and sudden staff redeployment and/or changes in team function (notably with regard to the PMHW team) to try and manage demand, were other notable concerns. There was a widespread view that senior clinical leadership within FRB was inadequate and that there had been a 'stripping out' of the management layer with little communication about this, or monitoring of its impact.

➢ Poor and incompatible data systems which impeded the sharing of information, compounded by a service infrastructure that a number of respondents described as not 'fit for purpose' were frequent complaints. With regard to the latter, this included staff lacking basic equipment such as fully functional laptops, tablets and telephones and adequate desk and clinic space, all of which negated the aim for so-called 'agile working' across FTB.

9.2 Recommendations

The following recommendations draw on the data collected across all aspects of the evaluation including the analysis of the activity data provided to the evaluation team by FTB, the data collected through the interviews and focus groups. Where possible, they have been clustered into some of the prominent themes/areas of concern just described.

The FTB model

It is clear that the service has become overwhelmed with referrals due to the success of the access and PAUSE structure. While these structures are welcome changes, their function needs review. Overall, the model needs rebalancing to ensure that its' front doors' are in line with all parts of the service in order to ensure patient flow and that access to both low level and higher level interventions is possible and timely.

The data show that old solutions that are inimical to the founding principles are being used to manage demand - principally 'signposting' to VCS partners, which is being used for nearly three-quarters of those not offered an appointment. This is occurring without i) discussion, agreement and appropriate training or funding/resourcing of the agencies ii) no follow-up of these young people to see if they attended, engaged and the outcome.

We recommend:

1. We understand that further 'pop-up' PAUSE centres are planned; we would urge FTB to delay this until the access/referral process is reviewed and 're-booted'.

2. A full review of the demand and capacity of the four community hubs and of the urgent care and inpatient provision is undertaken, including an audit of staff skill mix and expertise, numbers of senior band and lower band staff, and in particular, numbers of medical staff.

3. Where the use of agency and locum staff is unavoidable, attention is needed to ensure that these staff receive an induction programme and that clinical and management supervision are fully in place to minimize as much as possible any disruptions to care offered to young people. Processes for managing staff turnover, departures and deployment need to be better developed, to include ensuring that children, young people and their parents/carers are kept as informed as possible as to who they will see and when.

4. A re-engagement and review with VCS partners as to how to manage the demand, including training, capacity and including them in the access and assessment process is undertaken. In other words, FTB should reactivate, review and refresh the ideas originally set out for partnership working. Appropriate resourcing of this sector also needs to be revisited and made more transparent going forwards, not least in order to begin the process of rebuilding trust between this sector and FTB.

5. An audit of 100 cases that come through the Access Centre to examine what happens; ask the question: how many of these could be given good assessment and brief intervention without referral to the Hubs or VCS partners; how many might be handled at the primary care level with capacity allocated at that point.

6. Exploring options for developing online capacity as a part of the FTB offer. (While much was made of the digital platforms, we have seen no evidence of it).

7. FTB explore ways of working collaboratively and in partnership to strengthen its links with

primary care. The data clearly show that the main source of referrals is primary care and that GPs play a crucial role in the management/monitoring of medications prescribed to young people. Discussions are needed about how capacity can be built into primary care, perhaps with the PMHWs and FTB use of satellite premises in local GP practices/health centres (the availability of such space being noted in interviews with primary care stakeholders).

The FTB Partnership

Our study of the procurement process deserves careful examination. While the competitive tendering process was regarded as essential to overcome the inertia in the system, it had unintended consequences of creating further fissures across the City's main providers, that affected continuity at 25yrs.

In spite of attempts to engage Worcester Mental Health Partnership Trust in the evaluation, their representatives did not attend the CAYAMS learning meetings and the only interviews undertaken were in the very early stages of the evaluation. We are aware of separate reports on the acute care pathway expressing concerns about this.

Likewise the evaluation team encountered difficulties with gaining any information from the Priory, another key partner in FTB. How well or otherwise this partnership is working is thus unclear, however, there were reports of some issues around delayed discharged, partly due to a lack of step down services but also problems obtaining the DST (Decision Support Tool for continuing care needs) assessments. In developing and adjusting the model going forwards, careful consideration of the inpatient provision offered by the Priory, as well as the links between inpatient and community provision, must be fully factored in.

Going back to our procurement evaluation, the view was widely expressed that another fragmentation had been unintentionally created and we have been aware of the still unresolved bad feeling this seems to have been created. There is only one loser in this: the young people and their families to which end our assessment is that FTB needs to think more widely about how it integrates provision, alongside how it communicates its vision for joined up 'seamless' care to all relevant stakeholders across the City.

We recommend:

8. Perhaps the time has come to reconsider realigning the FTB partnership, to embrace the provider of 25+ in the city and to explore ways of developing partnership working.

Implementation of CAPA and 'intelligent' caseload management

The CAPA is placing impossible demands on the hubs with growing waiting lists and concerns have been expressed that interventions are delivered in haste and without sophistication. In the focus groups, widespread concerns were apparent as to how CAPA has been implemented in FTB and about unmanageable caseloads. In Appendix 2, we provide a summary by the authors of CAPA as to the eleven 'key components' of effective implementation of CAPA.

At the outset of the evaluation, BEACON were very much in evidence and the evaluation team attempted to agree an architecture capable of addressing the core outcome questions. This was not forthcoming. In presentations BEACON were described as having the ability to develop and apply algorithms overlaid on the IT system capable of supporting caseload management - again we have seen no evidence of this.

We recommend:

9. The use of CAPA across FTB needs revision and we suggest the senior management team

draw on the information provided in Appendix 2 to do this.

10. A similar review of the BEACON electronic caseload management system should be undertaken - if it exists, this should form part of the re-design of the access pathway.

Working with the VCS and other partners

Please see recommendation 4 above.

Participants from the VCS wished to emphasise firstly, that they remain keen to work with FTB in delivering a new model of mental health service; secondly that, in their opinion, FTB lacks links with a number of key services for children and young people and need to address this. Such services include: CRI, the local drugs and alcohol service, Umbrella, the sexual health service and youth justice services. It was also suggested that there was a serious lack of strategic links between FTB and initiatives such as the Early Help offer.

These informants identified a number of areas of provision that they felt had worked well previously and which needed to re-established and these included the communication channels with GPs, lost as a result of *"everything getting pushed through the Access centre"* and the consultation to schools previously offered by a number of VCS providers.

Via the second round of focus groups, interviewees from the VCS collectively agreed and put forward a series of recommendations for the development of FTB. The evaluation team agree with these proposals, namely:

a. Pause, the Access Centre and all other parts of FTB need to have suitably qualified and experienced staff; information about who they are and what they offer, needs to be regularly shared.

b. FTB needs to put in place an IT system that is compatible across all agencies that comprise or work with FTB.

c. There needs to be a protocol for information sharing (about those referred into, or from, the service) across FTB and its partners – e.g. about what is planned or being offered to a child or young person.

d. There should be a named person for management of referrals into FTB that partner agencies can contact for information as to what is planned/being offered.

e. VCS partners need up-to-date information on the overall structure of FTB and the roles within it; true partnership is needed in order for VCS providers to stop feeling like, as one described *"we are the crumbs off the table."*

f. A programme of training for the FTB workforce, and opportunities for CPD need to be developed, provided by FTB and also provided by VCS partners. These should include all the latest scientific developments in early identification, support and preventative approaches for children and young people with complex mental health problems.

g. In order to build capacity and longer-term sustainability of FTB, the use of one-year long commissions of VCS partners should be avoided and longer time periods used wherever possible.

Finally, in discussing how they would like to work with FTB going forwards, they warned of the dangers of trying to standardize VCS partners and "*pigeon-holing them into addressing gaps elsewhere*". They suggested this would put at risk the flexibility, responsiveness and young person-centred ways of working that the VCS is well-regarded for.

Building the FTB workforce

Unfortunately despite requests made by the evaluation team, we were not provided with information as to the current FTB staffing establishment, including vacancy and sickness rates, numbers of locum or agency staff. However, from a variety of sources we heard of high staff turnover, shortages of medical staff, departures of psychotherapy and psychology personnel and overall, of low staff morale amongst many of those remaining post. All of this suggests that FTB needs to focus efforts on building its workforce and urgently to change its approach to supporting and retaining current postholders.

Drawing on the body of literature concerning managing change (in particular culture change) and building teams in health systems, may be useful to FTB in this activity – not least in developing stronger ways to communicate the vision for FTB (and to avoid the spread of information via the 'grapevine'), to look for progress to celebrate and 'quick wins' to boost morale.

Leadership will be critical going forward and building a sense of inclusiveness at all levels across the model must be a key component of this activity. Alongside this, we suggest that it will be essential for partnership working with both VCS providers and primary care to be addressed as described previously.

Specifically, please see **recommendations 2, 3, 4, 7 and 9** and also **recommendation f** made by VCS informants to the evaluation. Please also see the following section.

Leadership

The feedback from commissioners, staff, children, young people and parents/carers is that the 0-25 model is one that attracts considerable support. What is hidden in this evaluation is the improvements in care from what went on before: better access, better consumer involvement and no transitions at an inappropriate age; indeed the graphs of referrals by age show clear peaks around the 16-18 range, a point where under the previous system, major discontinuities in service provision would occur.

The transformation needed to achieve this change has been enormous and we are struck by the passion and commitment of the senior team. We feel, however, the senior team need support to achieve this next transformation and to learn from the findings of this evaluation. We were impressed for example in our November meeting with them how open they were to creative thinking and shared problem solving.

We recommend:

11. It may be that there are staff within FTB, and from the VCS and primary care that can work with the senior team to take the FTB model forwards, to enhance and provide robust senior management direction, to stabilize and reinforce change where needed and to ensure that areas of difficulty are more strategically addressed rather than resorting to solutions that are reactive and driven by crisis.

Data and information systems

FTB's poor and incompatible data systems were evident throughout the evaluation and need to be addressed, not least because as Chapter 4 illustrated, there are important gaps in what data is collected and as Chapter 5, 6 and 7 described, this is a cause of significant frustration to staff trying to gain information about a child or young person referred to FTB, or to enter such data, and a major area of complaint by children, young people and their families.

Addressing this issue is closely aligned to our final recommendations concerning infrastructure.

We recommend:

12. FTB integrate and standardize its information systems into one model-wide system, including reviewing and agreeing which partner agencies need access.

13. How to integrate the MOSAIC database used by the Children's Society for one off visits by young people to PAUSE needs to be investigated further, not least in order to fully understand the full extent of the demand for mental health provision currently facing FTB.

Addressing infrastructure problems

Poor working conditions, including inadequate desk space, non-functional IT and other equipment, plus pressures on available clinic space in which to see children, young people and their families, is likely to be an important contributing factor to the low morale and sense of an overwhelmed and beleaguered staff group within FTB. Safeguarding risks have also been noted.

Alongside this, the evaluation team has heard from staff questioning the age-appropriateness of the environment within FTB's premises, in particular the waiting areas, and that ideas of pop-up clinics. e.g. for the under-5s, are being considered. We have also gathered that a number of staff have found creative 'workarounds' to the difficulties they have encountered, including providing their own equipment/keeping it in their cars; such a situation is not desirable or a tenable basis on which to develop a high quality, appropriately resourced service.

We recommend:

14. We understand that staff have raised this issues with FTB senior management on a number of occasions over the last 12 months; we recommend that as part of the work to develop and refine FTB going forwards, and to build workforce capacity, the resourcing of the service is fully reviewed and that essential equipment is provided.

15. We appreciate that FTB, like many NHS services, faces pressure on its available estate and limited resources with which to expand or upgrade current facilities. However, we have also received suggestions of available clinic rooms in local surgeries that FTB could utilize which could have the twofold effect of taking pressure of the Hubs and also providing accessible satellite provision across a wide range of Birmingham venues. Furthermore, delivery could be on a sessional basis for specific client groups thereby also addressing the issue of age-appropriateness. We recommend that such opportunities are explored further.

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Appendix 1: analyses of changes across time in service performance

Demographic changes over the first year.

Table 1: Gender time period 1

Overall Gender		
Grouping	Frequency	Percent
Male	4387	47.4
Female	4857	52.5
Unknown	7	0.1
Missing	3	0.0
Total	9254	100.0

Table 2: Gender time period 2

Overall Gender		
Grouping	Frequency	Percent
Male	5087	47.2
Female	5683	52.8
Unknown	2	0.0
Missing	0	0.0
Total	10772	100.0

There were slightly more referrals for females. There was very little difference in gender distribution between the 2 time periods.

Ethnicity

It is worth noted that 45.5% of the data were missing for ethnicity in time period 1 and 60.4% were missing in time period 2 so these results should be interpreted with considerable caution.

Table 3: Ethnicity time period 1

Overall Ethnicity		
Ethnicity	Frequency	Percent
White	3023	32.7
Black	909	9.8
Asian	423	4.6
Mixed Heritage	478	5.2
Any other Ethnicity/Chinese	213	2.3
Not Stated/Missing	4208	45.5
Total	9254	100

Where ethnicity data was recorded (5046) the predominant ethnic group was white (60.0%).

Figure 1: Overall ethnicity

Overall Ethnicity - Not Stated/Missing Removed
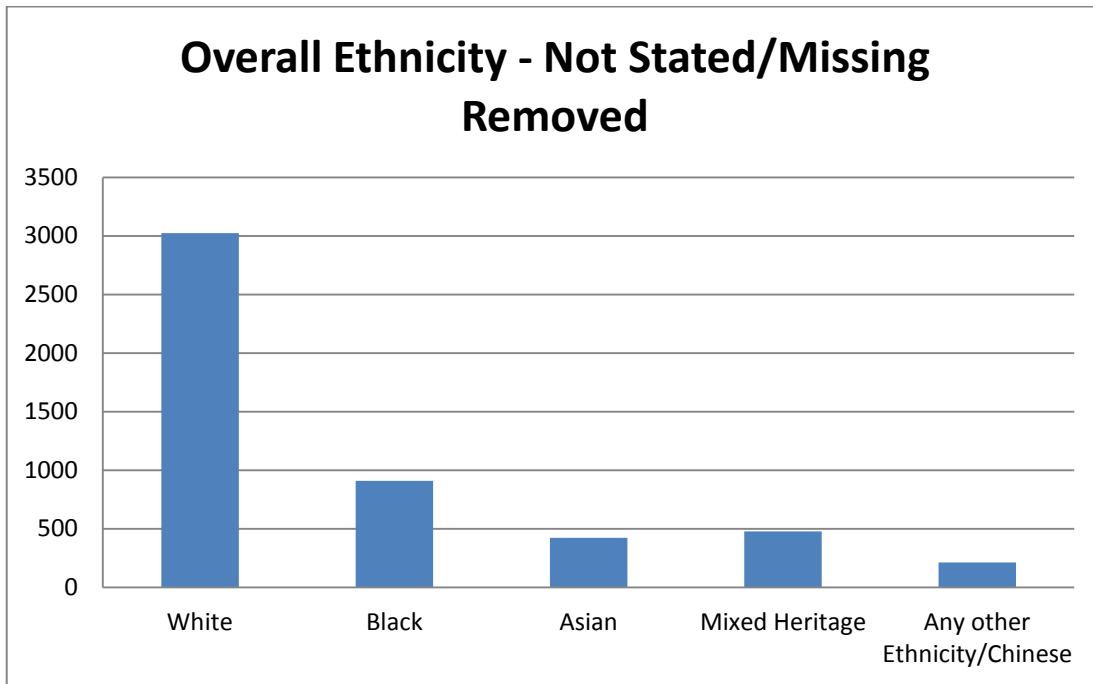
Table 4: Ethnicity time period 2

Overall Gender		
Ethnicity	Frequency	Percent
White	2291	21.3
Black	899	8.3
Asian	390	3.6
Mixed Heritage	505	4.7
Any other Ethnicity/Chinese	185	1.7
Not Stated/Missing	6502	60.4
Total	10772	100

Figure 2: Overall ethnicity with missing removed

Overall Ethnicity - Not Stated/Missing Removed
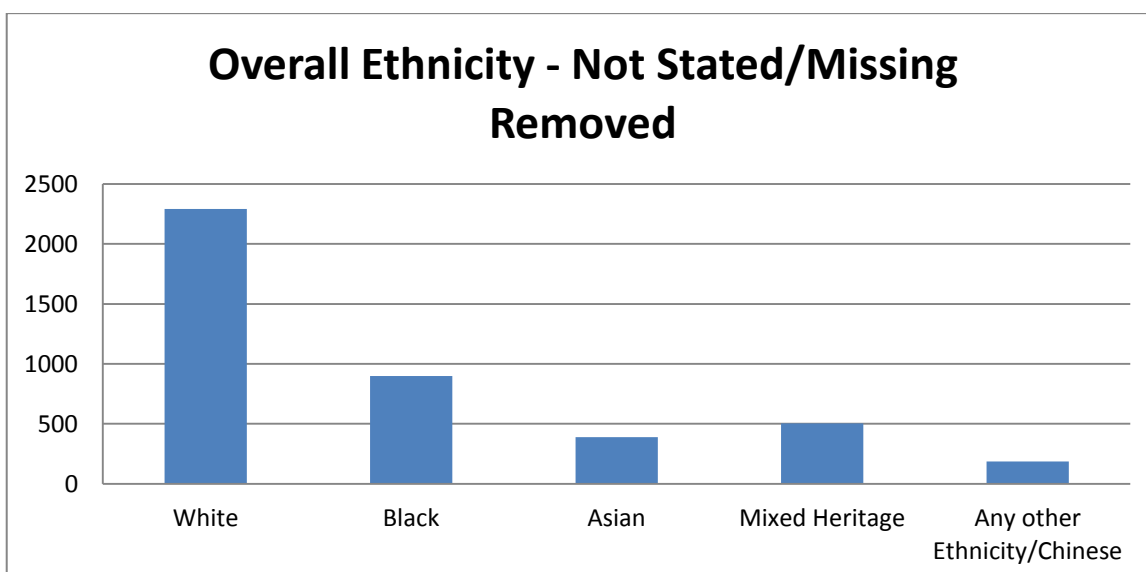
Of those where there was ethnicity data recorded (4270) then the predominant ethnic group was white (53.7%). This was a little lower than in time period 1 but the level of missing data precludes any real comparisons.

Age at referral

Table 5: Age at referral time period 1

Age at Referral Bracket	Frequency	Percent
0-5 yrs	256	2.8
6-11 yrs	1447	15.6
12-16 yrs	2917	31.5
17-20 yrs	2399	25.9
21-25 yrs	2076	22.4
25-30 yrs	99	1.1
30+ yrs	60	0.6
Total	9254	100

Table 6: Age at referral time period 2

Age at Referral Bracket	Frequency	Percent
0-5 yrs	318	3
6-11 yrs	1798	16.7
12-16 yrs	3433	31.9
17-20 yrs	2802	26
21-25 yrs	2272	21.1
25-30 yrs	95	0.9
30+ yrs	54	0.5
Total	10772	100

The highest referral rates were in the early adolescent group (12-16); the distribution was very similar at the 2 time periods.

Outcome of referrals

Table 7: Outcome of referrals at time period 1

Overall Breakdown of Appt Groups					
Grouping	Frequency	Percent	Age at Referral	Age at Ref Std	Age range
Appt offered - Appt attended	3021	32.6	17.23	5.00	0-34
Appt offered - NOT attended	350	3.8	17.72	5.04	0-30
Appt NOT offered - Discharged	4548	49.1	15.21	5.40	0-42
Appt NOT offered - NOT Discharged	1335	14.4	17.6	5.11	0-32
Total	9254	100.0			

32.6% were offered and attended an FTB appointment. The overall DNA rate for offered appointment was 4.4%

Table 8: Outcome of referrals at time period 2

Overall Breakdown of Appt Groups					
Grouping	Frequency	Percent	Age at Referral	Age at Ref Std	Age range
Appt offered - Appt attended	3084	28.6	16.72	5.26	1-34
Appt offered - NOT attended	196	1.8	17.79	4.98	4-32
Appt NOT offered - Discharged	4954	46.0	15.47	5.24	0-74
Appt NOT offered - NOT Discharged	2538	23.6	16.24	5.56	0-34
Total	10772	100.0			

28.6 % were offered and attended a FTB appointment in this period, a slight reduction from time 1; the DNA rate was lower at 2.4%.

Table 9: Outcome of referrals by gender time period 1

Overall Gender Breakdown of Appt Groups								
Grouping	Males	%	Females	%	Unknown	%	Missing	%
Appt offered - Appt attended	1430	47.3	1590	52.6	1	0.0	0	0
Appt offered - NOT attended	151	43.1	199	56.9	0	0.0	0	0.0
Appt NOT offered - Discharged	2170	47.7	2374	52.2	1	0.0	3	0.1
Appt NOT offered - NOT Discharged	636	47.6	694	52.0	5	0.4	0	0.0
Total	4387		4857		7		3	

Table 10: Outcome of referrals by gender time period 2

Overall Gender Breakdown of Appt Groups								
Grouping	Males	%	Females	%	Unknown	%	Missing	%
Appt offered - Appt attended	1471	47.7	1613	52.3	0	0.0	0	0
Appt offered - NOT attended	97	49.5	99	50.5	0	0.0	0	0.0
Appt NOT offered - Discharged	2274	45.9	2679	54.1	1	0.0	0	0.0
Appt NOT offered - NOT Discharged	1245	49.1	1292	50.9	1	0.0	0	0.0
Total	5087		5683		2		0	

There appeared to be little change in the gender distribution of the outcomes of referrals between the 2 time points. No further investigation was practical due to significant missing data.

Discharge destination outcome for those not offered an appointment (signposting)

The most common discharge destination for those not offered an appointment was to the VCS.

Figure 3: Destinations of those not offered an appointment

Frequency of Episode Discharge Outcomes - Appt NOT offered - Discharged
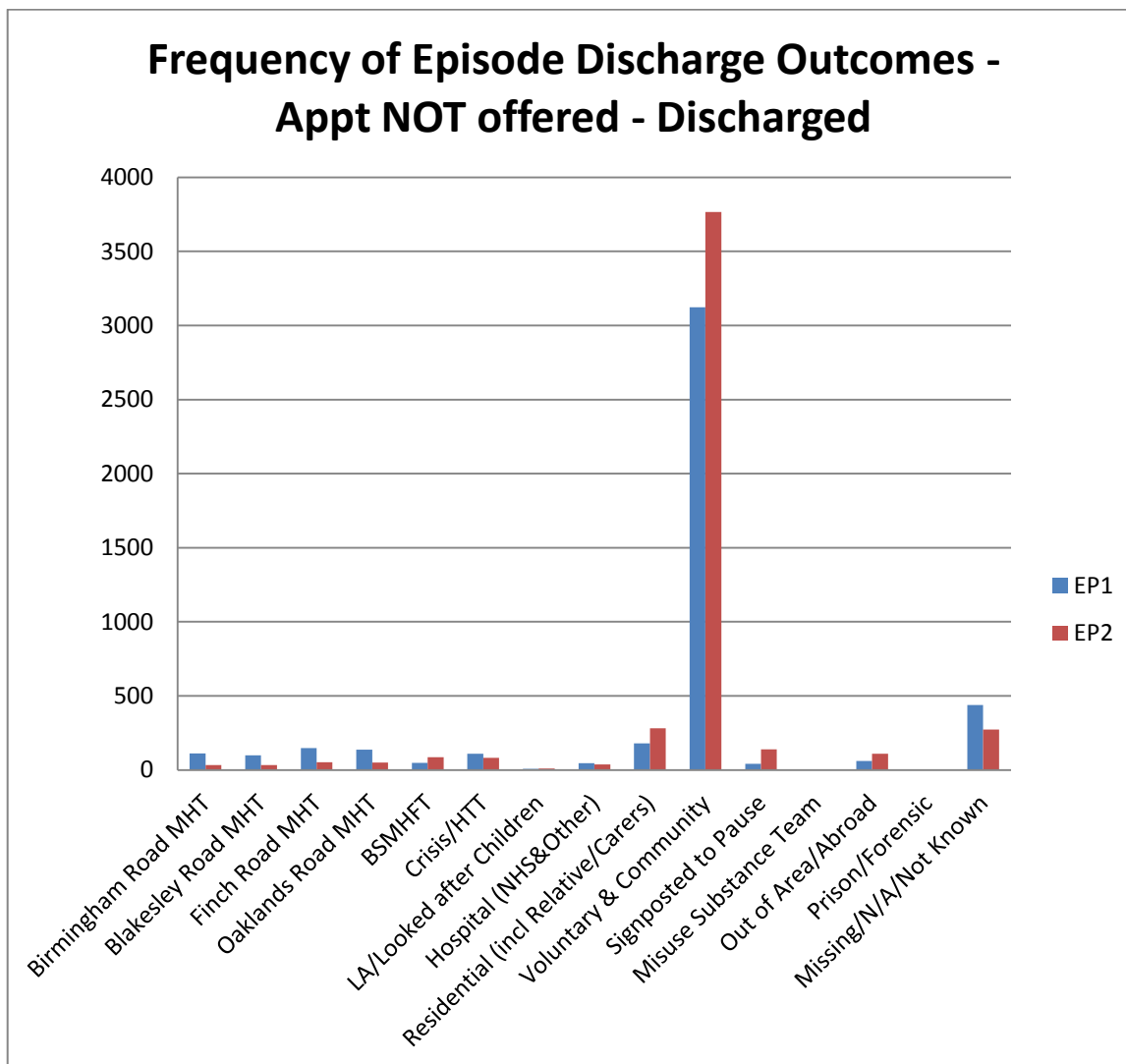
As can be seen, signposting to the VCS increased in the second time period. There was no specific information about which VCS were the destinations – however, this finding of increased signposting to this sector accords with some of the issues raised by VCS partners, in the second round of focus groups in particular, who highlighted growing numbers of referrals from FTB of young people to their services, often inappropriately. (Please see Chapter 6 for further details).

Postcode of referrals

Figure 4: Referrals by larger postcode at time period 1
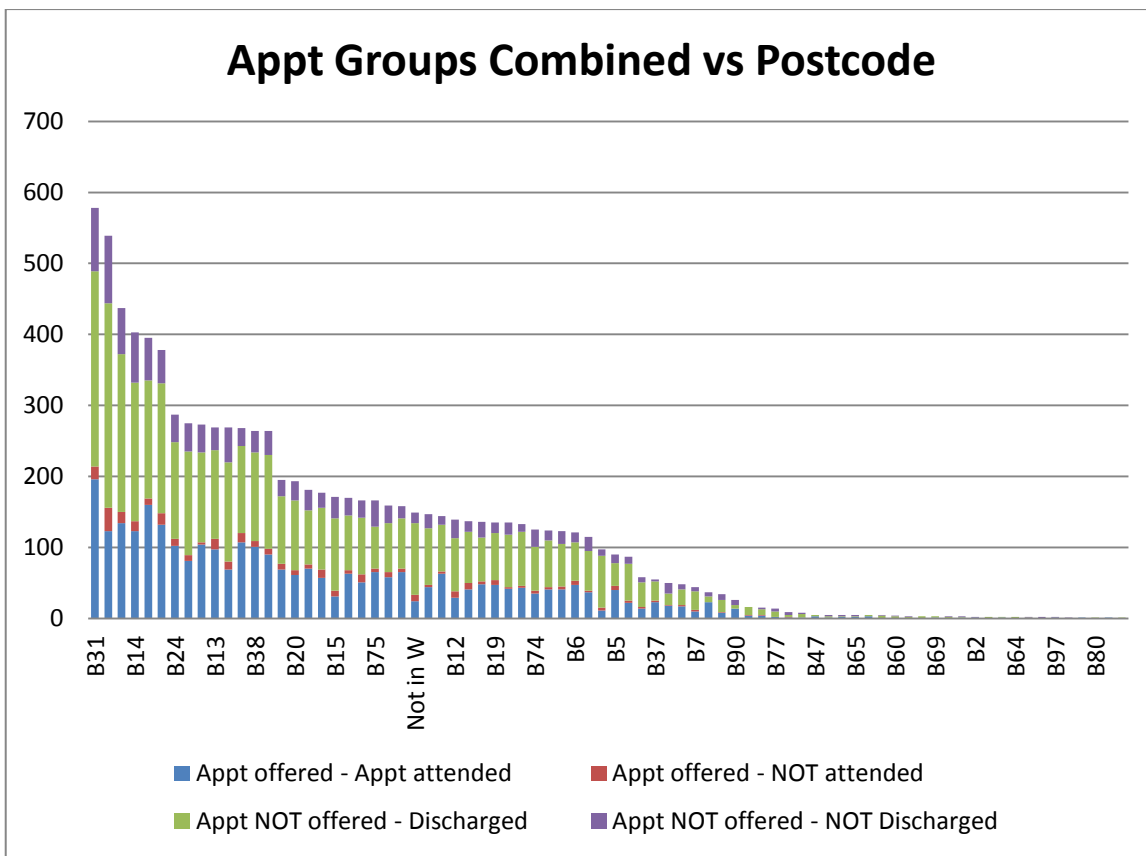
There was an uneven spread of larger postcode values with some larger postcodes having substantially more referrals.

We were not able to investigate whether there was a relationship between the deprivation index of an area and referral rate.

We were also not able to investigate expected referral rates per postcode given the distribution of people aged under 25.

There these results should be interpreted with these caveats and are therefore not weighted for population or deprivation.

Figure 5: Referrals by larger postcode at time period 2



Appt Groups Combined vs Postcode

Legend:
- Appt offered - Appt attended (blue)
- Appt offered - NOT attended (red)
- Appt NOT offered - Discharged (green)
- Appt NOT offered - NOT Discharged (purple)
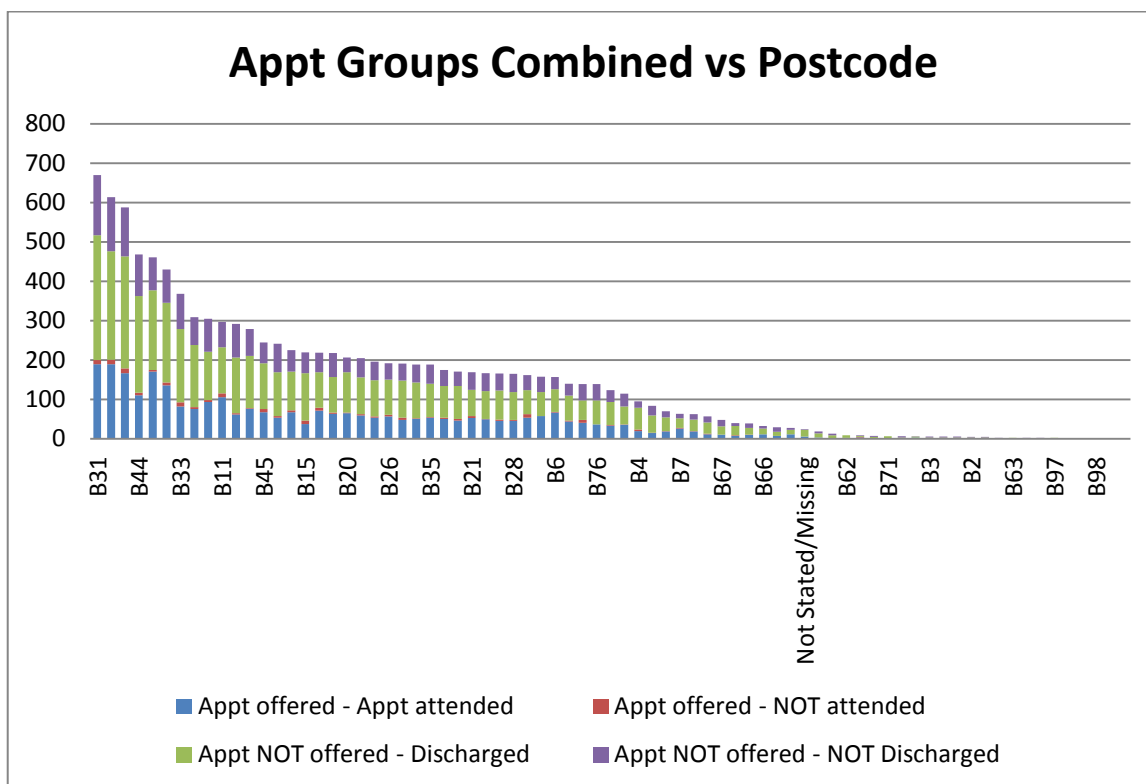
In both time periods the biggest numbers of referrals to the service came from 3 larger postcodes B31, B23 and B29 and there were very low numbers of referrals from other larger postcodes e.g. B2 and B37. The spread was possibly a marginally less uneven at the second time point.

Figure 6: Time point 1 and 2 referral postcodes compared

Total Referrals by Postcode Time 1 vs Time 2

Legend:
- T1 Referral Total (blue)
- T2 Referral Total (red)
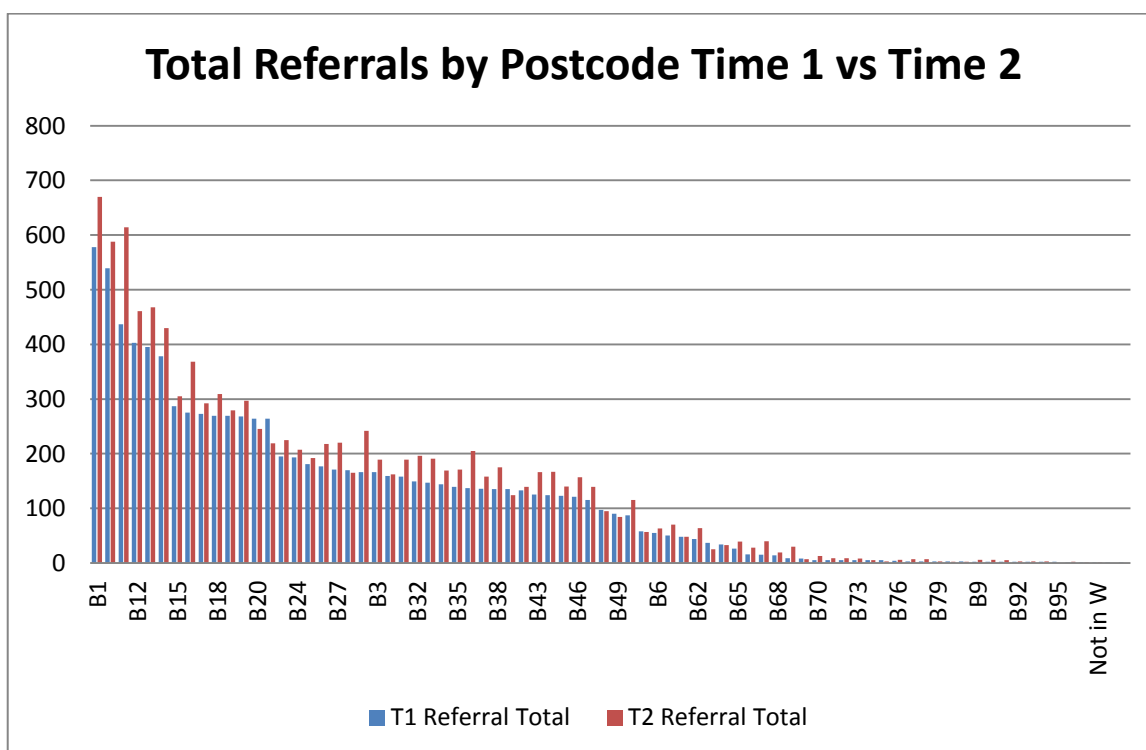
Source of referral

Figure 7: Source of referral at time period 1
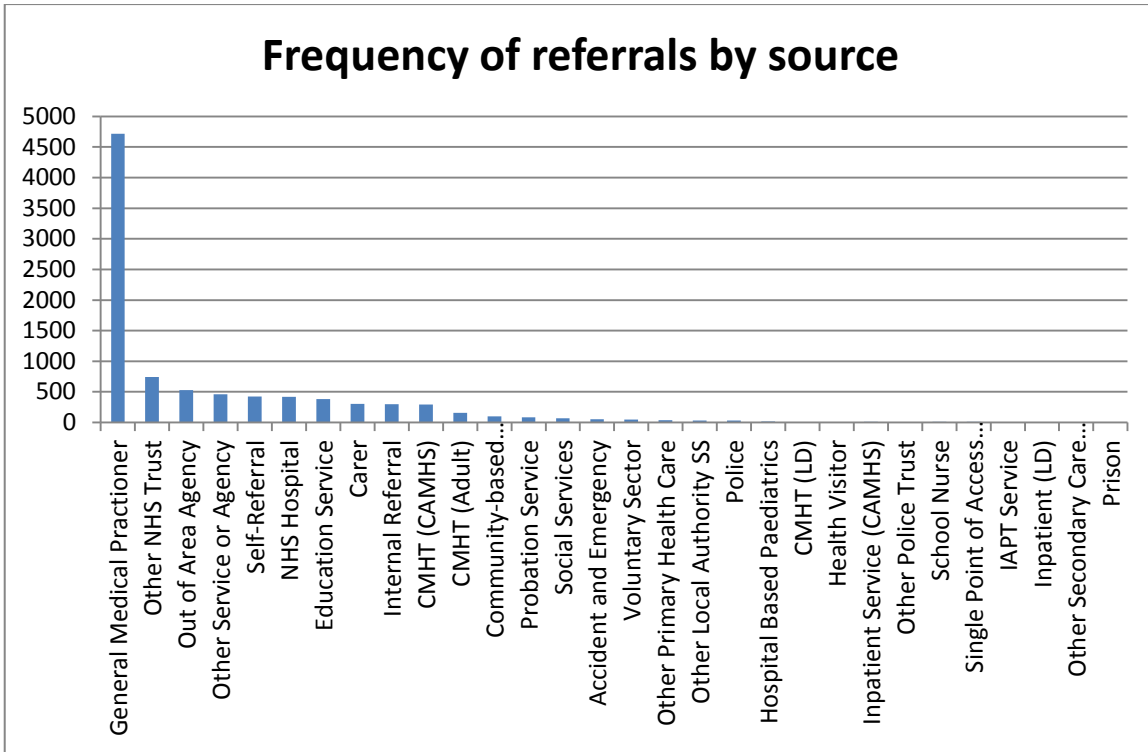
The majority of referrals during this came from general practitioners (51%).

Figure 8: Source of referral at time period 2

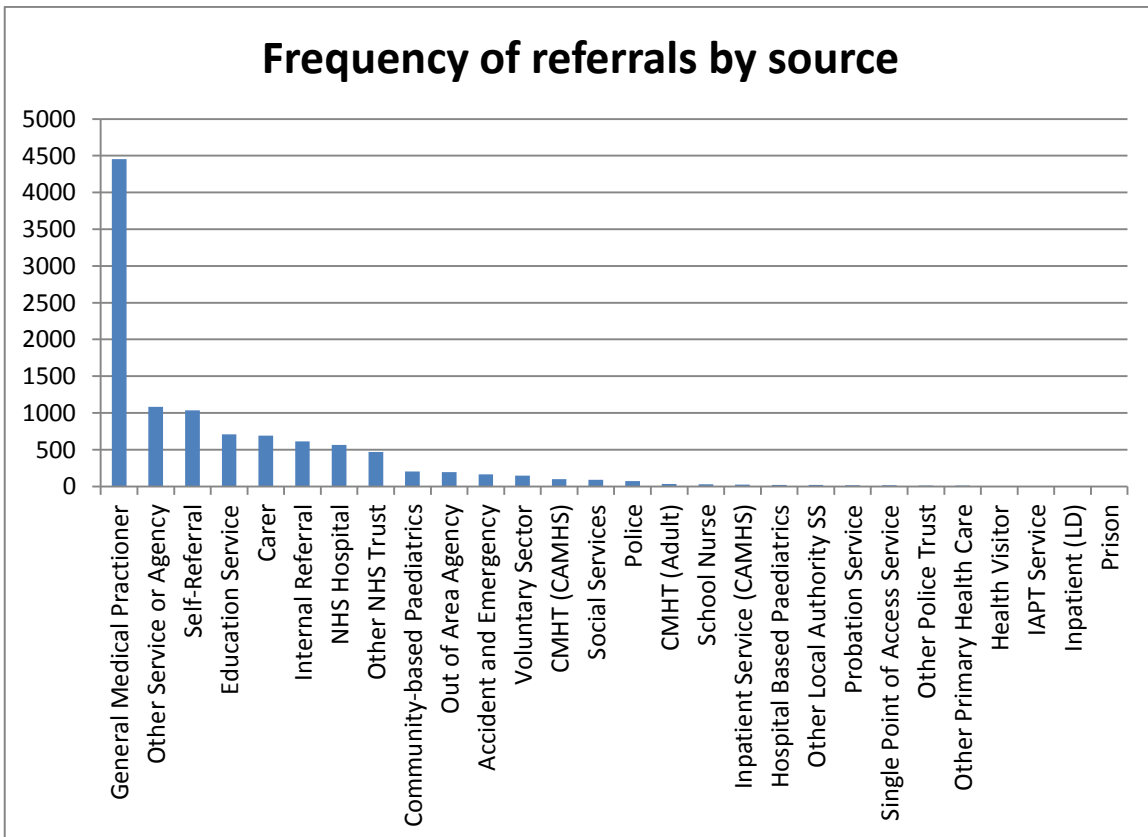General Practitioners were still the largest referrers at time period 2 but the rates were slightly lower (41.2%). Of particular note, there were higher numbers from self -referral (9.6% compared to 4.6%), carers (6.4% compared to 3.3%) and the education service (6.6% compared to 4.1%) in the second time period.

The data we have suggest the numbers of referrals from accident and emergency and the police prison or probation service were low (less than 2%). This is somewhat surprising as it would expected that these agencies would form a large share of the referral sources. We are not sure if this reflects a true finding or problems with data recording.

Figure 9: Total referrals by source (both time points)
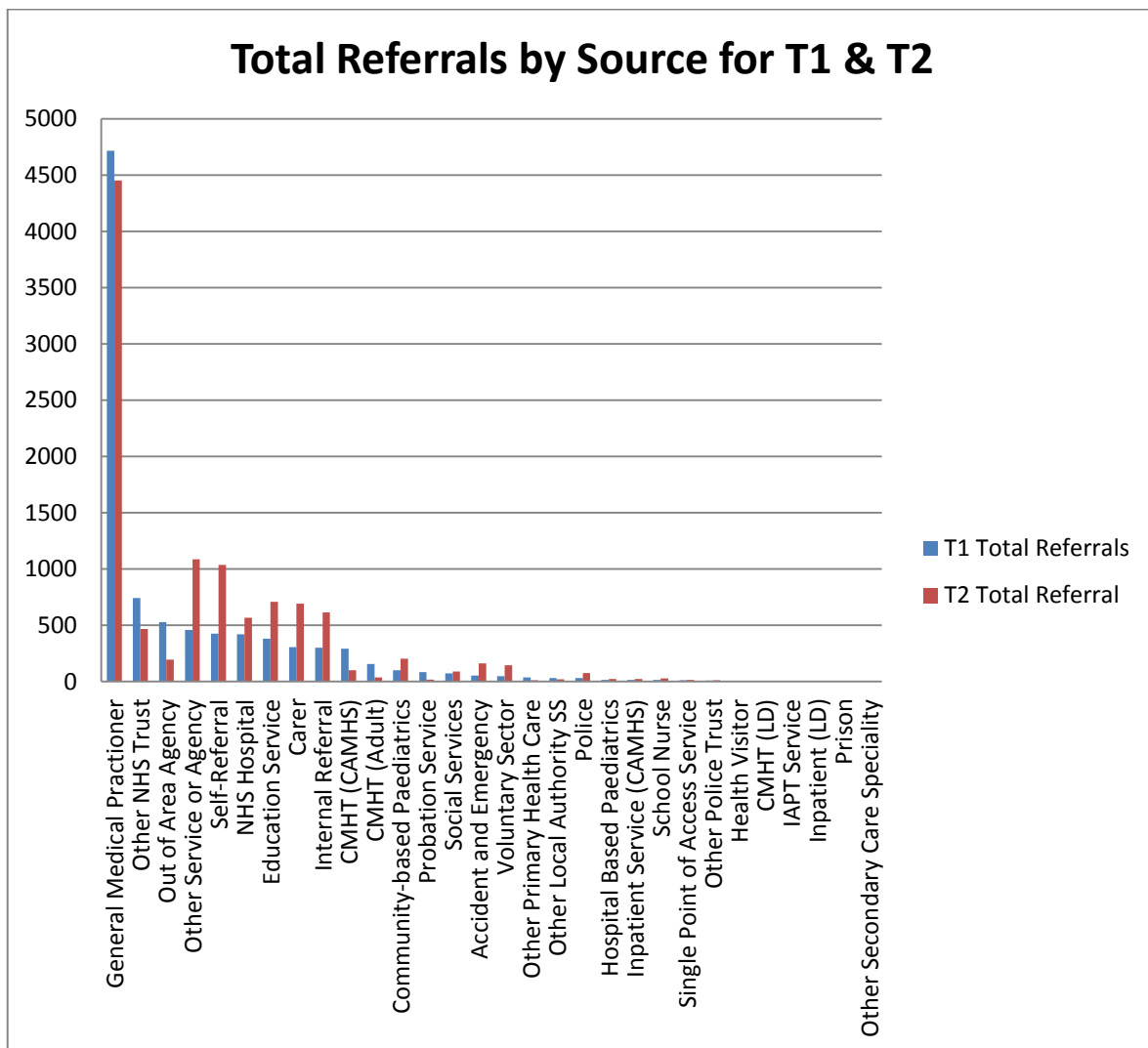
Service delays and time to discharge

Table 10: Service delays time period 1

Delay Coding		N	Minimum	Maximum	Mean (days)	SD	Missing
Appt offered - Appt attended	Total						
	Service Delay	2991	0	475	52.79	46.98	0
	Appt Delay	2671	0	338	7.1	28.02	350
	Total Appt Delay	2668	0	419	56.63	52.28	328
	Overall Delay	936	4	458	153.53	107.60	2081
Appt offered - NOT attended	Total						
	Service Delay	347	5	277	65.91	50.53	0
	Appt Delay	0	n/a	n/a	n/a	n/a	350
	Total Appt Delay	0	n/a	n/a	n/a	n/a	350
	Overall Delay	350	12	467	131.9	106.235	0

The average delay from assessment to appointment (service delay) was 52.8 days for those who attended and 65.9 days for those who DNA'd the appointment. In time period 2, the delays to first appointment were slightly less with the mean delay of 51.0 days for those offered appointment who attended and 40.6 days for those offered an appointment who DNA'd. Referrals were discharged more quickly (overall delay figure) in Time 2 as opposed to time 1; the mean time to discharge was almost half that of the first 6 months.

Table 11: Service delays time period 2

Delay Coding		N	Minimum	Maximum	Mean (days)	Std. Deviation	Missing
Appt offered - Appt attended	Total						
	Service Delay	3045	0	287	51.02	53.70	0
	Appt Delay	2244	0	222	2.46	11.05	350
	Total Appt Delay	2210	0	189	35.04	34.29	4954
	Overall	356	6	186	64.74	45.90	2538

	Delay						
Appt offered - NOT attended	Total						
	Service Delay	196	7	282	40.56	39.71	840
	Appt Delay	0					196
	Total Appt Delay	0					4954
	Overall Delay	196	11	182	54.25	45.773	2538

Priority of appointments

Data shown are for both those who attended an appointment and those who DNA'd an appointment.

Table 12: Priority of appointment in time period 1, attended

Appt offered - Appt attended		
Appt Attend	Frequency	Percent
Awaiting Further Information	2	0.1
Crisis	207	6.9
Normal	1	0
Query ED	3	0.1
Query EI	6	0.2
Routine	1232	40.8
To be Assessed	1000	33.1
Unknown	3	0.1
Urgent	567	18.8
Total	3021	100

Table 13: Priority of appointment time period 1, not attended

Appt offered - NOT attended		
Appt Off No Attend	Frequency	Percent
Awaiting Further Information	1	0.3
Crisis	10	2.9
Routine	141	40.3
To be Assessed	147	42
Urgent	51	14.6
Total	350	100

Table 14: Priority of appointment in time period 2

Appt offered - Appt attended		
Appt Attend	Frequency	Percent
Awaiting Further Information	51	1.7
Crisis	412	13.4
Query ED	41	1.3
Query EI	64	2.1
Query Perinatal	19	0.6
Routine	984	31.9
To be Assessed	1150	37.3
Urgent	363	11.8
Total	3084	100

Table 15: Priority of appointment in time period 2

Appt offered - NOT attended		
Appt Off No Attend	Frequency	Percent
Awaiting Further Information	16	8.2
Crisis	15	7.7
Query ED	8	4.1
Query EI	5	2.6
Routine	97	49.5
To be Assessed	46	23.5
Urgent	9	4.6
Total	196	100

Of note is that there were less appointments coded as "routine" and more coded as "crisis" in time period 2 than in time 1.

Appendix 2: Implementing CAPA

According to the originators of CAPA, "There are eleven key components and CAPA is most effective if all eleven are in place. Implementation, quality and sustainability will be impaired if they are not."

CAPA component	Key features	What happens if this is not in place
1. Leadership	There is a working group including 1) a manager 2) either a clinical leader or clinician/s 3) an admin lead.	The service is highly unlikely to get change going, or to sustain it.
2. Language	Move from 'assessment' and 'triage' to 'choice' and 'partnership'.	Teams that continue to use 'assessment' and 'treatment' find it harder to think about clients' goals. Published young person and family feedback reports they get too much assessment and no-one helps them enough.
3. Handle Demand	Service users can chose an initial Choice appointment when their referral is accepted i.e. full-booking. The service flexes Choice capacity in line with referral demand to prevent a waiting list.	If there are too many priority streams (emergency, urgent, soon, routine are common ones) referrers learn how to get someone prioritised ('this 4 year old is suicidal')! 'Routine' clients may never get seen. Limiting the number of priority streams means everyone is seen more quickly by minimising multiple queues; reducing variation and smoothing flow
4. Choice Framework	All clinicians work in a Choice framework. Clinicians complete appropriate tasks for clinical governance and risk management.	Service users are likely to feel less involved and passive in front of an expert. This is likely to lead to their experience being worse and their engagement, therapeutic and task alliance and motivation will be lessened.
5. Full Booking	Service users leave the Choice appointment with a booked Partnership appointment with the selected clinician/s. This requires a Partnership diary and no internal waiting list.	The team will lose some capacity and is likely to develop internal waiting lists. Many teams have good systems to manage first appointments but then put clients on treatment waiting lists.
6. Selecting Clinician	All clinicians select the Partnership clinician according to the skills needed: so the appropriate clinician for Partnership work is chosen based on the service user's goals and chosen therapy style.	The client may not get the intervention they want and the goals and care plan might be vague. Motivation, alliance and focus may be reduced. Treatment might be less effective and not directed to their goals. DNAs may increase.

7. Core and Specific Work	The majority of clinical work is carried out with the general principle of Core Partnership work first with Specific Partner- ship work added if required	The client experience is likely to be poor as their problem needs to fit the intervention, no matter what their preferred style or co-morbidities are.
8. Job Plans	Each clinician will have an individual plan containing their Choice activity, Core Partnership targets for each quarter, their defined Specific Partnership work and non-clinical activities.	Teams will lose capacity
9. Goal Setting	These are service users' goals using care planning. There are regular reviews that clarify the service user's preferences and choices.	Work becomes unfocussed; clients and clinicians are not clear about what they are both working towards. Things drift.
10. Peer group Discussion	Small group multi-disciplinary discussion (no more than 4 staff) to consider on-going work.	If supervision is only focused along professional lines, opportunities for learning and the challenge that comes from other professional perspectives is lost.
11: Team Away Days	Regular Team away days in which the agenda is set by the team and involves content to facilitate clinical learning, team relationships and business planning.	You are unlikely to ever implement substantial change, or if you do, it will be hard to sustain. You will not generate a strong and flexible team culture. Staff may leave, vote with their feet and carry on doing what they normally do, and clinical risk may increase. http://capa.co.uk/what-is-capa/11-key-components/

Ann York and Steve Kingsbury CAPA website accessed November 2017 http://capa.co.uk/what-is-capa/11-key-components