



department for  
children, schools and families



Department  
of Health

# Improving access to child and adolescent mental health services

Reducing waiting times policy and practice guide  
(including guidance on the 18 weeks referral  
to treatment standard)



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<b>For Recipient's Use</b>	

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# Foreword



This guide is intended to support those providing and commissioning child and adolescent mental health services (CAMHS) in their efforts to reduce waiting times for children, young people and families. It describes approaches that services have used to reduce waiting times and provides case studies showing how they have been applied in practice and what the results were. To help smooth the path for local areas to develop their plans for reducing waiting times this guidance also clarifies how the rules on the 18 weeks referral to treatment standard apply to CAMHS.

Children, young people and families have been consistently clear that timeliness is one of the key elements of an effective service. This was highlighted in Standard 9 of the National Service Framework for Children, Young People and Maternity Services (on the mental health and psychological well-being of children and young people) which pointed out that there is strong evidence that poor attendance rates in CAMHS are closely associated with longer waiting lists. More recently, the final report of the National CAMHS Review addressed the issue in one of its key recommendations, setting out the need to reduce waiting times to improve the experience of those receiving services. This is underlined by the new child health strategy *Healthy Lives, Brighter Futures*, which reiterates the fact that families, children and young people want timely, accessible support tailored to their needs.

Of course, CAMHS are part of a wider network of services providing a range of support for mental health and psychological well-being. It is vital that any effort to reduce waiting times should be designed as part of efforts to create a system that promotes high quality care and support, not only for those in contact with specialist services, but also for young people in contact with other children's services. The Government's vision is that CAMHS will work with others, across the full range of children's services, to support efforts to prevent chronic mental health conditions from occurring and to ensure that young people with mental health difficulties get the help they need. In this way we can bring about the best outcomes for children, young people and families.

We hope that you will make good use of the information in this document to develop your own plans for reducing waiting times as part of the development of an effective service.

**Professor Louis Appleby CBE**  
*National Director for Mental  
Health in England*

**Dr Sheila Shribman**  
*National Clinical Director for  
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# Executive summary



**Children and young people in need of more specialised help from child and adolescent mental health services (CAMHS) should have clearly signposted routes to specialist help and timely access to this, with help available during any wait.**

There are concerns that swift access to services is not always being achieved in practice:

- Some children and young people still have to wait too long to be seen by services and there is geographic variation in access.
- Some families find the procedures for accessing services confusing.

Findings such as these led the National CAMHS Review (2008) to make the following key recommendation:

‘improve the quality of CAMHS experienced by children, young people and families by reducing waiting times from referral to treatment.’

The Review’s vision for accessible services states that children, young people and their families should have:

- clearly signposted routes to specialist help
- an ‘open door’ into a system of joined-up support
- timely access to this.

This joint guide from the Department of Health and the Department for Children, Schools and Families explains the rules on the 18 weeks referral to treatment (RTT)

standard, as set out in the NHS Operating Framework for 2009/10 (Department of Health, 2008) and how these apply to non-emergency consultant-led CAMHS services and pathways. It does not set any new standards or targets. Good practice examples show how these rules can be achieved in practice.

It sets out key strategic and operational steps for both implementing mandatory waiting time standards and supporting the delivery of low wait, accessible, multi-disciplinary CAMHS.

The guide describes four service improvement models that can be used alone or creatively combined:

- 10 High Impact Changes
- the Choice and Partnership Approach
- Lean Thinking
- New Ways of Working.

These overviews are supported by local case studies which illustrate how the service improvement models have been applied to improve access to local services.

Advice is provided for both commissioners and providers of CAMHS and web links are used to signpost readers to a range of implementation tools and supporting resources.



# SECTION 1 Introduction

This guide has been produced to help providers and commissioners of child and adolescent mental health services (CAMHS) improve access and waiting times for children and young people.

It provides guidance on existing policy and mandatory standards and practice examples of how to:

- plan and implement transparent pathways
- achieve swift and easy referral and treatment with no delays
- measure progress.

In particular, the guide has two objectives:

- 1) To state clearly how the rules on the 18 weeks referral to treatment (RTT) standard, as set out in the NHS Operating Framework for 2009/10 (Department of Health, 2008) apply to non-emergency consultant-led services and pathways in CAMHS.
- 2) To provide guidance on how accessible low-wait CAMHS in England can be achieved by learning from the national programme set up to support the implementation of the 18 weeks standard (see [www.18weeks.nhs.uk](http://www.18weeks.nhs.uk)), and from local examples of good practice where improved access to CAMHS has been achieved.

This guide does not set any new standards or targets for CAMHS. This reflects the way the Department of Health is moving away from setting national targets and encouraging local priority setting and performance monitoring.

It builds on the vision for integrated services articulated in the child health strategy, *Healthy Lives Brighter Futures* (Department of Health / Department for Children, Schools and Families, 2009) specifically that:

*“Mothers and fathers are provided with the information they need to help their children live healthy lives, including through local areas setting out what parents will be able to receive.”*

This is in line with the expectations of the National CAMHS Review (2008) and the vision for a high quality NHS outlined in the final report of the Darzi Review, *High Quality Care for All* (2008).

This guide advocates and enables the development of local CAMHS pathways by drawing on the learning from:

- transformation work to achieve sustainable 18 weeks pathways in other services
- new ways of working in multi-disciplinary teams
- recognised service improvement approaches in CAMHS, including 10 High Impact Changes, Lean Thinking and the Choice and Partnership Approach.

## The vision for accessible CAMHS

Children, young people and families want mental health services which are accessible, provide support when needed and involve them as service users. They also want to know what services are available to help them (National CAMHS Review, 2008).

The vision of the National CAMHS Review is that children, young people and their families should have:

- clearly signposted routes to specialist help
- an 'open door' into a system of joined-up support
- timely access to this
- help available during any wait.

Everyone involved in delivering CAMHS has a role to play in realising this vision. In the fieldwork which informed the development of this guide a wide range of commissioners, managers and frontline CAMHS staff suggested the following principles to underpin service improvement:

- The requirement to implement the 18 weeks RTT standard for consultant-led services from January 1 2009 can be helpful in supporting service transformation work in all CAMHS (see Section 2).

- Commissioners should commission services that can intervene early and deliver assessments (including specialised and complex assessments) to enable consultant-led treatment to commence within 18 weeks of referral as a maximum wait.
- Commissioners in the NHS and local authority are responsible for agreeing acceptable waiting times for all the services they commission for children and families. No child or young person should then wait longer than has been agreed to receive the care, intervention or treatment that has been planned.
- CAMHS must be accessible to all – access should not be determined by who the referring agency is or which professional the young person sees.
- Pathways for accessing services should always be clear to families and the maximum waiting times for each stage of the pathway should be specified.
- Commissioners and services should adopt recording and tracking systems to support achievement of agreed standards. These should be comprehensible to administrative and clinical staff.

The rest of this guide provides policy guidance and practice examples for putting these principles into practice.

## Strategic issues

Improving access to CAMHS is underpinned by high quality commissioning and planning. There is a good fit between many of the suggestions in this guide and the 11 competencies of World Class Commissioning (see [www.dh.gov.uk](http://www.dh.gov.uk)), especially competencies 7, 8, 9 and 10 (stimulating the market; promoting

improvement and innovation; securing procurement skills and managing the local health system).

The case studies in *Sections 1 and 3* highlight the importance of engaging senior managers and key stakeholders – including children, young people and their families and carers – within CAMHS and across children’s services. All children’s services must play their part in providing emotional and mental health care and support to children, young people and their families. They can do this by:

- ensuring there is a shared vision and commitment to promoting the emotional health and well-being of all children and young people in the local area
- involving partner agencies, particularly local authorities in the development and commissioning of services for children’s emotional health and well-being
- agreeing a core offer that expresses clearly to families and referrers the services available, the types of needs they meet, and any waiting time standards that apply to them – this would involve locally agreeing definitions of specialist services, for example models could include varied elements of tier 2, 3 and 4 services.
- setting up mechanisms to engage and involve staff across universal, targeted and specialist services in planning and implementation.

## Case study 1

### SHA-level monitoring of CAMHS waiting times using RTT rules

In September 2008 NHS West Midlands Strategic Health Authority (SHA) launched work to pilot an 18 weeks pathway across all mental health services.

- A definition was agreed about the start of the first definitive treatment and possible events which would stop the 18-week clock.
- An improved performance management and reporting framework was developed, to inform demand and capacity gaps.
- A high level pathway was developed which incorporates three possible referral processes, two assessment approaches and a wide range of engagement rather than treatment options, all of which would be seen as meeting the 18 weeks target and therefore stopping the clock.
- A range of monitoring tools was made available, for example clinic outcome templates, patient tracking lists and local IT systems.

How things improved

- A clear pathway is now in place which shows how children and young people and the range of agencies which support them can access the service.

**Further information:** see *Implimentation tools*, page 26 for a link to the full case study online or contact [helen.hipkiss@westmidlands.nhs.uk](mailto:helen.hipkiss@westmidlands.nhs.uk)





## SECTION 2 The rules on the 18 weeks referral to treatment standard

The 18 weeks referral to treatment (RTT) standard is about improving patients' experience of the NHS by ensuring all patients receive high quality elective consultant-led care without any unnecessary delay.

As most CAMHS are delivered through multi-disciplinary rather than consultant-led teams the rules will not always apply. However, where the rules do apply the expectation is that from January 1 2009, patients will start their consultant-led treatment within a maximum of 18 weeks from the time they are referred for non-emergency treatment, unless they choose to wait longer or it is clinically appropriate to do so. Although the maximum wait is 18 weeks, it is hoped that most patients will start their treatment (consultant-led or otherwise) much sooner than that.

The standard applies to all patients registered with a GP in England whose care is commissioned by primary care trusts (PCTs) in England. Different waiting time standards apply to patients registered with GPs in Wales and Scotland whose care is commissioned by the health systems in those countries.

This section of the guide:

- sets out how the 18 weeks standard applies to CAMHS
- answers some frequently asked questions on this subject.

This section does not attempt to provide detailed guidance on how the rules should apply in every situation, but provide the NHS with a framework to work within to make clinically sound decisions locally about applying them, through consultation between clinicians, providers, commissioners and, of course, patients.

Where there is doubt about which services are covered by the 18 weeks standard, then local decisions should be made within the published framework of national rules (see [www.18weeks.nhs.uk](http://www.18weeks.nhs.uk)). The key determining factors should be the clinical interests of the patient and how the patient would perceive their waiting time.

## Applying the 18 weeks standard to CAMHS

The 18 weeks standard applies to referrals to elective services that do or might involve consultant-led care regardless of setting, including CAMHS consultant-led services such as inpatient units or assertive outreach teams. It sets a maximum time of 18 weeks from the point of initial referral to the start of first definitive treatment, for all patients where it is clinically appropriate and where patients want it.

A consultant is defined as 'a person contracted by a health care provider who has been appointed by a consultant appointment committee'.<sup>1</sup> He or she must be a person whose name is included in the register of specialists maintained by the General Medical Council. In CAMHS this would apply to consultant psychiatrists or paediatricians.

In other words, a referral to a consultant psychiatrist or a service led by a consultant psychiatrist starts an 18 weeks pathway. The 18 weeks standard applies to:

- referrals where a GP or other referrer makes known their intention to refer to a consultant (for example a consultant psychiatrist) before responsibility is transferred back to the referring health professional or GP (see *Frequently asked questions, page 9, question 2*).
- referrals where a GP or other referrer makes clear their intention to refer to a consultant – even if they refer via a service that is not led by a consultant (for example through a mental health interface service)

- referrals to diagnostic services, where the referral is made on the basis that the patient will (if clinically appropriate) be treated by a consultant-led service before responsibility is transferred back to the referring health professional or GP
- referrals from a multi-disciplinary team or community teams run by mental health trusts to a consultant-led service.

The 18 weeks standard does not apply to:

- referrals from primary care to mental health services that are not consultant-led (this may include multi-disciplinary teams and community teams run by mental health trusts) irrespective of setting, unless a decision has been made locally by PCTs that the 18 weeks standard should apply to these services.

In summary, the 18 weeks standard does not apply to non-consultant-led CAMHS where there is no intention to refer a patient to a consultant and/or no decision is made subsequently to refer a patient to a consultant.

It follows, therefore, that much mental health activity is outside the scope of the 18 weeks standard. In line with this, referrals to the following services do not fall within the 18 weeks standard (unless inclusion has been agreed by PCTs locally):

- services provided by primary mental health workers where treatment and intervention will not involve consultant psychiatrist input
- services provided by education or social care
- services provided by health professionals that do not involve input from a consultant psychiatrist

<sup>1</sup> As set out in *The National Health Service (Appointment of Consultants) Amendment Regulations 2004*

- services provided by undergraduate students.

First definitive treatment for mental health is defined as for all other treatment functions, that is: 'an intervention intended to manage a patient's disease, condition or injury and avoid further intervention.'

It is recognised that sometimes it is difficult to identify the start of first definitive treatment in mental health pathways. Ultimately, however, this must be a local clinical decision and it would not be appropriate to issue prescriptive national guidelines defining the start of treatment in the context of mental health, or any other treatment function.

## Frequently asked questions

### 1) Do all referrals to consultant-led services have to meet the 18 weeks standard?

Yes. As set out in the NHS Operating Framework 2009/10:

- From January 1 2009, the minimum expectation of consultant-led elective services will be that no-one should wait more than 18 weeks from the time they are referred to the start of their hospital treatment, unless it is clinically appropriate to do so or they choose to wait longer.
- PCTs and providers should plan how they will maintain delivery of this standard, and ensure that the patient's experience reflects this.
- Through the NHS performance regime, performance is measured against minimum operational standards of 90 per cent (admitted patients) and 95 per cent (non-admitted patients).

*Note: these tolerances provide for patients who choose to wait longer than 18 weeks and for patients for whom starting treatment within 18 weeks is not clinically appropriate.*

- Every PCT and trust must strive to achieve this standard across all consultant-led services and specialties, monitoring waits of more than 18 weeks so that patients do not wait for reasons other than choice or clinical exception.

### 2) Whose referrals come under the 18 weeks standard?

Referrals by any health professional or health service authorised to make referrals to a consultant-led service come under the standard, including referrals from:

- GPs
- GPs with special interests
- nurse practitioners
- allied health professionals
- accident and emergency departments
- minor injuries units
- NHS walk-in centres
- consultants (or consultant-led services), for example where a consultant already caring for a patient for a condition identifies an unrelated mental health problem
- other professionals where this is agreed locally by PCTs, for example school nurses, health visitors, educational welfare officers or social workers.

### 3) When does the 18 weeks standard apply to CAMHS?

A referral to a consultant psychiatrist or a service led by a consultant psychiatrist starts an 18 weeks pathway. As stated above the 18 weeks standard applies to:

- referrals where a GP or other referrer makes known their intention to refer to

a consultant (for example a consultant psychiatrist) before responsibility is transferred back to the referring health professional or GP

- referrals where a GP or other referrer makes clear their intention to refer to a consultant – even if they refer via a service that is not led by a consultant (for example through a mental health interface service)
- referrals to diagnostic services, where the referral is made on the basis that the patient will (if clinically appropriate) be treated by a consultant-led service before responsibility is transferred back to the referring health professional or GP
- referrals from a multi-disciplinary team or community teams run by mental health trusts to a consultant-led service.

#### 4) How is start of treatment defined for the 18 weeks standard?

First definitive treatment for mental health is defined as for all other specialties, that is: 'an intervention intended to manage a patient's disease, condition or injury and avoid further intervention.'

It is recognised that sometimes it is difficult to identify the start of first definitive treatment in mental health pathways. However, ultimately, this must be a local clinical decision and it would not be appropriate to issue prescriptive national guidelines defining the start of treatment in the context of mental health, or any other treatment function.

In a CAMH service, treatment would be deemed to have started upon:

### Example A

A GP refers Child A to a community-based primary mental health team run by the local authority because there are indications of low mood and low self esteem.

The team screen the child as a suitable participant for group work and enrol the child in the next available group. There a plan is developed to help the child to develop strategies to combat low mood and activities that support raising self esteem

**In this instance, the PCT considered that the team was not consultant-led, therefore the 18 weeks standard did not apply**

Subsequently the primary mental health team referred Child A for cognitive behavioural therapy (CBT) which can be provided by any CAMHS professional qualified or trained in CBT.

**In this instance, the primary mental health team considered that the CBT was not consultant-led. While a consultant was a member of the team offering CBT, he/she did not take overall clinical responsibility at any stage for children when therapy was delivered by another discipline.**

**The 18 weeks standard would only apply if the referral was made to a consultant psychiatrist either from the point of referral by the primary mental health team or the point of initial referral by the GP.**

- the commencement of a care plan activity by the family (for example behaviour management at home, attending group sessions in the community) with the clock stopping on the date on which the activity begins, provided there is no undue delay in accessing sessions
- first-line treatment (for example health education, reassurance, information or advice giving, activity planning) with the aim of avoiding the need for further treatment. A new 18 weeks pathway would start if a later decision were taken to provide more consultant-led intervention or treatment.

Treatment could be deemed to have started at the first appointment. Advice may or may not be part of the first stage of treatment. These would be clinical judgements.

#### 5) Does the 18 weeks standard apply to just hospitals?

No. The 18 weeks standard applies both to patients referred to a hospital based consultant and to consultant-led teams based outside of a traditional secondary

care environment, for example those based in an outreach clinic in a GP practice, a children's centre, an extended school or the community.

#### 6) How does the definition of a consultant-led service apply to CAMHS?

Decisions about which services are consultant-led must be made locally in line with the national definition of consultant-led, that is, where a consultant retains overall clinical responsibility for the service, team or treatment.

The NHS has the autonomy to make sensible, clinically sound decisions about how to apply the published rules for the 18 weeks standard, in a way that is consistent with how patients experience or perceive their wait.

In other words, NHS organisations need to agree locally who retains overall clinical responsibility for the care of all or individual patients. This may include developing protocols in relation to responsibility, authority and accountability for care co-ordination, caseload management and supervision.

### Example B

A paediatrician referred Child B to a child psychiatrist in a CAMHS team run by the local hospital foundation trust asking for a psychiatric assessment and treatment if appropriate.

**In this instance, the paediatrician considered that the referral response would be consultant-led, therefore the 18 weeks standard did apply.**

The consultant psychiatrist saw Child B and assessed that a neuro-developmental assessment was required to rule out developmental delay prior to advising on treatment, and referred Child B to a consultant psychologist for psychological development tests.

**This continues to be a consultant-led pathway even though the psychiatrist has no responsibility for the caseload or practice of the psychologist and the 18 week clock continues during the psychological testing. The results of the testing and the opinion of the psychologist will inform the psychiatrist's decision to treat. The clock will stop when treatment is delivered by the psychiatrist or a clinical decision is made and communicated to the patient that no treatment is necessary.**

## 7) Does the 18 weeks standard apply to all CAMHS?

No. The standard does not apply to non-consultant-led CAMHS, unless this has been agreed locally by PCTs.

### Example C

A GP referred Child C to a community CAMHS team run by the local mental health trust which screened and assessed the patient and subsequently referred Child C to a consultant-led day hospital service offering intensive treatment.

**In this instance, the PCT considered that the referral to the community CAMHS team was not consultant-led. Although a consultant was involved in the running of the service, he/she did not take overall clinical responsibility at any stage for Child C's care.**

**Therefore, the 18 weeks standard did not apply to Child C until the referral was made by the community CAMHS team and received by the consultant-led day hospital offering an intensive treatment service.**

## 8) How does the NHS measure and report 18 weeks pathways?

The Department of Health has published detailed information defining how delivery against the standard is measured (see [www.18weeks.nhs.uk](http://www.18weeks.nhs.uk)). This information covers all aspects of measurement including: IT systems; who can refer patients on to 18 weeks pathways; and when the 18 weeks waiting time clocks start, pause and stop.

## 9) When does a waiting time clock start on an 18 weeks pathway?

The clock-start date is the day on which the provider to whom the initial referral is made (including referral management centres) receives the referral letter or referral form.

The clock start remains the date of receipt of referral even if the service offers the family a choice of appointments bookable

by telephone. In the case of clocks started by consultants at follow-up outpatient appointments, it is the date of the consultant's decision to treat. If a patient is referred or booked into the wrong specialty clinic and needs to be re-referred or re-booked, the clock still starts on the date that the original referral was received.

Where a referral is made using the Choose and Book service, the clock starts on the date on which the patient's unique booking reference number (UBRN) is converted. Where the slot unavailability process has operated, this will be the date that the provider receives electronic notification from the national Choose and Book appointments line that the patient has experienced slot unavailability.

*Note: this is NOT the date that the health care provider opens or actions the electronic notification.*

## Example D

A CAMHS looked after children team provides services to a local authority-commissioned low secure children's home. A social worker requests specialist input for Child D who has been involved in fire setting. The social worker does not know if input from a consultant psychiatrist, consultant psychologist or the looked after children's nurse specialist is required at this stage but follows an agreed referral pathway that could lead to input from a consultant psychiatrist.

**The referral is to an NHS multi-disciplinary team even though the service is not provided in a health setting and CAMHS input to the service is funded by the local authority.**

**This is not however a consultant-led service. The psychiatrist has no responsibility for the caseload of the consultant psychologist or the looked after children's nurse even though he/she provides supervision of the nurse specialist as a nurse prescriber.**

**The referral does not start an 18 week clock however local agreements may require a service for looked after children to be provided within a specified number of weeks.**

## Example E

A single point of access CAMHS receives a referral from a school nurse asking for an assessment for attention deficit hyperactivity disorder (ADHD) for Child E who has concentration difficulties and struggles to sit still at home or in school. The single point of access sends questionnaires out to the family and the school and when these are returned and scored the case is passed to the local attention difficulties clinic.

The clinic is staffed by an ADHD specialist nurse, a paediatrician, a drama therapist, an educational psychologist and a consultant psychiatrist. Initial appointments are always with two professionals and diagnoses are formulated in multi-disciplinary team meetings before care plan discussions with the family commence.

**This is not a consultant-led service. The psychiatrist has no responsibility for the caseload of the other professions and participates in formulating a diagnosis and treatment options rather than carrying case management for all patients referred to the clinic.**

**Diagnosis and treatment options are discussed with the family. If it is agreed that medication should be considered Child E will be referred to a consultant psychiatrist and an 18 week clock will start when the referral is made by the attention difficulties clinic and received by the consultant. If the family opt for another form of treatment, for example a parenting or behaviour group provided by nursing staff, or to go away and think about options then an 18 week clock does not start.**

### 10) What ends an 18 weeks pathway?

The basic rule is that an 18 weeks pathway ends when first definitive treatment begins or when a clinical decision is made that treatment is not required.

The following clinical decisions end an 18 weeks pathway, with the proviso that this happens only when the decision is communicated to the patient, to their responsible guardian in the case of a young child, to the patient's GP and (if different) to the original referring health professional:

- first definitive treatment (with or without discharge)
- a decision not to treat
- a decision to embark on a period of watchful waiting or active monitoring
- a decision to refer a patient for treatment in primary care (excluding consultant-led treatment) or non-consultant-led treatment led by another discipline (for example a psychologist or therapist).

### 11) What activities do not end an 18 weeks pathway?

The following examples do not stop the 18 week clock:

- a first (or subsequent) outpatient appointment or assessment that does not involve starting treatment or a care plan
- medication to aid sleep or other steps to manage a patient's condition in advance of definitive treatment
- consultant-to-consultant referrals where the underlying condition remains unchanged
- simply making a tertiary referral, or a referral to any other provider
- further onward internal referral for treatment within the service (for example family therapy or assessment for medication for ADHD) after initial advice or brief intervention that does not constitute start of definitive treatment.

### Example F

Child F has difficulty sleeping, appears anxious and rarely communicates outside the home. Child F has been referred to a consultant-led, community-based CAMHS team by their GP and following an assessment the problem appears in part to be related to school-based anxieties following a move to a new school. A clinical decision is made not to start any treatment at this stage but to commence a period of watchful waiting involving Child F's teacher in this until the end of the next term when there will be a review appointment.

**The 18 week clock stops when the decision is made to start active monitoring/watchful waiting. If a decision to treat is made at the review appointment, a new clock would start.**

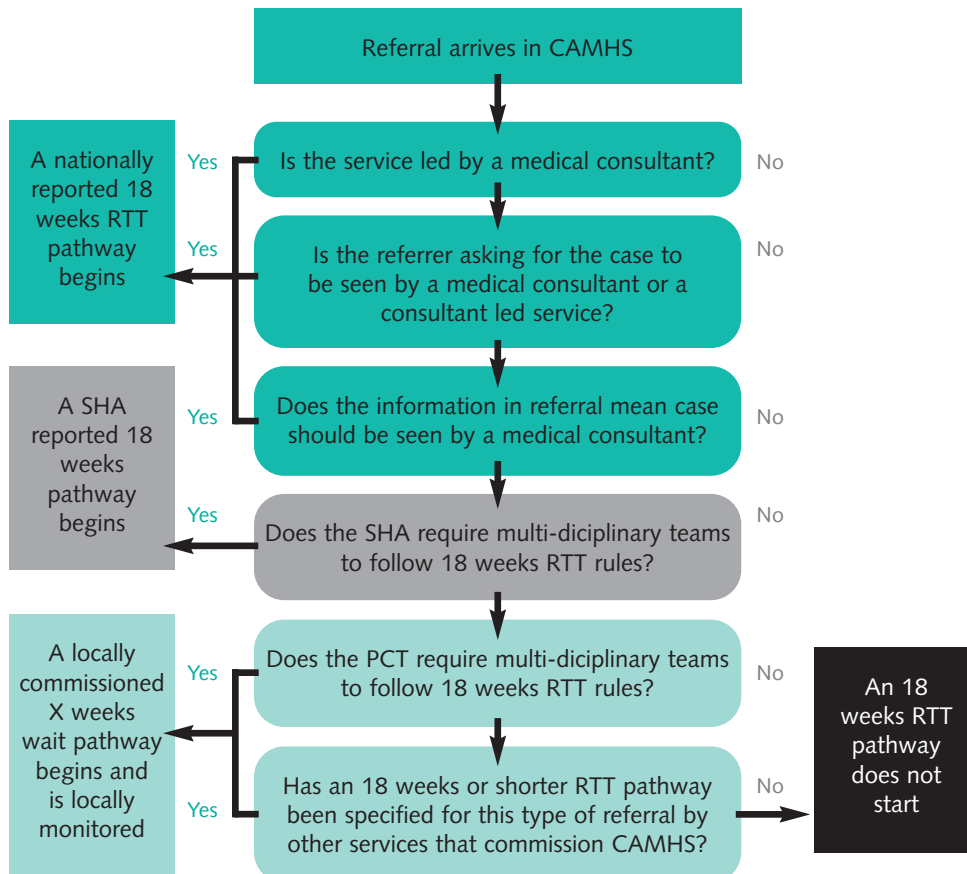


## Example G

Child G has difficulty concentrating, appears anxious and rarely communicates at school but can get frustrated and throw things or push over chairs. Child G has been referred to a consultant-led community-based CAMHS team by the school nurse and, following an initial assessment, the problem appears in part to be related to school-based anxieties. A school observation is planned by CAMHS staff but this cannot take place during the school holidays. A decision about treatment is delayed until input from school and school observation of Child G is possible.

**The 18 weeks standard applies to this referral. The clock continues to run during the holiday period and continues to run until first definitive treatment begins or a clinical decision is made that treatment is not required.**

Figure 1: Does the 18 week standard apply? A decision tree:





## SECTION 3 Implementation

### Service delivery issues

Swift access to services has benefits both for children, young people and their families, and for service efficiency (Moss, 2008). For service users, intervening as

quickly as possible reduces the likelihood of chronic mental health problems developing. For services, clear access routes require an understanding of demand which in turn makes it easier to plan and manage staff capacity and workloads.

#### Case study 2

#### Capacity and demand modelling to implement an 18 weeks pathway

Doncaster and Bassetlaw Foundation Trust used learning from its 18 weeks early implementer site to improve waiting times for assessment and treatment.

- Ward rota and urgent outpatient assessment clinics were merged into one daily on-call urgent rota.
- The routine clinic focused on routine work only, offering a higher number of weekly appointment slots.
- Regular feedback on referral flow rates and waiting times were made available.

#### How things improved:

- Waiting times for initial assessments and therapeutic interventions reduced.
- Staff continuously update their clinical skills in risk assessment and urgent need.
- Staff have a greater understanding of the requirement for user feedback, and performance monitoring mechanisms in CAMHS to improve patient outcomes.
- The project has prepared and equipped the tier 3 service for the implementation of the 18 weeks care pathway.

**Further information:** see *Implementation tools*, page 26 for a link to the full case study online or contact [tracey.carter@dbh.nhs.uk](mailto:tracey.carter@dbh.nhs.uk)

### Case study 3

#### Developing local monitoring tools

Robust performance monitoring was the starting point for service change for Cornwall CAMHS, which needed a baseline before it could achieve its aim of a waiting time standard of four weeks from referral to initial assessment. Performance charts were introduced to enable managers to monitor the throughput of service users. These show average activity as well as standard variations above and below the average. Data is captured relating to those patients who are waiting more than four weeks to be seen.

#### How things improved:

- The service is better managed in terms of allocation of staff resources in different clinical and geographical areas. An analysis of the data indicates where blockages in the system are occurring. Clear data regarding expected peaks and troughs in referrals enables better allocation of staff resources, thereby reducing waiting times.
- There is robust data to support the claim that to reduce the underlying trend of waiting times of more than four weeks, more clinical resources are needed. The aim is to reduce the wait from referral to initial assessment to 21 days.

**Further information:** see *Implimentation tools*, page 26 for a link to the full case study online or contact [linda.bennetts@cpt.cornwall.nhs.uk](mailto:linda.bennetts@cpt.cornwall.nhs.uk) or [davidthompson@cpt.cornwall.nhs.uk](mailto:davidthompson@cpt.cornwall.nhs.uk)

A number of practical steps need to be taken in any work to improve access to services. These include:

- defining the services being provided and the scope of what is offered by each
- understanding current performance or waiting times for CAMHS, inclusive of all agencies
- setting and agreeing locally defined standards and pathways to be developed
- setting and agreeing expectations for the timely delivery of treatments and interventions
- agreeing performance measures
- establishing reporting mechanisms.

Many of the examples in this guide refer to the use of pathways when redesigning services. Feedback suggests that clear

pathways can be helpful both for staff and for children, young people and families. A service pathway is an agreement between commissioners and providers based on the model of care that is appropriate to meet local needs effectively. An example of a commissioned 18 weeks service pathway is described in case study 5 and can be down-loaded as a resource (see *Implimentation tools*, page 26, item 8).

### Implementing pathways

An integrated care pathway (ICP) is a document that describes a process within health and social care (National Leadership and Innovation Agency for Healthcare, 2005). An ICP is both a tool

and a concept which embeds guidelines, protocols and locally agreed, evidence based, patient-centred, best practice into everyday use for the individual patient. Uniquely, an ICP records variations from planned care in the form of 'variances'.

An ICP aims to have:

- the right people
- in the right order
- in the right place
- doing the right thing
- at the right time
- with the right outcomes
- all with attention to the patient experience.

In CAMHS a fully implemented ICP would include:

- a definition of the patient group

covered, for example all new presentations of self harm

- local and national standards and intended outcomes for that group of patients
- references to the evidence based practice used to inform local practice
- maps and flow charts showing the clinical and non-clinical processes designed to implement good practice in the diagnosis, treatment and management of the patient group
- a way of recording and monitoring variances (when the care of an individual patient or the outcome of care is different to that planned for the patient group and the reason for that difference
- a family-friendly leaflet describing what will happen when, where and why.

#### Case study 4

#### Monitoring CAMHS waiting times and agreeing 18 week definitions

Local PCT commissioners asked Birmingham CAMHS to comply with the 18 weeks standard. When the project started there were around 300 children waiting, with the longest wait being over two years. Clinicians were engaged to agree and implement a definition of 'start of treatment'.

##### How things improved:

- The 18 week definition is being used by all staff.
- 70 per cent to 90 per cent of patients are now seen within 18 weeks.
- The standard of data is much improved and allows the service to produce weekly and monthly reports of performance against the 18 weeks standard.
- All partners have a much greater understanding of the complexity of community-based CAMHS and the challenges of applying apparently straightforward targets within this environment and with complex national IT systems.

**Further information:** see *Implimentation tools*, page 26 for a link to the 18 week clock examples and the full case study online or contact [iain.nelson@bch.nhs.uk](mailto:iain.nelson@bch.nhs.uk)

## Case study 5

### Commissioning an 18 weeks pathway

Large caseloads, staff shortages and slow progress through the system led local commissioners to support Wakefield CAMHS to redesign the whole of their tiered service into one based on planned and unplanned care pathways where referral to treatment time could be monitored.

#### How things improved:

- Children and families have a choice of where to access services.
- Timely intervention is available on a 24-hour basis.
- Caseload sizes have reduced and waiting lists have been eliminated.
- An increase in staffing has enabled prevention and early intervention work.
- Referral to assessment to treatment is well within the 18 weeks standard.
- Care bundles are being produced to underpin the pathway.
- Admissions to specialist inpatient services have been drastically reduced.
- All staff have clear job plans, morale has improved and there are no recruitment problems.

**Further information:** see *Implimentation tools*, page 26 for a link to the pathway and the full case study online or contact [sharon.tinker@wdpct.nhs.uk](mailto:sharon.tinker@wdpct.nhs.uk)

## Four service improvement models

This section describes four generic approaches which can be adopted by CAMHS to improve service delivery. Each of them has already been used in some areas by commissioners and providers. There is no one recommended approach that fits all CAMHS. This chapter includes practice examples of the ways in which the different approaches have helped local areas address specific difficulties or circumstances.

## The 10 High Impact Changes

These are ten changes that mental health services can make to achieve the biggest impact in improving service delivery. The changes were originally developed by the NHS Modernisation Agency in 2004, and adapted for mental health services in 2006, drawing on quantitative data, case studies and a literature review (CSIP, 2006). The ten high impact changes for mental health services are relevant across the range of health and social care statutory and non-statutory mental health organisations, including CAMHS.

### How can they be applied in CAMHS?

A baseline assessment is carried out to help map where the service currently is in relation to the ten areas. There is also a range of tools and techniques available to support implementation. The ten high impact changes are:

- 1) Treat home based care and support as the norm for delivery of mental health services.
- 2) Improve flow of service users and carers across health and social care by improving access to screening and assessment.
- 3) Manage variation in service user discharge processes.
- 4) Manage variation in access to all mental health services.
- 5) Avoid unnecessary contact for service users and provide necessary contact in the right care setting.
- 6) Increase the reliability of interventions by designing care based on what is known to work and that service users and carers inform and influence.
- 7) Apply a systematic approach to enable the recovery of people with long-term conditions.
- 8) Improve service user flow by removing queues.
- 9) Optimise service user and carer flow through an ICP approach.
- 10) Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce.

**Find out more:** The baseline assessment tool can be downloaded at:

[www.yhip.org.uk/silo/files/10-high-impact—changes—for-mental-health-services-.pdf](http://www.yhip.org.uk/silo/files/10-high-impact—changes—for-mental-health-services-.pdf)

## The Choice and Partnership Approach<sup>2</sup>

**What is it?** The Choice and Partnership Approach (CAPA) is a clinical system that brings together the active involvement of young people and their families, demand and capacity ideas and a new approach to clinical skills and job planning. The aim is to enable services to:

- do the right things (having a clear working goal with the family and young person)
- with the right people (using clinicians with the appropriate clinical skills)
- at the right time (without any external or internal waits).

CAPA puts into practice many of the 7 HELPFUL habits of effective CAMHS – handle demand, extend capacity, let go of families, process map and redesign, flow management, use care bundles and look after staff.

### How can it be applied in CAMHS?

CAPA was developed in Richmond and East Herts CAMHS. It has been implemented in many CAMHS teams in the UK, Australia and New Zealand. CAPA is focused on a collaborative approach with the child or young person and their family. For the clinician there is a shift from an 'expert with power' to a 'facilitator with expertise'. There are 11 key components:

<sup>2</sup> This section has been informed by York and Kingsbury (2009) *The Choice and Partnership Approach* (see References). Available from [rowe.york@btinternet.com](mailto:rowe.york@btinternet.com) or [www.camhsnetwork.co.uk](http://www.camhsnetwork.co.uk)

- 1) management and leadership
- 2) language
- 3) handle demand
- 4) 'choice' framework
- 5) full booking to partnership
- 6) selecting partnership clinician by skill
- 7) extended clinical skills in partnership
- 8) job plans
- 9) goal setting and care plan
- 10) peer group supervision
- 11) team away days.

Both CAPA and the 7 HELPFUL habits have associated self-rating scale tools that can be used for baseline assessment and monitoring of ongoing implementation (see *Implimentation tools*, page 27, items 6 and 7).

**CAPA clinical pathway:** For the child or young person and their family, the first clinical contact is in a 'choice' appointment. Here they may choose:

- not to return to the service because they can get back on track themselves

- to be put in contact with a different agency more suited to help
- to return to CAMHS.

This appointment aims to combine assessment, motivational enhancement, psycho-education, goal setting and things to try at home. If the child or young person chooses to return they will be able to choose an appointment with a clinician who has the right skills to help them. This next appointment will be the start of 'core partnership' work with that clinician. Most people will find this is enough to achieve their goals. Core partnership work is delivered by clinicians with extended clinical skills, supplemented by additional specific specialist partnership work as needed. An example could be individual psychodynamic psychotherapy alongside core work with the family. CAPA encourages teams to define the skills and competencies required by clinicians. It requires a learning culture, strong peer support and effective leadership.

**Find out more:** [www.camhsnetwork.co.uk](http://www.camhsnetwork.co.uk)

## Case study 6 Implementing CAPA

Unacceptable waiting lists led Stockton CAMHS to use CAPA to redesign their service

### How things improved:

- The team now sees 70 per cent of new clients within four weeks.
- The service operates with a central point of access and agreed internal pathways.
- The service no longer uses the team as the key decision making forum for new referrals – this is now undertaken by one clinician with access to support.
- Staff morale and overall functioning has improved and primary mental health workers are better integrated into the service.
- IT systems capture relevant data for monitoring improvement.
- There is flexibility and control over the demands on the service.

**Further information:** see *Implimentation tools*, page 26 for a link to the full case study online or contact [tracy.splevins@tney.northy.nhs.uk](mailto:tracy.splevins@tney.northy.nhs.uk)

## Case study 7

### Using the CAPA audit tool

Local commissioners and the SHA required Lincoln and West Lindsey Child and Family Services Team to reduce waiting times for new referrals from 52 to 18 weeks. The team introduced the CAPA model and audit tool to assess progress.

#### How things improved:

- Using CAPA all referrals were seen within local and regional waiting time targets
- There was no undue wait between 'choice' and 'partnership'.
- A large proportion of the processes were administration-driven, highlighting the important role of effective administrative support in delivering CAPA.
- The audit identified individual clinician variance in implementing CAPA which then enabled more reflective team discussion.
- CAPA has been embedded in the team's working practices since early 2007.

**Further information:** see *Implimentation tools*, page 26 for a link to the full case study online; copies of the local standards and the audit tool can be requested by e-mail from [gill.walker@lpt.nhs.uk](mailto:gill.walker@lpt.nhs.uk)

## Lean Thinking<sup>3</sup>

**What is it?** Lean Thinking is a service improvement approach to maximising value adding activities, improving flow and eliminating waste. It was developed by Toyota but has been applied in other sectors. In health and social care, Lean Thinking is about identifying what adds value for those using services, and getting the right people or things to the right place, at the right time, in the right quantities, while minimising waste and being flexible and open to change.

**How can it be applied in CAMHS?** Some services have found the Lean Thinking

approach helpful in understanding how families access and flow through services. In particular the concepts of 'adding value' and 'elimination of waste' can be useful.

- 1) The first stage is to map out the steps families go through and how information flows through the service to support the pathway. This is used to sort those activities families feel add value to their care, from those which add no value.
  - Value adding activities are activities which the service user perceives to be valuable, for example meetings with clinicians out-of-hours in community locations.

<sup>3</sup> This section has been informed by the following: IHI (2005) *Going Lean in Healthcare*; Womack, Jones and Roos (1991) *The Machine that Changes the World*; Womack and Jones (2005) *Lean Solutions*. See References.



- Waste is anything that does not add value for the child or young person. Plans for future service development should reduce or eliminate as much waste or non value adding activity as possible.
- 2) The next step is to analyse the whole process – ‘flow analysis’. Activities which add value from the patient’s point of view need to be identified and distinguished from other clinical and administrative steps. A summary of the current situation can be produced by identifying the total number of process steps, the number of value adding steps and time spent.
- 3) The final stage is to develop a future model of care or ‘core care pathway’, based on the analysis carried out. The aim is to eliminate unnecessary process steps, reduce batch sizes, predict length of stay and discharge dates and link up processes that need to run sequentially.
- If each part of the process is able to deal with the same level of demand at the same time, patients can flow from one stage of the pathway to the next at the same rate. The pace of a CAMHS flow can be determined by the arrival rate of children and young people who require assessment and treatment. By analysing historical flow

## Case study 8

### Lean Thinking to improve tier 3 services

Adopting a whole team approach to Lean Thinking enabled Bexley CAMHS to improve access by developing a more consistent and streamlined patient journey. A number of processes were introduced:

- pre-assessment telephone consultations with service users
- tracking to manage the flow of patients through the service
- routine use of outcome measures including patient reported outcome measures
- a detailed operational policy with timelines
- standardised letters and clinical records templates
- meetings focused on key tasks
- increased administrative support to save clinical and management time.

#### How things improved:

- The system is now more efficient, in particular:
  - greater capacity for assessments and new processes
  - faster responses to referrals and lower waiting times from referral to completed core assessment
  - better quality service, for example through use of outcome measures, better clinical recording and data quality and better information sharing with service users
  - improved use of resources and team functioning.

**Further information:** see *Implimentation tools*, page 26 for a link to the full case study online or contact [beverley.mack@oxleas.nhs.uk](mailto:beverley.mack@oxleas.nhs.uk)

## Case study 9

### A child and family-led approach for continuous improvement

West Kent and Medway CAMHS used a demand-led, systems-thinking approach enabling frontline staff to properly understand the needs and requirements of each team's local community of children, young people and families.

Staff developed new skills in systems management and were involved in the review, design and implementation of service improvements.

Staff designed and developed Team locality 'dash boards' to display patient-focused and service improvement performance measures.

#### How things improved:

- Frontline clinicians and the people who use the service are actively involved in collecting and analysing their performance and supported to make change.
- There have been measurable reductions in waiting times and it is quicker and easier to access services.

**Further information:** see Implementation tools (page 26) for a link to the full case study online or contact [nick.coulter@cyf.org.uk](mailto:nick.coulter@cyf.org.uk) or [vicky.stevens@kmpt.nhs.uk](mailto:vicky.stevens@kmpt.nhs.uk)

rates by day of the week or month of the year and setting the pace over a week or a month a plan can be developed to match available capacity to likely demand. The pace can be adjusted in line with changed demand when necessary.

**Find out more:** [www.institute.nhs.uk/building\\_capability/general/lean\\_thinking.html](http://www.institute.nhs.uk/building_capability/general/lean_thinking.html)  
[www.leanuk.org/pages/research\\_health\\_care.htm](http://www.leanuk.org/pages/research_health_care.htm)

## New Ways of Working in CAMHS

**What is it?** The need and demand for child mental health services is greater than the ability to supply.

These workforce pressures are considered the key constraining factor in the effective delivery of the NHS Plan and the CAMHS agenda (Kurtz et al, 2006). New Ways of Working (NWW) is about developing new, enhanced and changed roles for mental health staff, and redesigning systems and processes to support staff to deliver effective, person-centred care in a way that is personally, financially and organisationally sustainable. NWW is a cultural shift – it involves rethinking values, ways of working and roles to deliver person-centred care (CSIP/ NIMHE, 2007a and 2007b; Department of Health, 2005).

**How does it apply to CAMHS?** New Ways of Working has emerged as a good practice solution to significant difficulties

facing the mental health workforce (Department of Health, 2006). It is about enabling all workers:

- to work effectively in teams
- to focus on their skills, competencies and capabilities rather than their status
- to bring new people into extended and new roles
- to meet children and families needs
- to work together across boundaries.

There is no single route to improving services. This approach is a useful resource for those wishing to make positive change and it should form part of a strategic workforce approach. A variety

of tools and resources that are specific to CAMHS have already been developed (CSIP/NIMHE, 2007b) but in some cases individual solutions will be needed that can use the principles of NWW. The National CAMHS Workforce Programme commissioned a project to look at New Ways of Working in CAMHS. Examples ranged from implementing an extended model of service delivery to user and carer involvement in service redesign.

**Find out more:**

[www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)

[www.healthcareworkforce.nhs.uk](http://www.healthcareworkforce.nhs.uk)

Tim Morris: [timmorris@liverpool.ac.uk](mailto:timmorris@liverpool.ac.uk)

Barry Nixon: [Barry.Nixon@5bp.nhs.uk](mailto:Barry.Nixon@5bp.nhs.uk)

## Case study 10

### A new tier 2 service to manage capacity and demand

In 2005 Oxfordshire CAMHS had waiting times of around a year. In order to eliminate waiting lists the service took a whole system approach to change across all the county and established a robust tier 2 service with a single point of access:

**How things improved:**

- There are no waiting lists for services at tiers 2, 3 or 4.
- The tier 2 service provides a single referral point with targets to screen up to 3,000 cases annually and a direct service to 1,400 children and young people.
- Clear thresholds and eligibility criteria are in place.
- A greater variety of community-based interventions are provided.
- There is high service user satisfaction.
- The use of robust data is enabling continual service improvement.
- New Ways of Working was introduced for consultant psychiatrists alongside a new case management system for all clinical staff.

**Further information:** see *Implimentation tools*, page 26 for a link to the full case study online or contact [paul.sheffield@obmh.nhs.uk](mailto:paul.sheffield@obmh.nhs.uk) or [yvonne.taylor@obmh.nhs.uk](mailto:yvonne.taylor@obmh.nhs.uk)

## Case study 11

### Improving discharge planning and caseload management

Variation in the size of caseloads and a lack of accurate data about activity led Harrogate CAMHS to introduce new systems to reduce waiting times, in particular new processes for allocation and case management; new discharge guidance and a new format for allocation meetings.

#### How things improved:

- The new system is working well and waiting times have reduced.
- Discharge procedures are being strengthened by developing 'step down discharge' using the principles of the common assessment framework.
- Staff understand why it is important to provide accurate information to commissioners.

**Further information:** see *Implimentation tools*, page 26 for a link to the full case study online or contact [joanne.james@nyypct.nhs.uk](mailto:joanne.james@nyypct.nhs.uk)

## Implementation tools

The case studies have referred to a number of tools which services have found particularly helpful in implementing improved access to services. These are described in more detail in the text below, along with links for online access where relevant.

### 1) Case studies on improving access

Fuller versions of the case studies included in this guide.

[www.cypf.csip.org.uk/camhs/improving-access-to-camhs](http://www.cypf.csip.org.uk/camhs/improving-access-to-camhs)

### 2) Checklist for commissioners

To assist commissioners in taking a strategic approach to improving access. Derived from case studies and workshops held during development of this guide.

See *Checklist for commissioners* page 28

### 3) Checklist for service providers

To help service providers ensure they have clear pathways through the service and good care planning arrangements.

See *Checklist for service providers* page 30

### 4) CAMHS contact form (template)

Developed by Birmingham CAMHS for clinical staff to record decisions so that administrative staff know what to enter onto the IT system for patient information.

[www.cypf.csip.org.uk/camhs/improving-access-to-camhs](http://www.cypf.csip.org.uk/camhs/improving-access-to-camhs)

### 5) 18 week clock examples

A flow chart developed by Birmingham CAMHS showing five possible pathways for 18 week clocks.

[www.cypf.csip.org.uk/camhs/improving-access-to-camhs](http://www.cypf.csip.org.uk/camhs/improving-access-to-camhs)

### 6) 7 Helpful Habits assessment tool

Questionnaire structured around the seven helpful habits to be completed with the team. Enables you to decide which items you do well and which require action.

[www.camhsnetwork.co.uk](http://www.camhsnetwork.co.uk)

### 7) CAPA Components Rating Scale (7 Helpful Habits edition)

Rating scale to help you review your service and see how far you are to fully implemented CAPA

[www.camhsnetwork.co.uk](http://www.camhsnetwork.co.uk)

### 8) CAPA Care pathway

Developed by Wakefield PCT to ensure swift and easy access using CAPA

[www.cypf.csip.org.uk/camhs/improving-access-to-camhs](http://www.cypf.csip.org.uk/camhs/improving-access-to-camhs)

### 9) Learning disabilities care pathway

A Mental Health Care Pathway for Children and Young People with Learning Disabilities – resource pack (CAMHS Publications, 2007). Developed for the Do Once and Share project

[www.annafreudcentre.org/ebpu/#mhlDcarepathway](http://www.annafreudcentre.org/ebpu/#mhlDcarepathway)

### 10) Article on commissioning

Describes the 11 world class commissioning competencies and how they relate to improving children's mental health.

[www.csip.org.uk/silo/files/wcc-camhs-paper.pdf](http://www.csip.org.uk/silo/files/wcc-camhs-paper.pdf)

### 11) Service improvement website

A web-based library of quality and service improvement tools from the NHS Institute

of Innovation and Improvement. Builds upon the No Delays Achiever website, launched in 2006 to support work towards 18 weeks pathways.

[www.nodelaysachiever.nhs.uk](http://www.nodelaysachiever.nhs.uk) in future at: [www.institute.nhs.uk/creativity\\_tools/creativity\\_tools/coming\\_soon\\_page.html](http://www.institute.nhs.uk/creativity_tools/creativity_tools/coming_soon_page.html)

### 12) CAMHS self assessment matrix

Used by most CAMHS partnerships to help review and plan their priorities, investment and services.

[www.childhealthmapping.org.uk/self.assessment/](http://www.childhealthmapping.org.uk/self.assessment/)

### 13) Emotional health and well-being toolkit

This toolkit was produced in Bristol and helps schools find out the services, strategies and resources available to support children's emotional health.

[www.sw-special.co.uk/documents/misc/docs/BristolCarePathwayToolkit.doc](http://www.sw-special.co.uk/documents/misc/docs/BristolCarePathwayToolkit.doc)

### 14) User participation website

Participation Works is a consortium of six national children and young people's agencies. Its website is an online gateway for information, resources, news and networking on children and young people's participation.

[www.participationworks.org.uk](http://www.participationworks.org.uk)

### 15) Participation standards

CAMHS participation standards and the 'you're welcome' quality criteria (Department of Health, 2007) are available online along with a self assessment toolkit to help with the design of child and youth friendly services.

[www.cypf.csip.org.uk/camhs.html](http://www.cypf.csip.org.uk/camhs.html)

Checklist for commissioners	No Red	Partial Amber	Yes Green
1) Commissioners have involved partner agencies and clinicians in the development and commissioning of services to meet mental health, emotional health and psychological well-being of children and young people			
2) Commissioners have defined the services being provided and the scope of what is offered by each provider/team			
3) A local directory/local offer of all CAMHS for children and families is available to referrers in all agencies, staff and families			
4) Commissioners understand the current performance or waiting times for CAMHS			
5) Commissioners understand where the 18 week RTT standard applies to local services			
6) The impact of emergency care on planned care capacity has been identified			
7) Commissioners have established the effectiveness of the current CAMHS pathways by assessing accessibility and patient outcomes			
8) A vision for accessible local services has been agreed across agencies and tiers of services. Local standards for acceptable waiting times for first appointments and timely delivery of treatments and interventions are in place			
9) Effective plans for service improvement and pathway redesign are in place if needed to implement national and local strategies, operating frameworks and the results of local needs assessments. Pathways have been prioritised for redesign based on volume, variation, cost, history, efficiency, service improvements required and outcomes. Lean Thinking/CAPA principles have been applied in redesigning pathways			
10) Clear pathways for accessing services are available with: - graphical summaries (flow charts) showing maximum wait times - a core offer statement that expresses clearly to families and referrers the types of needs to which local waiting time standards apply			

Checklist for commissioners	No Red	Partial Amber	Yes Green
11) Plans for/use of mental health and/or community contracts are in place. Redesigned accessible CAMHS have been secured through contracting and procurement			
12) Positive relationships to support pathway performance are in place; sustainable activity planning and capacity plans have been agreed in line with contracts and projected demand for redesigned pathways			
13) Service level agreements that specify the direct interventions and the staffing capacity needed to meet the number and nature of referrals are in place. Service level agreements take into account the training and consultation that also needs to be provided for other agencies and tiers of service			
14) There is agreement on performance measures (including 18 weeks RTT rules where appropriate), incentives and actions to be taken if performance does not meet standards			
15) Monitoring includes: missed appointments/'do not attends' (as lost capacity needs to be minimised), discharge and transfer information (to help ensure flow through services and avoid blockages, e.g. access to specialist therapies) and actions to improve engagement and letting go if needed			
16) Reporting mechanisms have been set up, tested and implemented			
17) A local impact assessment has been conducted to ensure redesign is affordable and does not have adverse impact on particular communities			
18) Regular review and monitoring of pathway performance is in place to manage and resolve problems.			
19) Providers are supported as required to accelerate improvements across their service			

There is a good fit between this checklist and world class commissioning competencies 7,8,9 and 10

For detailed guidance visit [www.institute.nhs.uk](http://www.institute.nhs.uk) and download Commissioning for Patient Pathways: A practical guide to achieving and sustaining 18 weeks.

Checklist for service providers	No Red	Partial Amber	Yes Green
1) Clinical and administrative staff understand when and how to apply the 18 weeks RTT standard			
2) The service has worked with commissioners to agree: <ul style="list-style-type: none"> <li>- who can refer</li> <li>- acceptable length of wait for assessment and or treatment</li> <li>- location of provision and accessibility of venues</li> <li>- hours when services should be available</li> <li>- provision of materials in appropriate formats to meet needs of families</li> <li>- ensuring accessibility of booking and assessment and treatment services to all community groups including vulnerable, e.g. availability of interpreters</li> </ul>			
3) The service has established the effectiveness of the current access routes by consulting with and considering the suggestions of children, young people and families			
4) There are clear access routes to ensure families get the right service quickly. These have been agreed with universal services/agencies and specialist child health services			
5) The service has agreed criteria for accepting and declining referrals with commissioners and referrers. There is a clear rationale for the type of referrals that teams within the service are established to work with as well as those they are not resourced to work with			
6) Staff have information about all local provision for children and families and inform referrers and families of appropriate sources of help and support when the service is not best placed or resourced to meet identified needs			
7) The service has identified service improvement objectives and has an action plan in place which: <ul style="list-style-type: none"> <li>- targets any concerns about performance</li> <li>- specifies pathways for redesign based on volume, variation, cost, history, efficiency, achievable benefits and outcomes for children young people and families</li> <li>- contains measurable outcomes</li> </ul>			
8) The service has redesigned its processes to deliver fast (daily) triage of referrals. This is supported by an agreed protocol and checklist			



Checklist for service providers	No Red	Partial Amber	Yes Green
9) The service ensures that all accepted referrals are processed in date order, with the exception of emergency appointments (where the child or young person must be seen on the same day as the referral is received). Families are offered the next available appointment but have a choice to wait longer if they wish			
10) Professionals accept and build on assessments documented by others rather than repeating information gathering that has happened earlier in the patient journey, e.g. from the common assessment framework			
11) The service ensures that families are able to choose an appointment rather than being sent one. This includes choice of date, time, venue and clinician			
12) The service provides clear information for families on questions such as: - what is CAMHS? - who I will see? - where and when? - what are my choices? - what will happen next? - what can I expect from the pathway or package of care?			
13) Waiting times are equitable and adhere to stated expected standards. All staff are clear about the agreed local standards (applying the 18 weeks standard appropriately when required) and can explain to families any expected length of wait for initial or subsequent appointments			
14) The service monitors demand weekly and knows the number of new referrals accepted and the number of families discharged in the previous week			
15) The service plans activity weekly in line with actual demand and has a capacity plan that can be adjusted monthly or quarterly			
16) Analysis of numbers of referrals and discharges in a time period and waiting times for first and subsequent appointments is discussed with staff			

Checklist for service providers	No Red	Partial Amber	Yes Green
17) The service is able to deploy staff flexibly to manage the impact of emergency care on planned appointments and interventions. The service has developed predictors based on local daily, weekly and annual monitoring of demand			
18) The staff have clear job plans showing when they are delivering appointments, group sessions and other interventions			
19) The service has a workforce plan that ensures the development of the required skills to maintain capacity and offer a range of core interventions to support the volume of presenting problems referred to the service. This enables flexible deployment and delivers the productivity needed to meet local waiting time standards			
20) The service has developed activity/performance monitoring systems that ensure data is recorded accurately and provided in a timely way to commissioners			
21) Staff appreciate the importance of gathering data accurately and systematically and complete required recording in a timely way. Clear standardised forms and templates that link to data collection and monitoring systems are in place			
22) Staff are supported in discharge planning and caseload management by using an agreed, documented process			
23) The service agrees care plans with children, young people and families which are: <ul style="list-style-type: none"> <li>- documented on the IT system</li> <li>- kept in the clinical notes</li> <li>- shared with families</li> <li>- shared with all agencies involved with the family, if they consent to this</li> </ul>			
24) Staff meet with commissioners to review and monitor pathway performance and to manage and resolve problems			

A fully accessible service requires no column to be 'No' and no more than three items to be 'Partial'.

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