Child and Adolescent Mental Health Services

Berkshire Healthcare Foundation Trust

Overview

Berkshire CAMHS are commissioned to provide Specialist Child and Adolescent Mental Health Services (CAMHS) for the population served by the Berkshire Clinical Commissioning Groups and the 6 local authorities in Berkshire.

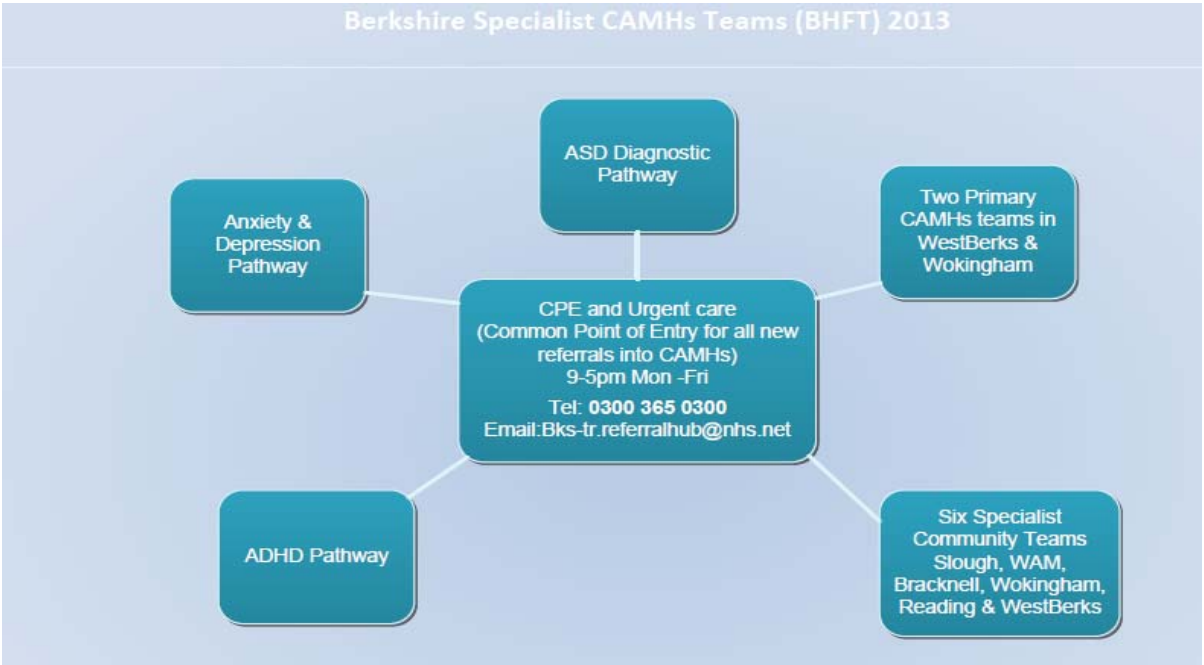
CAMH Services are defined through a 4-Tier system. Berkshire CAMHS provide Tier 3 specialist child and adolescent mental health services across the whole of Berkshire and Tier 2 services in Wokingham and West Berkshire.

Tier 3 services are defined in the NHS Health Advisory Service publication Together We Stand as: *services that are more specialised than those provided at Tier 2*. Teams of CAMHS professionals provide integrated, multidisciplinary and multi-agency care to children and young people with complex health and social need. The aim of Tier 3 services is to provide the assessment, care and treatment of young people whose needs are such that they cannot be effectively or safely managed by individual or pairs of practitioners at Tier 2 level. A detailed definition of the 4 tiers is given in Appendix 1.

The service is provided to children and young people aged 0-18 years and their families who may be experiencing severe and or complex mental health problems and neuro-developmental disorders which have a significant impact on the child or young person's development and cause distress to the child, young person and their parents/carers.

Service Structure

The structure of Berkshire CAMHS is shown in Figure 1 below.



Common Point of Entry

All referrals to the CAMHS service are received by the CPE (Common Point of Entry), who assess and direct the referral to the most appropriate team.

The CPE team is also available for advice and consultation regarding urgent concerns; if the professional needs support in determining whether the referral meets CAMHS criteria; or for help in identifying other relevant local services.

CPE clinics are held in the locality clinics and clinicians assigned to specific localities to enable the development of local knowledge and relationships with key partners. The main CPE base is at Fitzwilliam House however locality clinics are also held in Bracknell CAMHS, Churchill House.

The chart in Appendix 2 shows the flow of referrals through CPE and into the Specialist CAMHS service.

Urgent Care

The Urgent Care team are based alongside CPE at Fitzwilliam House and offer a same day response for urgent cases referred by local hospitals, GPs and other professionals (on weekdays only).

Specialist Pathways

We have three specialist pathways that work across all localities in Berkshire:

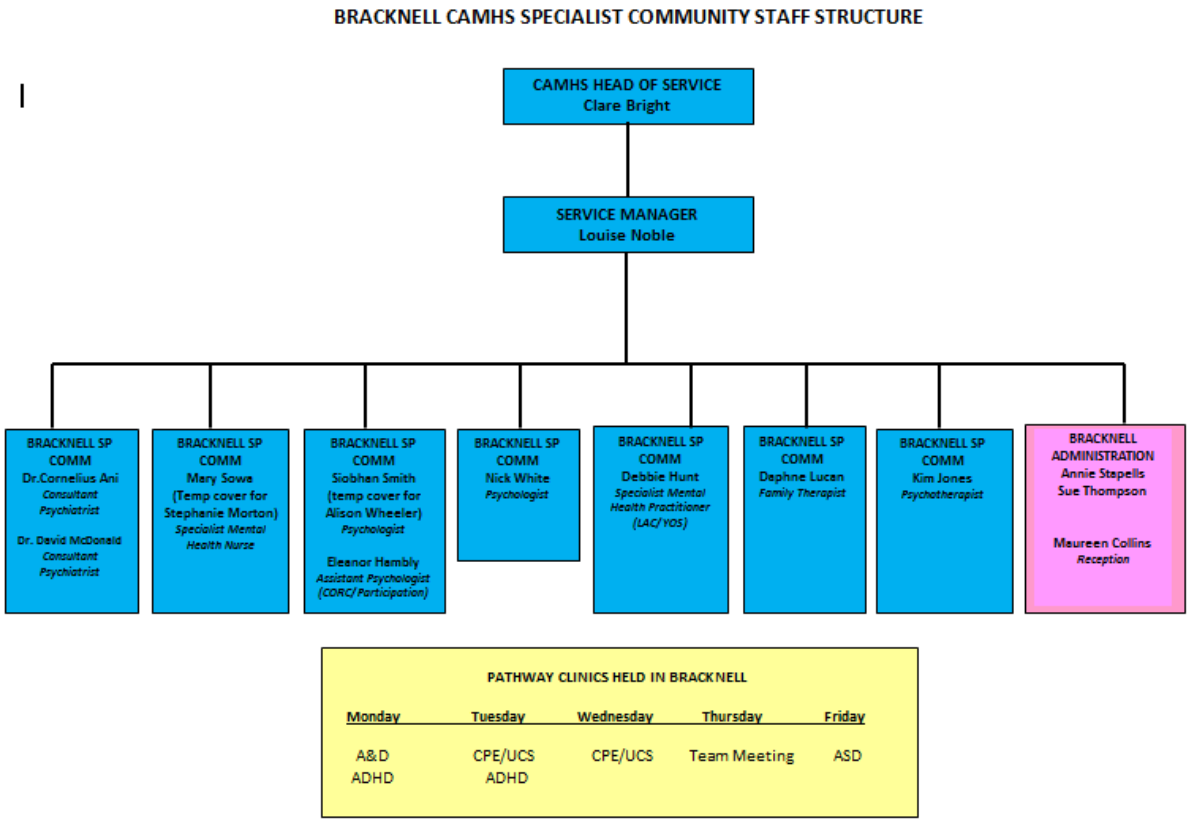
- *Attention Deficit Hyperactivity Disorder (ADHD):* The service provides a centralised team approach to the diagnosis and management of ADHD.
- *Autism Spectrum Disorder (ASD)*: The service is provides a centralized team approach to the diagnosis of ASD.
- *Anxiety & Depression*: The service provides CBT-based treatment programmes for children and young people who meet the ICD10/DSMIV criteria for a diagnosis of anxiety or depression, including OCD and single-event PTSD.

Bracknell children who meet criteria for one of the 3 pathways will be referred through CPE to the pathway central admin team and accepted onto the pathway case list. All Pathways operate locality clinics so children and families can be seen in the location that is most appropriate for them.

Specialist Community Teams (SCT's)

We have six Specialist Locality Teams based in the six localities across Berkshire. The Bracknell SCT is based at Churchill House, Bracknell. The SCT specialise in managing complex presentations requiring multiple interventions, complex or intensive risk management plans and high levels of multiagency working. The young people treated within the specialist community CAMHS require intensive treatment provided through different modalities and inter agency working. Therapies provided include: specialist nursing, psychology, child psychotherapy, systemic and family psychotherapy, cognitive behavioural therapy and child and adolescent psychiatry.

Figure 2 gives detail of the staff in the Bracknell SCT:



There are currently 248 children with open referrals receiving treatment within the Bracknell SCT. 30% of these cases are and are receiving a number of different treatments from the team and a similar % will require multiple series of treatments e.g. psychiatric care, CBT and family therapy.

The 3 case studies given in Appendix 3 provide further information on the complexity of young people seen in the SCT and the types of interventions provided.

Berkshire Adolescent Service

The BAS, at Wokingham Hospital, provides a 5-day per week inpatient and day-care facility. Bracknell children who require more intensive intervention than can be provided on an outpatient basis will be referred to the BAS. Services provided at the BAS include the Specialist Eating Disorders service and the Early Intervention in Psychosis Services as well as specific therapies for children with complex needs such as DBT and multi-family therapy.

There are currently 5 young people receiving care jointly from the BAS and the Bracknell SCT.

Tier 2 CAMHS

Berkshire CAMHS is commissioned to provide Tier 2 services in Wokingham and West Berkshire. In these localities, small teams of Primary Mental Health Practitioners offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at

Tier 1 to support service delivery. The teams also ensure safe and timely step up and step down from Tier 3 specialist CAMH services. Berkshire CAMHS are not currently commissioned to provide Tier 2 services

Bracknell LAC and YOS Service

BHFT has been commissioned to provide a specific CAMHS service to children and young people within the LAC and YOS teams. The CAMHS clinician is based within the CAMHS service at Churchill House but works as an integrated member of both teams.

There are 3 separate elements to this role:

1. Advice and consultancy to both extend the CAMHS provision to these children and young people by enabling and supporting to team to provide effective emotional wellbeing and mental health care and to facilitate early identification and treatment of those who require a CAMHS intervention.
2. The provision of direct patient care. Referrals from YOS or for LAC or Edge of Care children in Bracknell are fast-tracked through CPE to the CAMHS clinician for treatment. Quick and safe step-up to and step-down from tier 3 CAMHS services are also facilitated where appropriate.
3. Education and training for colleagues and carers.

Quarterly monitoring meetings are in place for this service.

Tier 4 Services

Tier 4 CAMHS Services are currently commissioned on a national basis through NHS England. There is currently no Tier 4 provision in Berkshire and limited provision across the county so children requiring secure, 7-day per week inpatient care for complex mental health needs will be placed in units outside of the county.
Work is currently on-going to consider options for Tier 4 provision in Berkshire moving forwards. No decisions have been taken as yet.

Bracknell CAMHS currently have 4 young people in Tier 4 placements in units in Oxford, Southampton and Northampton. Bracknell CAMHS remain involved in the care of these young people throughout their placement, with the Consultant Psychiatrist and other relevant clinicians attending regular Care Planning Assessment meetings at the Tier 4 unit.

Performance

Bracknell Forest is an active member of the pan Berkshire CAMHs Strait partnership Board. The Board is chaired by the Asst. to the CCG Commissioners, Sally Murray, Lead for Child Mental Health commissioning and attend by both lead CCg representatives and the 6 local authorities. Performance monitoring is part of the remit of the Board.

Data from the first quarter of 2013 shows that:

- The number of children and young people referrals into CAMHS has increased by approximately 31% compared to the same quarter last year.
- The number of cases of young people presenting with ‘deliberate self harm’ has increased by 52%
- The total CAMHS caseload had increased by 21%

This increase has been seen across all localities throughout the county; it is perhaps also reflected in the shortage of T4 in patient beds nationally.

New referrals received

Table 1 MR1Apr-18Aug

LA area	Apr	May	Jun	Jul
Bracknell Forest	56	77	58	67

In this financial year on average CAMHS have received 65 referrals a month for children living in the Bracknell area.

Caseload

The number cases of children who live in the Bracknell area currently open in each of the pathways is shown below

Table 2 MR91Apr-18Aug

Pathway	Total
Bracknell SP Comm	**248**
CAMHs A&D	**79**
CAMHs ADHD	**278**
CAMHs ASD	**87**
Grand Total	**692**

Waiting Times

From April 2013, CAMHS waiting time performance measure has changed from time to first contact to time to treatment, that is a specific programme of work or intervention.

Currently all referrals identified as being urgent on receipt in CPE are assessed within 24hours.

A paper on CPE was presented to the pan-Berkshire CAMHS Strategic Partnership Board in August and is given in Appendix 4.

Table 3 Average Waiting Times to Treatment

Team	Average waiting time in weeks	% cases seen within 12 weeks
Bracknell SCT	9	100%
ADHD Pathway	10	70%
ASD Pathway	12	56%
A&D Pathway	10	75%

The Table above gives current average waiting times to treatment in the SCT and pathways. Referrals are prioritised on the basis of clinical need and risk so high priority referrals will be seen more quickly.

The Service have a quality improvement target (CQUIN) to improve waiting times as follows:

- Waiting times for the assessment of ‘Urgent’ cases to 24hrs
- Waiting times for the assessment of ‘Soon’ cases to 4 weeks
- Waiting times for the assessment of ADHD and ASD cases to 7 weeks
- Waiting times for face to face appointments for routine cases to within 12 weeks

by end of Q4 13-14

To put this into context, Table 4gives average waiting times to **assessment** for Specialist CAMH Services across the country:

Table 4

Area	Average Waiting time to Assessment
North Essex	18 weeks
Gloucester	20 weeks
Kent	10 weeks
Warwickshire	20 weeks

Outcomes for children

Berkshire CAMHS is a member of CAMHS Outcome Research Consortium (CORC) which is a world-leading collaboration of mental health specialists from over 70 Child and Adolescent Mental Health Services (CAMHS) across the UK and beyond. Outcome measures are collected at a fixed time point, Time1 – Assessment, Time 2 – 6 months, Time 3 – 12 months.

Measures used in CORC are:

SDQ – **Strength & Difficulties questionnaire**

ESQ - **The Experience of Service Questionnaire** assesses users' views of SERVICES with respect to accessibility, humanity of care, organisation of care, and environment.

CGAS - The **Children's Global Assessment Scale** (CGAS) is a numeric scale (1 through 100) used by mental health clinicians to rate the general functioning of children under the age of 18.

Outcomes are presented in the CAMHs performance report at the quarterly Pan Berkshire CAMHS Strategy Group.

New Service Developments

Children & Young People IAPT project

Berkshire Healthcare NHS Foundation Trust are in partnership with Oxford Health NHS Foundation Trust, forming collaboration with the University of Reading as one of the three Children and Young People's Improving Access to Psychological Therapies (CYPIAPT) national sites.

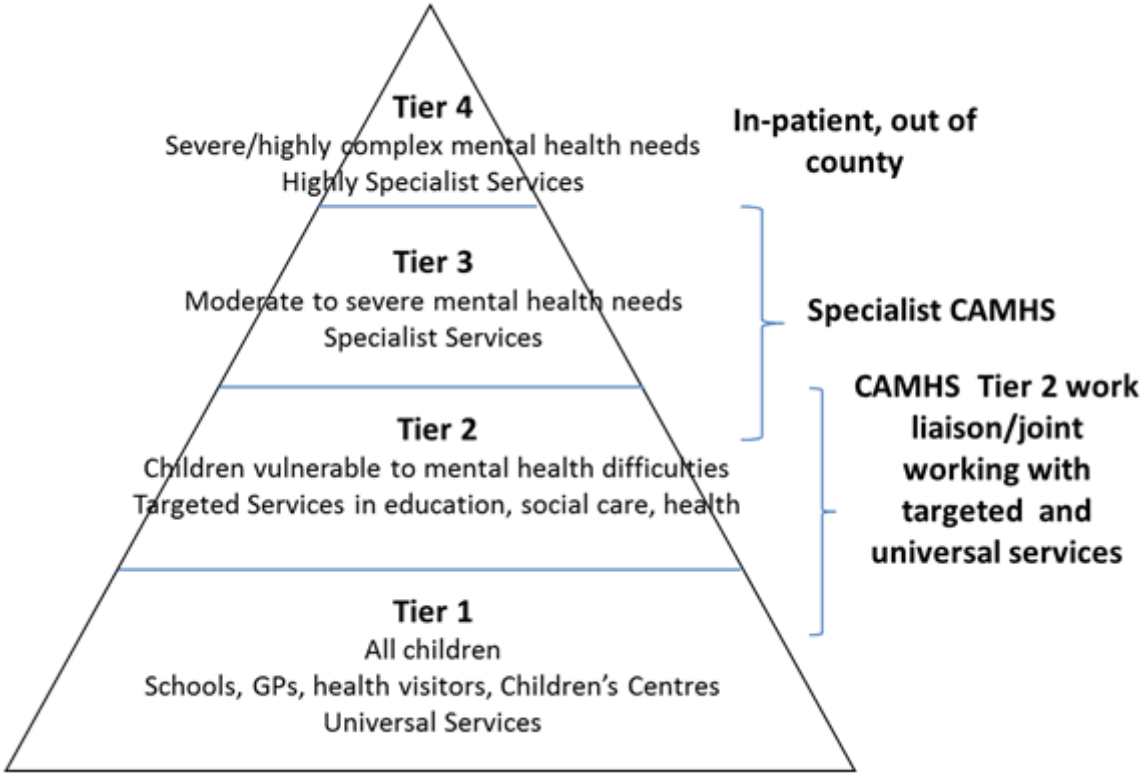
The pilot’s started in early 2013 and its aim is to transform the existing service through the adoption of the programme which will help to improve services for children and young people. This will be done by:

- Working in partnerships with children and young people to shape local services, this includes service user participation.

- Develop session by session outcome monitoring to enable the practitioner and child/young person/parent to work together to improve outcomes.(A change from CORC which monitor by Time 1 Time 2)
- To further enhance the skills of CAMHS staff through training in evidence-based interventions.

There are currently two treatment pathways; Cognitive Behaviour Therapy (CBT) for Emotional Disorders and Parenting Training (PT) for Behavioural Disorders which comply with the NICE guidance for Depression, Anxiety, and Conduct Disorder.

Appendix 1: The four-tiered CAMHS framework



CAMHS: Four-tier strategic framework

Child and adolescent mental health services (CAMHS) deliver services in line with a four-tier strategic framework which is now widely accepted as the basis for planning, commissioning and delivering services. Although there is some variation in the way the framework has been developed and applied across the country, it has created a common language for describing and commissioning services.

Most children and young people with mental health problems will be seen at Tiers 1 and 2. However, it is important to bear in mind that neither services nor people fall neatly into tiers. For example, many practitioners work in both Tier 2 and Tier 3 services.

Similarly, there is often a misconception that a child or young person will move up through the tiers as their condition is recognised as more complex. In reality, some children require services from a number (or even all) of the tiers at the same time.

The model is not intended as a template that must be applied rigidly, but rather as a conceptual framework for ensuring that a comprehensive range of services is commissioned and available to meet all the mental health needs of children and young people in an area, with clear referral routes between tiers.

Tier 1

CAMHS at this level are provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies.

Practitioners will be able to offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

Tier 2

Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services).

For example, this can include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.

Tier 3

This is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.

Tier 4

These are essential tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (e.g. for children who have been sexually abused), usually serving more than one district or region.

Practitioner agencies

Practitioners working in CAMHS will be employed by a range of agencies. Many (but not all) of those working at Tier 1, for example, will be employed directly by the Primary care trust (PCT) or the local authority (LA).

CAMHS specialists working at Tier 2 are less likely to be working for the PCT (although some of them might be), and more likely to be working for another NHS trust (or the LAs in the case of educational psychologists).

Most practitioners working in the more specialised services at Tiers 3 and 4 will usually be working

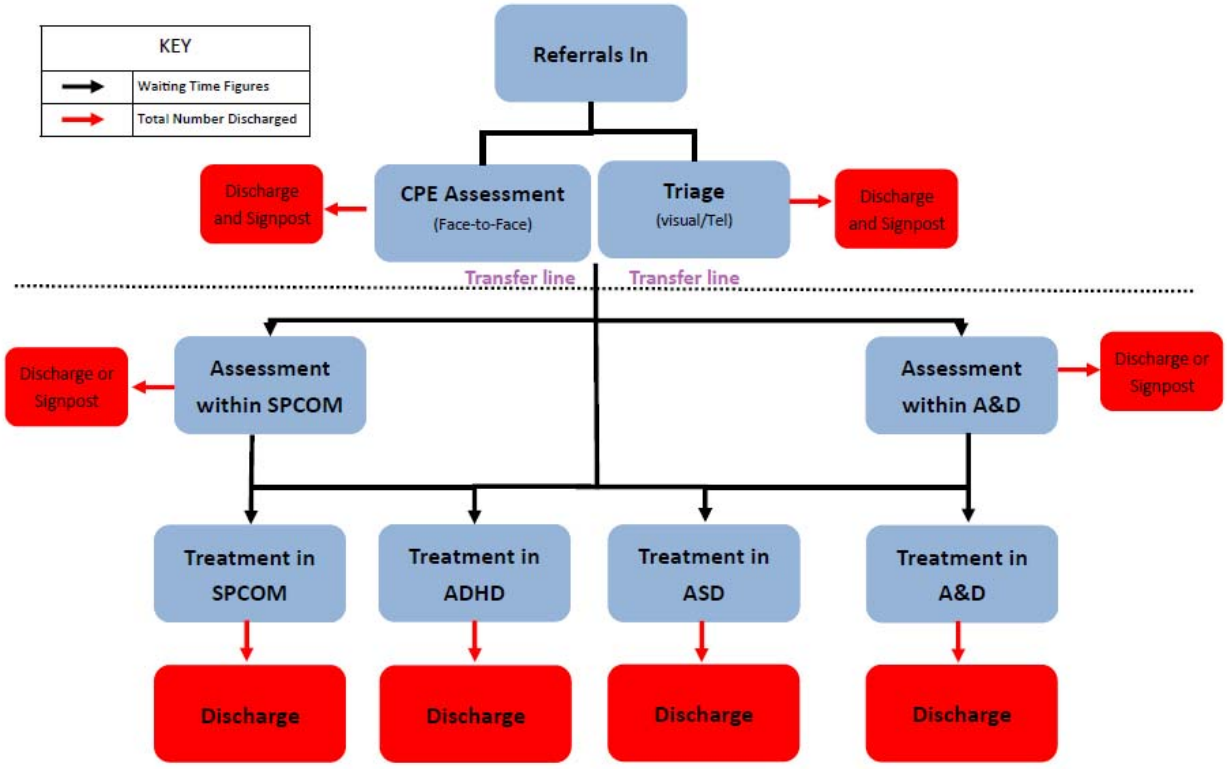
for other types of NHS trust (such as mental health trusts, acute trusts or care trusts, for example).

Clear supervisory arrangements and structures should be in place to ensure accountable and safe service delivery.

Where service delivery demands effective partnerships between agencies (e.g. children and young people with complex, persistent and severe behavioural disorders) joint protocols should be agreed at senior officer level between the NHS, social services and education.

(Taken from Department of Health, Every Child Matters website)

Appendix 2 Flow Diagram showing Referral Pathway through CAMHS



Appendix 3: Case Studies

Case Study 1:

Background:

A is a 9 year old boy who was initially referred to CAMHS in Sept 2012 with behavioural difficulties, primarily anger and aggression, possibly linked to an episode of trauma approx. 6 years prior to referral.

Assessment identified that difficulties had been present at home and school for the past 2-3 years but increasing over past 12months. The problems were more prevalent at home with differences in the behaviours reported by schools and parents. At school A could be silly, disruptive and rude, struggled to maintain friendships over any length of time and appeared to be on the outskirts of social groups; at home he was reported to have unpredictable explosive outbursts in which he could be physically aggressive and showed little understanding of or remorse for his actions. It was also noted that A showed some obsessive interests, sensory difficulties and had particular skills in his memory for detail and mental calculations.

Intervention

- Following Specialist ASD and ADHD assessments, A was diagnosed with high functioning Autism Spectrum Disorder (ASD); Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD). There remains a possibility of some post-traumatic stress disorder.
- A was referred to ASSK for a parenting programme and individual support in school.
- Following this, his family received a specialist parenting intervention, delivered to A and his family at home
- Consultant Psychiatrist involvement input to initiate and monitor prescription of Risperidone
- Coordination of and attendance at multi-agency meetings

Multi-agency input initiated by CAMHS:

- Referral to Educational Psychology for assessment with respect to observation of learning difficulties
- Referral to Occupational Therapy for assessment and support in relation to sensory difficulties.
- Referral to Children's Social Care in relation to concerns re risk of A's behaviour to other family members **and** concerns re parents parenting capability.
- Signposting to other support services including the Berkshire Autistic Society

Additional Multi-agency input:

- BST one to one support for family and access to advanced parenting support (to follow on from CAMHS parenting intervention if required).
- YOS prevention involvement wrt enabling A to understand when behaviour becomes criminal and prevent this
- Talking Therapies referrals for both parents & Anger management referral for father.
- Aiming High for respite activities and care.

Case Study 2

Background

K is a 17 year old female, who had previously been seen within CAMHS Services in relation to anxiety issues.

She was re-referred due to concern regarding low weight and absence of menstruation.
K was ambivalent regarding involvement in a specific therapy but did consent initially to attend for weight monitoring and further discussion.

Intervention

- K attended sessions of cognitive-behaviour therapy with clinical psychologist.
- Weight monitoring completed on weekly basis.
- Liaison with consultant paediatrician at Wexham Park Hospital with regard to medical monitoring.
- Liaison with paediatric dietician regarding diet plan.
- Joint discussion completed with young person and family members with consent from young person.

Outcome

- Weight monitoring initially indicated consistent weight over year long period.
- BMI continued to be below average range for age.
- Young person continued to be ambivalent regarding engagement with CBT, changes in diet and small further reduction in weight observed.
- Liaison with Tier 4 Eating Disorder service results in referral to BAS Eating Disorders programme.

Case Study 3

Background

R is a 17year old male who was initially referred to CAMHS in 2009 following a suicide attempt and again in 2011 for the same reason. He had been successfully treated with CBT in the past and had also been prescribed fluoxetine but that had been stopped in September 2012 as his mood had been stable for 12 months.

R was re-referred in August 2013 with low mood, suicidal ideas and parental concerns around the use of drugs. His mood had been low since the beginning of the year, triggered by a realisation that his decision to leave school was probably wrong and that he was not happy in his job. As his mood had gradually been getting lower R had started using drugs (mephedrone, cannabis) on a weekly basis.

Intervention

Referral received in CPE on 12/8/2013 and passed to Bracknell Specialist Community Team

Urgent telephone call received from R's mother on 13/8/2013. This was handled by the SCT Duty Clinician

Urgent appointment arranged for 16/8/2013 at which the following action was taken:-

- Referred to Drug & Alcohol Team
- Referred to Connexions
- CBT to be provided by CAMHS psychologist
- Referred for CAMHS Psychiatrist for medication review (GP had restarted Fluoxetine)
- Risk assessment carried out. No suicidal intent. Out of Hours emergency contact information provided for family.

R reported missing by parents on 19/8/2013. Police called.

Over the next few days, R goes missing several times. His family express concern re his capacity to make decisions in his own best interest and risks are identified wrt potential loss of home if R continues with substance misuse, theft from family and absconding.

CAMHS involved in significant liaison with Children's Social Care, Thames Valley Police and the Drug & Alcohol Service with regard to risk to R and his capacity to make decisions in his own best interest.

Tier 4 CAMHS placement identified. R agrees to admission however expresses a wish to remain in a local in-patient unit and a preference to be treated in an adult facility. This is agreed on the basis of the closeness of his 18th birthday.

R admitted to Ward 12 under the Admission of Minors Policy on 22/8/2013

Outcome

R transferred to the Berkshire Adolescent Unit for in-patient care on 28/8/2013

Appendix 4 CPE Paper to CAMHS Strategic Partnership Board

CAMHs Partnership Board

Update : Common Point of Entry_July 2013

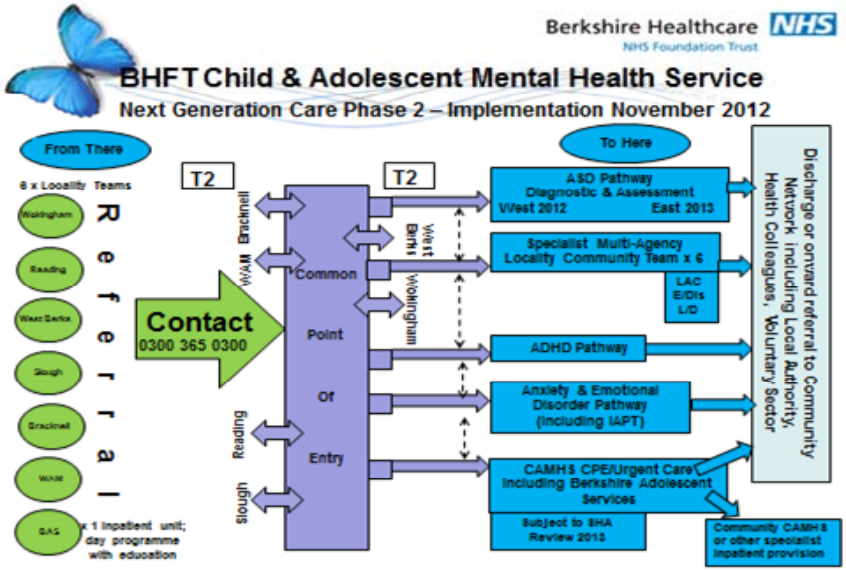
BHFT CAMHs – Common Point of Entry

The BHFT CAMHs Common Point of Entry (CPE) was formerly implemented on 19th November 2012 in line with the CAMHs Next Generation Care redesign and implementation roll out.

The function of CPE is to act as:

- (a) First point of contact for all referrers and referrals in respect of CAMHs.
- (b) Initial triage and assessment to ensure the child and/or young person is either signposted to most appropriate service outside of BHFT CAMHS provision or directed to the most appropriate care pathway.

From There to Here:



Establishment

Full establishment for CPE = 9wte: current 8wte recruited with full established to be achieved by 30th September 2013. This will enable a consistent approach to be developed in respect of approach to triage, local knowledge and where necessary initial assessments. Further it will enable a coherent approach to be further developed with adult services in respect to urgent care and presentation at both the local acute hospitals.

Referrals

Referrals into CAMHs via CPE has increased by approximately 30 % an additional increase of 20% over the last 12 months. In Q1 actual number received 121 compared to Q1 (2012) actual 919. In parallel to this there has also been a considerable increase in the number of 'urgent' crisis self harm or risk of self harm referrals that have required a response within 24 hours.

Breakdown by localities and CCG

New referrals received

	2012		2013							Grand Total
LA_Band	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Bracknell Forest	40	48	54	42	61	40	55	52	32	**424**
Reading	31	48	38	76	62	72	95	83	69	**574**
Slough	33	47	54	44	51	36	52	64	51	**432**
West Berkshire	52	70	65	50	85	80	84	78	70	**634**
Windsor and Maidenhead	24	63	59	66	74	41	58	59	57	**501**
Wokingham	41	56	62	78	64	71	64	72	67	**575**
OOA	10	17	11	15	22	11	29	13	14	**142**
Grand Total	**231**	**349**	**343**	**371**	**419**	**351**	**437**	**421**	**360**	**3282**

Number of referrals received into CAMHs CPE from the 14th November 2012 to 22nd July 2013 by Local authority. OOA – Out of area home address but have a Berkshire GP.

	2012		2013							Grand Total
CCG_Band	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
NHS BRACKNELL AND ASCOT CCG	45	53	66	50	69	46	68	52	39	**488**
NHS NEWBURY AND DISTRICT CCG	37	55	50	34	68	55	63	47	47	**456**
NHS NORTH & WEST READING CCG	20	31	32	45	49	41	53	64	56	**391**
NHS SLOUGH CCG	32	50	51	45	47	37	53	62	53	**430**
NHS SOUTH READING CCG	27	43	26	55	37	63	68	52	41	**412**
NHS WINDSOR, ASCOT AND MAIDENHEAD CCG	22	58	54	61	73	40	56	56	54	**474**
NHS WOKINGHAM CCG	37	50	53	75	63	66	60	73	63	**540**
OOA	11	9	11	6	13	3	16	15	7	**91**
Grand Total	**231**	**349**	**343**	**371**	**419**	**351**	**437**	**421**	**360**	**3282**

Number of referrals received into CAMHs CPE from the 14th November 2012 to 22 July 2013 by CCG. OOA – Out of area GP but have a Berkshire home address.

Deliberate Self Harm

Team	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Total
East	8	6	10	7	12	1	10	7	18	79
West	10	7	9	14	16	16	18	24	11	125

Number of deliberate self-harm referrals received into CPE. All are seen within 24 hours of referral being made. The number of urgent deliberate self harm referrals has increased to on average one a day across Berkshire.

DSH Locality	Total
Bracknell	11
Out of Area	19
Reading	69
Slough	36
WAM	26
West Berks	18
Wokingham	25
Grand Total	**204**

Audit highlights that an awareness and access to CPE has led to an uptake in contact with the service especially by GP's.

Re-organisation and the cessation of some Local Authority T2 services has also impacted in the rise of referrals. This has also had an impact on signposting, where applicable to appropriate Local Authority T2 provision. This combined with usage of agency and locum staff at CPE has contributed to the variable quality of assessments. Further signposting to more appropriate services for children and young people particular needs.

In June – July 2013 focused approach has been made to re-establish and strengthen links with Local Authority T2 provision as well as the voluntary and independent sector. This has led to a rise of referrals signposted to other services post triage and/or assessment to 27%.

Children awaiting initial triage or first assessment.

20/07/2013	0-4 weeks	05-13 weeks	14-18 weeks	>18 weeks	Grand Total
CAMHs CPE	141	54	6	5	206
Grand Total	141	54	6	5	206

Number of CYP awaiting triage or first assessment. All referrals more than 14 weeks have an assessment appointment booked.

Signpost destination

Signposted destination 17/07/13	Total
Adult CPE	1
ARC	2
Assist	1
Autistic Society	2
Behavioural Services	28
Back to referrer/GP	162
CAF	2
Family Counselling	1
Health Visitor	2
ICP - Integrated Care (Bracknell)	4
Learning Disability	1
No 5 Counselling	1
Out of Area	2
Paediatrics	10
Parenting	3
Reading CAT North	16
Reading CAT West	17
Reading CATSouth	8
Relate	3
School Counsellor	4
Slough Early Help (Wellbeing & Mental Health)	14
Talking Therapies	3
Tier 2 Service	21
YOS	1
Youth Counselling	24

In respect of numbers, the largest number of referrals into the service has remained consistent with the overall thematic of CAMHs referrals in Berkshire i.e. Reading and West Berkshire children constitute the two largest groups referred to CAMHs for a service; predominantly ADHD and ASD in boys aged between 10- 15years. A change in the overall referral pattern is that whereas previously there has been a 50- 50 split between gender, a significant number of boys rather than girls are referred to CAMHs. This may reflect the decline in socio economic conditions for many families in the county exacerbated by the gap or cessations of T2 options in some areas i.e. counselling, connexions, behaviour support and the introduction of “traded services” in schools.

Consideration

CPE has been successful in working to be the common place for first point of contact with CAMHs.
A review of both access criteria and application of criteria to T3 service needs to be undertaken as part of the CPE team development plan.

Further work need to be undertaken with partners to ensure consistency of signposting to agencies where appropriate for T2 and T1 services through the enlivenment of local ‘ patch’ meetings, shared training and opportunities to work in partnership.

On-going quarterly review to update and track the child journey through the CAMH service and or where the child ‘s needs have been assessed as being best met from another service.

Cb/July/2013