



Children and Young People's Mental Health and Wellbeing Local Transformation Plan 2018-2020

Bristol

October 2018 Refresh

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1. Introduction

In summer 2015, the Departments of Health and Education published a joint five year strategy 'Future in Mind'¹ to transform services for children and young people's emotional health and wellbeing.

In response we published a comprehensive transformation plan for Bristol; refreshed each year in order to update in relation to key achievements and proposed activity as we work towards the provision of a joined-up and comprehensive approach to children's mental health across the City.

Our vision for 2015 to 2020 remains to ensure that every child, everywhere, receives the right support, as early as possible via a whole system, whole City approach to emotional health and wellbeing. Much broader than just Children and Adolescent Mental Health Services (CAMHS), this includes working with schools, the local authority, universal and primary services such as GPs and school nurses, as well as the voluntary and community sector.

In July 2016, NHS England published 'Implementing of the Five Year Forward View for Mental Health'². This guidance identified new areas for us to focus on and this has again been included in our plans for 2018/19. This plan does not include our work on perinatal mental health, as that is covered elsewhere.

In April 2018, NHS Bristol Clinical Commissioning Group (CCG) merged with NHS South Gloucestershire and North Somerset CCGs to form Bristol North Somerset & South Gloucestershire (BNSSG) CCG. Our Bristol LTP links closely with our local BNSSG Sustainability and Transformation Plan (STP) and contributes to the Integrated Assessment Framework. The key headlines are:

- Priority across BNSSG to improve access and waiting times for children and young people who need evidence based interventions for diagnosable mental health conditions, providing parity of esteem with physical services.
- Building resilience through the delivery of training to non-specialist workforces to improve capacity and capability to support children and young people in community settings
- Services are part of the children and young people's Improving Access to Psychological Therapies Collaborative, but this needs to be developed in both specialist and wider children and young people's workforce

¹https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

²<https://www.england.nhs.uk/mentalhealth/taskforce/>

- Work towards a sustainable 24/7 urgent and emergency mental health service
- Provide community eating disorder services, compliant with access targets and independently accredited
- Improve access to and quality of perinatal and infant mental health care
- Deliver improved access to mental health support to children and young people at risk of or in the early stages of criminal justice involvement.
- Ensure data quality and transparency - increase digital maturity to support interoperability of healthcare records

The STP plans on a page relating to this area of work can be found in Appendix 1.

From April 2017 we have had a new contract for community children's health services led by Sirona with Avon Wiltshire Partnership delivering the CAMH and Off The Record services. The new service specification was informed by:

- Around 900 young people
- Over 300 parents and carers
- 19 schools
- 38% of those we spoke to were from the Black Minority Ethnic community
- 21% were from 'seldom heard' communities
- 61% were females and 39% were males

We have spoken to people with different protected characteristics from communities such as Gypsy Roma Travelling (GRT), Black Minority Ethnic, Polish, Somali, faith groups and those with sensory impairments

The emphasis on participation continues in the new service developments including expanding sessional and performance review feedback and supported by the new participation contract with Barnardos. In addition, we continue to work closely with Off The Record's campaign group Mentality along with the Youth Council and Freedom of Mind Community Interest Company.

Recent feedback from young people and their families report that the CAMH service is non-stigmatising, accessible and delivered in a joined up way with other services for young people. From 2017/18 Experience of Service Questionnaire responses:

I feel that the people who have seen me are working together to help me – 90% (243/270)

I feel that the people who saw me listened to me – 94% (255/270)

I was treated well by the people who saw me – 92% (257/270)

My appointments are usually at a convenient time (e.g.; don't interfere with school, clubs, college, work) – 87% (234/270)

There are agreements in place regarding sharing out of hours support with Tier 4 inpatient provision. Our evidence-based Early Intervention Psychosis service is available for all children and young people with Early Intervention Psychosis (EIP) taking the lead from age 16 and CAMHS taking the lead under 16.³

There are monthly performance meetings for the new contract with Local Authority and Clinical Commissioning Group commissioners; all NHS commissioned CYP mental health services are outcome commissioned (CAMHS, OTR, Kooth). Our Children and Young People's Local Transformation Plans are progressed across Bristol, North Somerset and South Gloucestershire (BNSSG) through our BNSSG STP/Emotional Health Transformation meetings.

The Mayor of Bristol, Marvin Rees has continued to make the emotional wellbeing of children and young people a priority. It is also one of four priorities in Bristol's Strategy for Children, Young People and Families 2016⁴ – 2020. In addition, the Youth Mayors have included reducing stigma and focusing on male mental health as part of their manifesto⁵. The recently updated JSNA chapter on children's mental health⁶ is being used to inform Public Health and wider system work via the development of an all-age mental health strategy, an important aspect of our whole-city Thrive approach⁷. The all-age strategy includes a dedicated 0-25 years' strand, the development of which is being supported by the Centre for Mental Health. The JSNA references various groups of children more at risk of mental health issues and inequalities such as those who have been abused or neglected. This is an opportunity to build on our work to date and ensure a wide range of stakeholders are also involved with the development of this programme of work.

³ NHS England feedback on 2016/17 LTP requested more details about EIP in the 2017/18 LTP: In 2017/18 the EIP service supported 4 under 16s and 12 16 – 17s in Bristol.

⁴ www.bristol.gov.uk/cyf

⁵ https://www.bristol.gov.uk/en_US/youth-council-youth-mayors

⁶ <https://www.bristol.gov.uk/documents/20182/34748/Children+and+Young+People+Mental+Health+report+March+2017/0d364755-31a1-7d6e-0512-4eacdb3231e0>

⁷ <https://www.bristol.gov.uk/mayor/thrive-bristol>

This transformation plan has been developed with the involvement of the Health and Wellbeing Board, the Children and Families Board and the Joint Health Outcomes Challenge sub-group and the TCP Steering Group. Relevant reports are taken to the Bristol Children's Safeguarding Board. We also work closely with colleagues across the region and play an active part in the Strategic Clinical Network. Nationally we learn from other areas with similar issues or that have implemented innovative ways of delivering services.

We will keep engaging with a variety of stakeholders to develop our plans over the course of the programme, which runs until 2020.

Healthier Together

- We have 10 Healthier Together priority Programme areas, including an all age Mental Health Strategy and Integrated Community Localities Programme, of which Locality Transformation is a core component.
- Children & young people's mental health needs and services are being addressed across these programme areas. Healthier Together recognises the significance of the opportunity to improve outcomes and experiences for patients and staff in this area.
- Core themes emerging from our all age BNSSG Mental Health Strategy include;
 - Developing an all age strategic framework with partners to underpin all aspects of mental health and wellbeing within BNSSG - including improving access and reducing variation
 - Ensuring that our mental health services are comprehensively integrated with wider health and social care services and can respond to changing needs
 - Ensuring that current and planned changes to mental health services, change programmes and planned investments work for the BNSSG population
 - Re-focusing our efforts towards prevention, early intervention and resilience with a specific emphasis on children and young people
 - Identify opportunities to improve physical health outcomes and reduce activity in non mental health services by taking a psychologically informed approach to the delivery of services.

2. What have we achieved since our last transformation plan in 2017/18?

We have continued to develop, build on and implement our programme of transformation since we published our last transformation plan refresh in October 2017⁸. This has built on our work since 2015 and supports our vision of ensuring that every child, everywhere, receives the right support, as early as possible.

In September 2017, Bristol was one of the ten areas chosen for inspection by the CQC as part of a Thematic Review of whole-system CYP mental health services. Chosen due to the work undertaken by Bristol in relation to the roll out of CASCADE (CAMHS & Partnership) Training to 94% of schools, learning was used to inform the *Transforming children and young people's mental health provision* Green Paper published in December 2017.

Our May 2016 survey of schools informed us that schools either deliver or commission the following:

What's happening in Bristol schools?

Primary:

- Play Therapy
- SEAL
- Mindfulness
- Restorative Justice
- Nurture
- Thrive
- Friends
- Mentoring
- Lego Therapy
- Pastoral Support Team
- Family Link Worker
- Learn Together
- Educate together
- Core Skills inc. Edison
- Conflict Resolution
- JIGSAW
- Behavioural Support
- Consultation and supervision around cases
- Educational psychology
- Group Counselling
- Individual Counselling
- Learning Mentor
- Parent Support Advisor
- Parenting Programme
- Staff training
- Staff wellbeing support
- Thrive training

Secondary:

- MAST
- Anxiety Groups
- Butterfly therapy
- SEAL
- Mindfulness
- Restorative Justice
- Nurture
- Thrive
- Friends
- Behavioural Support
- Consultation and supervision around cases
- Educational psychology
- Group Counselling
- Individual Counselling
- Learning Mentor
- Parent Support Advisor
- Parenting Programme
- Staff training
- Staff wellbeing support
- Thrive training

Children & Families Partnership

BRISTOL CITY COUNCIL

NHS Bristol Clinical Commissioning Group

Work with schools has progressed as follows:

Work with Schools

Following CASCADE (CAMHS & Partnership) Training which was commissioned and successfully rolled out to 94% of Bristol schools, including

⁸<https://www.bristol.gov.uk/documents/20182/305531/CYP+Emotional+Health+and+Well+Being+Transformation+Plan+refresh+2017+to+18/455cdb91-2433-4bf8-8b7e-5bebd97bc60f>

special schools, between January and May 2017 there have been a number of sustainability initiatives and development opportunities put in place to support schools in relation to their emotional health and wellbeing work:

Mental Health Area Network Meetings were set up in consultation with schools. The networks, facilitated by Public Health colleagues, aim to support the ongoing development and sharing of good practice across education settings. They are run termly (3 times per year) and on a locality basis across North, South and East Central Bristol. As well as Mental Health Leads, the Networks are also attended and supported by other professionals such as CAMHS Primary Mental Health Specialists, Early Help (Families in Focus staff) and beyond. Over 80 people attended the second round of meetings and feedback has been consistently positive.

The newly launched **Public Health Bristol Healthy Schools' Award Mental Health & Wellbeing Badge** has been well received by Bristol schools who are encouraged to sign up and work towards achieving the badge which is focussed around a 'whole school approach' to mental health. It is comprised of a set of standards, developed in partnership with Bristol schools and in line with Public Health England and NICE guidance. The award is part of a wider Bristol Healthy Schools award and is endorsed by Bristol's elected Mayor. Thirty-four schools are actively working towards the badge and forty have registered their interest. Eight schools have achieved the award with one of these having achieved the advanced level.

The 10 Heads of Wellbeing from Bristol primary, secondary and special schools residing in the most deprived areas of the City are coming to the end of their pilot year. Headlines are as follows⁹:

- In the majority of pilot schools the role will be continuing; two of the academies have created a trust-wide lead for mental health.
- As of the end of the academic year 2017/18, half of the pilot schools have achieved the Mental Health & Wellbeing Badge. The remainder are due to submit early in the next academic year.
- Across the schools a vast number of interventions and activities have been initiated and implemented; anti-bullying programmes, positive behaviour management and reward systems, whole school activities to celebrate diversity and tackle racism, the development of more robust systems to identify and support children who need additional input, the delivery of evidence based interventions, etc.

⁹ NHS England feedback on 2016/17 LTP requested the detail of progress against the Heads of Wellbeing Pilot in the 2017/18 LTP.

The pilot will be fully evaluated by Bristol Educational Psychologists. In the meantime, emerging practice is being disseminated via the Schools' Mental Health Networks during May and Nov/Dec 2018 meetings.

Key factors impacting upon the role can be summarised as follows:

- The size and structure of secondary settings pose challenges to establishing/embedding the role.
- The ability of the professional within role to lead and influence a whole school approach is influenced by their status, prior experience, knowledge and skills.
- Senior Leadership Team buy-in is key to the success of the role.
- The current school context is very challenging with factors such as staff capacity issues and stress levels impacting upon the success of the role. In two of the settings, the person in the role has changed over the course of the pilot.

Primary Mental Health Specialists from CAMHS continue to work with schools (including BESD) to provide training, consultation and some direct work and our newly commissioned providers of 11-18 counselling (Off The Record) and online provider (Kooth) are working closely with schools in the City (see below).

New CAMHS referral pathways which have allowed schools to directly refer in to the service have been in place since Autumn 2017 with new arrangements being closely monitored.

In December 2017, commissioners along with colleagues from Public Health and CAMHS presented at Public Health England's South-west Mental Health in Schools Masterclass, detailing our transformation journey across schools and the wider system. In June 2018, commissioners presented at the University of Manchester's Institute of Education's inaugural conference entitled Mental Health & Education: Building Relationships to share information and learning about the whole-system approach to CYP mental health transformation in Bristol.

Progress of work across other aspects of the system is as follows:

- **Online Directory**

Published in June 2017, our Online Directory for 0-25 year olds, their families, carers and professionals has undergone its first refresh in following consultation with stakeholders, including young people earlier this year.¹⁰

- **Training**

Between 2015 and 2018 we made significant investment to ensure the additional capacity and capability of the Bristol workforce in order to support the principles of prevention and early intervention. Previous plans give details of the following training:

- 402 social care and early help (Families in Focus) staff; emotional trauma with a focus on self-harm and suicidal ideation.
- 48 school nurses, sexual health nurses & Youth Offending Team practitioners; Mental Health First Aid (MHFA) Training.
- Incredible Years Parenting Courses; 22 practitioners trained with 16 going on to deliver courses. 86 parents completed the evidenced-based programme via a total of 12 courses.
- 126 Youth Workers trained in Youth MHFA.
- 115 Children's Centre staff received training in 2016/17 with sharing undertaken across the wider networks.

Further progress has been made since our last LTP refresh:

An additional Incredible Years parenting course was delivered in Autumn 2017 as part of the original commission outlined above; a total of 100 parents trained over a total of 13 courses.

The first wave of Youth Mental Health First Aid courses to Youth Workers across the City resulted in high demand. Additional funding allocated has ensured sustainability of approach with the training of two staff as part of a MHFA train the trainer programme. To date, those trained have delivered 2 x 16 hour courses to Families in Focus team (Early Help) and to faith-based Youth Workers; 32 people in total. The two trainers will also go on to become MHFA Lite trainers allowing them to offer a menu of training options in the future.

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https://media.bnssgccg.nhs.uk/attachments/Emotional_health_and_wellbeing_directory_FINAL_2018_1HObjhB.pdf

Bristol CCG and the South West Strategic Clinical Network Innovation Fund funded Off The Record to develop open access drop-ins (called Youth Hubs) each week in both established premises and on a pop-up rotational basis in local youth and community settings. This project built upon and expanded existing support which combines quality participation (hubs are co-delivered by OTR Engagement staff and trained Peer Navigators aged 18-25) with information, signposting, psychological education and wrap-around specialist support (including counselling, creative therapies, IAPT and CYP-IAPT therapies, group work, online therapies, and specialist youth groups for issues of gender and sexuality as well as race and ethnicity). Activity covered the period December 2017 – May 2018 and focussed on the following outcomes:

- More CYP can access flexible, responsive and open Youth, Information, Advice and Counselling Services (YIACS) within their local communities
- Reduced demand on primary and secondary care services (including reduced CYP hospital admissions for mental health conditions and self-harm; reduced A&E attendances)
- Improved support for young people with emotional wellbeing and mental health needs
- Increased number of CYP in crisis responded to in community settings (away from A&E)
- Improved outcomes for vulnerable and disadvantaged CYP

In addition, the following, which was not funded from the CYP Emotional Health Transformation fund, has been supported over the life of Transformation to date:

- 24 secondary school staff trained in MHFA as part of first wave of a three year Government pilot to ensure at least one member of staff trained in all secondary settings.
- All Children's Centres have accessed professional development with 'Five to Thrive' – supporting healthy attachment and emotional development in the earliest years <https://www.fivetothrive.org.uk/>
- The pre-natal Mental Health HIT is strengthening pathways for new parents who may be experiencing mental health challenges
- Children's Centres also work with Bluebell and commission Rockabye – a programme that promotes the formation of secure attachment.

- Four Children's Centres host Drop-In Services for Gypsy, Roma and Traveller (GRT) families, working with a dedicated Health Visitor. Over 300 GRT families have accessed Health Services for the first time through this route
- Children's Centres play a key role in Bristol's strategy to support children affected by parental imprisonment (CAPI)
- Strengthening the Circle' training, funded by Health Education England has recently been delivered in Bristol. This training aims to strengthen the skills, confidence and competence of the joint agency non-specialist workforce – those who provide the circle of support around individual vulnerable children and young people.

Additional whole-system developments have also been made during the course of transformation:

- **Online counselling and support**

Our online counselling and support service for all 11-19 year olds in Bristol www.kooth.com continues to be well utilised having been widely promoted across secondary schools and colleges by an Involvement and Participation Worker. From the 1st April 2018 the service forms part of the Community Children's Health Partnership and has fully integrated care pathways with Off The Record and CAMHS.

Within Off The Record there are 6 qualified Psychological Wellbeing Practitioners¹¹ (PWPs) posts and 3 who are currently in training until March 2019. All work to a strict referral criteria and are supervised by trained supervisors who have been through the CYP-IAPT programme in Exeter. The PWP build relationships with schools and utilise physical space, safeguarding leads and other school staff in order to support referrals for young people who would benefit from short term, low intensity Cognitive Behavioural Therapy (CBT) interventions. Referrals are for young people with low mood and anxiety along with a range of other presentations. The work, which is short-term and focused on self-care and home practice, is young person centred and driven by the desire to reach young people where they are before the issues they are experiencing become entrenched and problematic.

- **Working with GPs and primary care**

¹¹ The Health Education England led programme to create Psychological Wellbeing Practitioners is a response to the target for offering an evidence based intervention to 70,000 more children and young people annually by 2020, by training up 1700 new staff in evidence based treatments, outlined in Implementing the Five Year Forward View for Mental Health. These posts will enhance services, to ensure they are equipped to see children and young people who wouldn't otherwise reach local thresholds for CAMHS; they will be distinct roles, not assistants to existing therapists or working from specialist settings.

The information available on the GP referral support tool has been reviewed and updated. This provides GPs and other primary care staff with information on how to signpost and support children and young people and their families to a wider range of services and resources than just those commissioned by the NHS. It also includes a link to our newly refreshed online directory, first published in June 2017¹².

A crisis risk screen tool which was developed by CAMHS and GPs is also included. This supports GPs in assessing children and young people who present in mental health crisis and in providing an appropriate level of response.

- **Self-harm**

Self-harm is a manifestation of emotional distress rather than a primary disorder. Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the motivation or intent¹³. Rates of self harm among Young people in Bristol are high, with a hospital admission rate of 608.6/100,00 among 10-24 year olds in 2016/17 compared to a rate of 404.6/100,000 among 10-24 year olds in England, and 185.3/100,000 for all ages in England¹⁴. Risk factors for self-harm include socio-economic disadvantage, being socially isolated, stressful life events, mental and physical health problems, and alcohol or drug misuse.¹⁵

The Partnership Outreach Service (CAMHS/Off the Record/UHB/Families in Focus (Early Help) commenced in Sept 2015 as a pilot. This service and the Central Intake Team provided assessments for children who presented with urgent mental health needs primarily to the Emergency Department and provides an outreach service for those not engaged in a service. The pilot has since been fully evaluated and these two teams merged to form the CAMHS Triage, Assessment and Outreach (CTAO) Team. GPs are now referring to this service rather than the child presenting to the Emergency Department.

The CTAO Team triage referrals and see all young people who present in crisis at the hospitals and who require urgent appointments following referral. The service has recently extended the hours of provision to 8am-10pm weekdays and 9am-5pm at weekends. The team provides limited outreach

¹²

https://media.bnssgccg.nhs.uk/attachments/Emotional_health_and_wellbeing_directory_FINAL_2018_1HObjhB.pdf

¹³<https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1/pat/15/par/E92000001/ati/6/are/E12000004/iid/21001/age/1/sex/4>

¹⁴<https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/0/gid/1938133090/pat/6/par/E12000009/ati/102/are/E06000023/iid/92796/age/7/sex/4>

¹⁵

[https://www.bristol.gov.uk/documents/20182/34748/Children+and+Young+People+Mental+Health+report+Mar](https://www.bristol.gov.uk/documents/20182/34748/Children+and+Young+People+Mental+Health+report+March+2017/0d364755-31a1-7d6e-0512-4eacdb3231e0)
[ch+2017/0d364755-31a1-7d6e-0512-4eacdb3231e0](https://www.bristol.gov.uk/documents/20182/34748/Children+and+Young+People+Mental+Health+report+Mar)

work through Off The Record staff who require additional supervision and routinely work alongside a qualified member of staff.

Recently agreed transformation funding will further support the expansion of this service¹⁶. Nationally and locally the number of young people presenting in crisis has significantly increased. This data has only been captured accurately since 2017; it is therefore difficult to review trends. The number of children accessing these services has increased across Bristol and South Gloucestershire from 315 in 2014 to 364 in 2015 and 391 in 2016 and 456 in 2017/18.

The initiatives above all aim to contribute to reducing self-harm but nationally it is increasing due to a range of issues including the impact of social media.

As outlined above, suicidal ideation and self-harm training was run for social care and Families in Focus staff to support increased confidence, capacity and capability in relation to early identification and to enhance the support of Practice Leaders within the teams. Practice Leaders are still developing an assessment tool and are clear about their roles:

- Leading on practice
- Equipped in completing initial assessments of a child or young person's health and social care needs
- Producing the assessment tool
- Developing and supporting safety plans and risk assessments with children, young people and their families.
- Mentoring staff
- Offering a network of support
- Sharing knowledge and skills within their service
- Linking with multi-agency partners when required.

- **Health & Justice**

The review of mental health support for children and young people involved in the criminal justice system¹⁷ prioritised 3 areas for BNSSG:

- Additional mental health support embedded in the YOS

¹⁶ For further details of additional CCG investment, please see Section 4. Where are we now?

¹⁷ NHSE (2016) Review of Health and Justice Pathways for the CAMHS Transformation NHS England South (South West and South Central); A,Hewitt.

- DBT provision – supporting CYP with Trauma
- Specialist speech and language therapy (SALT) for CYP in the community and secure care home Vinney Green

The speech and language therapy (SLT) service into Youth Justice was set up June 2017 following a successful bid for funding by the South Gloucestershire Clinical Commissioning Group to NHS England. The recurrent funding provides SLT for 4 days a week into South Gloucestershire Youth Offending Service, Bristol Youth Offending Service and Vinney Green Secure unit.

Delivery of Trauma and Recovery training as part of an Enhanced Case Management approach has been undertaken by professionals from the Youth Offending Services and multiagency professionals who work with CYP with criminal justice system involvement.

From Spring 2018, the Bristol YOS have directly employed a Primary Mental Health Specialist working within Bristol’s multi-agency Families in Focus (Early Help Team). The role is still in its infancy with the post-holder working with a variety of organisations and professionals to clarify priorities and approaches to this sensitive area of work.

Forensic CAMHS for Bristol is provided by Oxford Health covering South West ‘North’. Care pathways are outlined within the attached service specification at Appendix Four.¹⁸

3. What are we planning in 2018/19 and beyond?¹⁹

Improving Access

The Five Year Forward View for Mental Health (MH5YFV) highlights children and young people as a priority group. It highlights the importance of prevention at key moments in life, mental health promotion and commits to “by 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it”. A recent Healthwatch report, the result of capturing the views of residents in Bristol, North Somerset and South Gloucestershire who had used CAMHS in the last 12 months, recommended that wait times be reduced in order that young people can access the service as quickly as possible.

¹⁸ NHS England feedback on 2016/17 LTP requested information re. pathways for CYP in contact with health and justice in relation to specialised commissioning in the 2017/18 LTP.

¹⁹ NHS England feedback on 2016/17 LTP requested inclusion of sustainability plans beyond 2020 (future work/planning) in the 2017/18 LTP.

The *2017-2019 NHS operating planning and contracting guidance*²⁰ stipulates:

- More high quality mental health services for children and young people (32% of children with a diagnosable condition are able to access evidence-based services by April 2019).
- Commission community eating disorder teams (95% of children and young people receive treatment within four weeks of referral for routine cases and one week for urgent).

There is a national ambition that by 2020/21, at least 35% of children and young people with a diagnosable mental health conditions receive treatment from an NHS-funded community services. This data is currently reported to NHSE every two weeks.

In addition there is other activity; for example, voluntary sector activity along with any work happening in schools. For example, it is acknowledged that some schools employ their own counsellors, learning mentors and family support workers. In addition, we know that schools also commission services to support mental health, often from the rich mix of VCS organisations within the City. However, within the current environment of challenging school finances we are aware that these additional pastoral resources and commissions cannot be considered secure and may, in many cases, be reducing. However, Local Authority Early Help services are being remodelled and will include a Team around the School (TaS) approach which is outlined in further detail below. In addition, we are also developing an all age mental health strategy which will link in with the developing work resulting from CAMHS i-Thrive, both of which are also detailed below.

We aim to continue to improve the level of access to NHS funded services. We are awaiting publication of the results of the 2018 ONS survey which will provide updated national prevalence data. We expect to see prevalence rates rise which would affect the number of children that services would be expected to treat in order to achieve the 2018/19 access target of 32%.

In 2017/18 we achieved NHS England's access target whereby 30%²¹ of children and young people with a diagnosable mental health condition received treatment from an NHS-funded community mental health service. This is based on our activity figures from our providers (CAMHS, Off The Record, www.kooth.com). The percentage is calculated based on figures for our child and young people population in Bristol using data from the refreshed

²⁰ <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf>

²¹ NHS England feedback on 2016/17 LTP requested inclusion of performance figures against access and waiting times in the 2017/18 LTP.

JSNA chapter on children and young people’s emotional health and wellbeing, as referenced elsewhere within our LTP. MHSDS data is flowing from Bristol CAMHS and Off the Record already and will be from Kooth following a national data flow solution which is in development and should be available in October.

The new access times are being monitored as part of the Key Performance Indicators within the new service specifications with the aim of reducing Emergency Department Crisis referrals to be seen within 2 hours, urgent referrals to being assessed within one week and routine within 4 weeks.

Commissioners work closely with the Children and Young People’s Programme Manager within the South West Strategic Clinical Network to ensure adherence national and local expectations with regard to data recording and reporting. This also involves participating in regular webex/teleconference sessions and attending regional training and information sessions as required. Monthly meetings are in place with the lead provider to monitor the scorecard performance data of CAMHS, Off The Record and Kooth and to ensure they are up to date with data reporting requirements.

Following a recent demand and capacity analysis undertaken by our CAMHS provider, the following posts are required in order to support demand within urgent and crisis care:

Service	WTE	Banding	Cost
CTAO	6.20	3 x band 5, 3 x band 6	£220,180
Eating Disorder Team	4.20	2 x band 4, 2 x band 7	£155,187

Recently negotiated transformation funding will support achievement of trajectories. Agreed milestones are detailed in a recently developed Gantt chart.

In terms of access waiting times, the percentage of patients seen in month within 18 weeks was 82.5 % in 2017/18. The increased funding will support the service to reduce waits, as will the ongoing implementation of the i-Thrive model.²²

A Psychiatry Liaison BNSSG project relating to 16 and 17 year olds was completed to increase clarity and more alignment of pathways across

²² NHS England feedback on 2016/17 LTP requested inclusion of performance figures against access and waiting times in the 2017/18 LTP.

BNSSG. There has been training for adult Emergency Department staff. The pathways will be reviewed with future investment.

A joint CQUIN is in place regarding improving Transition. A Transition protocol has been developed and is being implemented and monitored quarterly against four key milestones across CAMHS and AMHS:

- Sending provider to undertake Casenote Audit assessing those who transitioned out of CAMHS.
- Sending provider to undertake assessment of discharge questionnaires for those who transitioned out of CAMHS.
- Receiving provider to undertake assessment of post-transition questionnaires of those who transitioned to AMHS to CAMHS.
- Sending & Receiving providers to present to commissioners a joint report outlining overall CQUIN progress to date. Results to be submitted to NHS England via Unify2 Collection.

In Q4 2017/18, 18 young people transitioned out of community CAMHS teams during; 9 to the care of their GP and 9 into Adult Mental Health Services²³.

Remodelling of Local Authority Early Help Services

Bristol's Early Help (Families in Focus) offer is in the process of being remodelled with a focus on understanding and supporting Adverse Childhood Experiences (ACEs). At the heart of the approach will be a Team around the School (TAS) offer, recognising that existing knowledge of, and relationships with families, are key to improving outcomes for children and families. Key principles of this approach will be to:

- Refocus resources on prevention rather than crisis intervention.
- Strengthen multi-agency partnership working in localities.
- Identify options for support for children and young people who have additional needs but do not require specialist services, preventing difficulties escalating to crisis point.
- Provide an opportunity for early conversations to take place about children and young people where schools have concerns.

²³ NHS England feedback on 2016/17 LTP requested numbers of children transitioning from CAMHS to AMHS in the 2017/18 LTP.

- Support and engage with families more efficiently in relation to school related issues, identifying and removing barriers to learning and closing the gap for vulnerable groups in each locality.

Improve outcomes for children with SEND, ASD and severe behaviour problems.

Health Commissioners are working closely with the local authority on the quality and timeliness of mental health input into Education, Health and Care Plans and engaging strategically with community children's health SEND governance.

Following the undertaking of a needs assessment of Social Communication and Interaction Needs (SCIN) and autism, which included the views of parents, gaps in services were identified. A multi-agency deep dive workshop included parents, social care and education with health as part of a wider whole system review of services for children with autism and social communication and interaction needs. This workshop focussed on identifying the needs of those at risk of hospitalisation, home or out of area school or social care placements with a view to if and how these needs could be met locally.

Building on our Intensive Positive Behaviour Support Service for children with Learning Disabilities Bristol and South Gloucestershire CCGs and Local Authorities submitted a bid to NHS England as part of the Bristol, North Somerset and South Gloucestershire (BNSSG) Transforming Care Partnership Plan. The pilot is extending our Positive Behaviour Support Service to meet the needs of children and young people with ASD/ Asperger's without a moderate or severe learning disability in order to reduce out of area and costly social care and education placements, also hospital inpatients. Early indicators are encouraging and initial outcome information will be available in due course. Schools benefit from the modelling by the IPBS whose techniques are then used with wider groups of children.

New basic training relating to autism is being accessed by the wider workforce and more specialist training is being developed CAMHS as part of the Increasing Access to Psychological Therapies (IAPT).

In terms of the Families in Focus Team around the School (TaS) one of key areas will be to identify options for support for children and young people who have additional needs but do not require specialist services, preventing difficulties escalating to crisis point.

For children presenting in crisis who have Autism/LD, the Crisis Triage Assessment & Outreach (CTAO) team establish if there is a specialist team

already involved with the young person and, if so, liaise with them on how best to support. The options available would involve undertaking a joint assessment (utilising staff with LD/ASD expertise) or for the specialist team to lead. Decisions would be made based on what approach is in the best interest of the child or young person whilst liaising with the family in terms of previous input.

Integrated Personal Commissioning for Looked After Children (IPC LAC) Project

Bristol, supported by NHS England, is exploring new ways of working in a pilot known as Integrated Personal Commissioning (IPC). Looked-after children and care leavers aged 14-21 who meet specific criteria are being supported by way of small personal budgets to support equipment/activities aimed at improving their mental health and wellbeing. In relation to the small budgets, the project is currently working with 60 young people and has 40 live budgets with 20 at the referral stage. In addition, a small number of larger budgets have also been provided to support higher levels of need.

Those with early personal budgets are being encouraged to help shape the ongoing design of the project to ensure co-production with support provided by Barnardo's. Sustainability options are currently being explored in order to support the mainstreaming of the initiative.

Improve Data reporting²⁴

We are continuing to work closely with our providers to ensure comprehensive and high-quality data is submitted to the Mental Health Minimum Data Set²⁵. We are focusing on improving both the quality and quantity of the information available about service delivery and who is being seen. This intelligence will allow us to make more informed and transparent commissioning decisions in the future.

Develop new i-Thrive children and adolescent mental health model

Our new CAMHS providers are leading the development of this whole-system model with multi-agency partners. The model sets out four domains related to getting advice, getting help, getting more help and getting risk support. Children's mental health commissioners along with senior CAMHS managers have been closely involved in the development of Bristol's 0-25 mental health strategy to ensure the programmes, objective and subsequent outcomes are

²⁴ NHS England feedback on 2016/17 LTP asked us to report on the continued prioritisation of data access in the 2017/18 LTP.

²⁵ <http://content.digital.nhs.uk/mhds>

joined-up. Governance will include monitoring of outcomes at the Joint Health Outcomes Group.

The Bristol context is characterised by a strong and diverse VCS who play a vital role in supporting children's mental health through a wide variety of programmes, initiatives and interventions. Some of these are commissioned directly by schools whereas others are embedded within specific communities – both geographic and cultural. Taking a strategic approach to the development of system-wide mental health services for children and young people's mental health is key to the success of both i-Thrive and our mental health strategy work. Working this way will continue to support our ability to understand and find innovative ways to address emerging gaps in the system for all age groups.

Improve Eating disorders service

With recent increased investment we will have, an evidence-based community eating disorder services for children and young people will be in place across Bristol within the next year. We are working towards ensuring that 95% of children receive treatment within one week for urgent cases, and four weeks for routine cases.

New NICE guidelines for the treatment of eating disorders were published in May 2017²⁶. We will ensure that eating disorders services in Bristol reflect the recommendations made and underpin the joint service across Bristol, North Somerset and South Gloucestershire, working towards being Maudsley Model compliant.

All referrals for young people with suspected eating disorders are diverted at the point of referral to the Specialist Eating Disorder Service. They make contact with the family or young person within 24 hours, Monday to Friday, and arrange to see urgent referrals within one week and routine referrals within four weeks. Young people are usually assessed within the national waiting targets however the total caseload is increasing which makes delivering ongoing treatment more challenging.

Both Routine and Urgent targets have improved over 2017/18 year. In Qtr. 4:

- 100% of urgent CYP were seen within one week
- 90% of routine CYP were seen with four weeks²⁷

Our CAMHS provider has additional staff in post, funded by transformation monies. Recently secured additional transformation funding will support the

²⁶ <https://www.nice.org.uk/guidance/ng69/chapter/Recommendations>

²⁷ NHS England feedback on 2016/17 LTP requested inclusion of performance figures against access and waiting times in the 2017/18 LTP.

ongoing development of this team. They are continuing to develop a model of care that covers BNSSG and are a member of the Quality Network for Community CAMHS – Eating Disorders²⁸.

We also funded a research project with stakeholders to get a better understanding of how we can improve primary care for children and young people with eating disorders via Bristol Health Partners²⁹. This involved exploring with patients, their families and GPs how children and young people with eating disorders can best be supported by primary care providers.

Improve Crisis care and reduce inpatient treatment

We are working with colleagues in NHS England and across our Sustainability and Transformation Plan footprint to develop a collaborative plan for commissioning pathways including inpatient beds. The intention is to develop appropriate community services and potentially home treatment to reduce the need for inpatient admissions, especially in out of area facilities.

We developed an initial BNSSG wide collaborative commissioning plan with our local NHS England team by December 2016. Since then, we have engaged with NHS England to explore how we can develop and improve services further.

We are also working in partnership with the Local Authority, the police and hospitals to get a better understanding of the needs of children and young people in crisis, and identify if there are gaps in the services provided.

For more information about our CTAO, please see information outlined elsewhere within our LTP.

Develop the workforce

We continue to prioritise workforce development, as outlined within our LTP. In Bristol we are part of Wave 2 of the South West CYP Improving Access to Psychological Therapies (CYP IAPT) Collaborative Programme. Historically, this has included NHS Bristol making a financial contribution to the salary support costs of CYP IAPT training from our transformation funding. Again, additional CCG funding has been secured in 2017/18 to support the IAPT programme and ensure sustainability³⁰. Our CAMHS and Off The Record service are commissioned to be CYP IAPT compliant and we continue to promote and integrate the principles and values throughout the wider workforce. Aggregated routine outcome measures will be available in Sept to

²⁸<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/childandadolescent/communitycamhsgncc/qncc-ed.aspx>

²⁹ <http://www.bristolhealthpartners.org.uk/health-integration-teams/eating-disorders/projects-and-activities>

³⁰ NHS England feedback on 2016/17 LTP requested information regarding sustainability for CYP-IAPT in the 2017/18 LTP.

set as a baseline prior to agreeing trajectories of improvement. Feedback from CYP is gathered via the use of ROMs and used to inform ongoing therapeutic support. Parents/carers feedback is given via the Experience of Service Questionnaire. six months into treatment.

Demand and capacity modelling identified additional staffing needs and as a result investment has been made available through the Mental Health Investment Standard³¹. This will ensure a sustainable plan is in place beyond 2020. Additional investment has been provided to also ensure sustainability of IAPT. As a result of consulting with recent CAMH service users the recent Healthwatch report referred to above also outlined the need to improve staff understanding and attitude in order to ensure that patients feel listened to, treated with compassion, respect and kindness via the provision of holistic care. We will continue to work to ensure these standards are met via workforce development opportunities that influence both individual approaches and organisational culture.

The new BNSSG IAPT procured service will include the need to forge strong connections with, and referral pathways to and from those organisations which have embedded trained CYP Wellbeing Practitioners and work with 16 to 19 year olds, to ensure clear communications in relation to referrals and cross-service advice and support on young people's issues and treatments.

Specialist training, including trauma recovery model training for a range of practitioners in Bristol working with vulnerable and complex children and young people, such as those who have been abused or neglected, took place in Autumn 2017. This training was funded by NHS England Health and Justice Collaborative Commissioning.

Parenting support has been identified in the JSNA and will feature within the 0-25 strand of the all-age mental health strategy. Over the course of the next 2-3 years the LA aim to roll out a universal parenting programme called Parent Gym for all parents with children starting at primary school. The offer will consist of taking part in a 6 week parenting course hosted by their school as part of their journey through their child's education process. As a result it is hoped that their relationship with their child will measurably improve as will their confidence in their own parenting ability along with their mental wellbeing. It is hoped that the course will support the formation of friendships and will lead, in some cases, to parents meeting regularly in a parent-led support group. This will in turn support the establishment of the parent/school relationship, supporting future communications and boosting the school's community engagement. Parent Gym was independently evaluated by UEL in

³¹ NHS England feedback on 2016/17 LTP requested information regarding our continued prioritisation of workforce development, Identifying additional staff required (in addition to a workforce plan & CPD) in 2017/18 LTP.

2011, and Canterbury Christ Church University in 2012 – which found that two months or more after they had completed the programme 100% of parents interviewed reported that their relationships with their children had improved. Parent Gym has subsequently been independently evaluated by the University of Hertfordshire (2014) and the University of Warwick (2014 & 2016).

We are also rolling out MHFA training to primary school staff. To support future sustainability, in late 2017/18 we commissioned a Youth MHFA Train the Trainer course which resulted in a multi-agency cohort of 10 trainers for Bristol. These trainers are now delivering courses to staff from primary settings. To date five two-day courses have been run with 64 staff trained. More courses have been arranged for the Autumn term 2018/19. Following feedback from schools in relation to their capacity to undertake training, these will be MHFA Lite courses. It is hoped that this shortened approach to the training will increase the number of primary schools who are able engage with the opportunity.

We have also been approached by MHFA E as part of the Government pilot for secondary settings (see above) with regard to providing 'mop up' training for those Bristol settings not captured by the first wave of the training programme.

4. Where are we now?

Please see the table below for how much we spent in 2017/18 and plans for 2018/19:

Description	Actuals			
	2014-15 Bristol CCG	2015-16 Bristol CCG	2016-17 Bristol CCG	17-18 Bristol CCG
Main block CAMHS	4,467,377	4,557,362	4,334,741	4,334,741
Total Block	4,467,377	4,557,362	4,334,741	4,336,131
Other				
Off the record	50,895	60,215	62,360	106,476
Crisis Outreach Pilot	400,000	61,724	-	-
CHC Children's	311,365	421,225	291,422	378,395
ED and transformation	-	869,411	1,028,551	998,576
CYP IAPT	-	51,250	196,750	171,000
Total other CAMHS	762,260	1,463,825	1,579,082	1,653,027
Combined Total	5,229,637	6,021,187	5,913,823	5,989,188

BNSSG CCG - Bristol

Children and Young People's Mental Health and Wellbeing Transformation Plan 2018 - 2019

Description	Planned 2018/19 BNSSG CCG -Bristol
CCHP (Sirona) CAMHS	£4,335,000
Total Block	£4,335,000
<u>Other</u>	
ED and transformation schemes	£1,217,000
Total Other CAMHS	£1,217,000
Combined Total	£5,552,000

In addition to the above there will be:

- £1.25 million that has been identified and agreed recurrently across Bristol, North Somerset and South Gloucestershire CAMHS. A proportion of this will be spent in 2018/19 in Bristol.
- Further spending for the TCP autism pilot across Bristol / South Gloucestershire – funded by NHS England
- Further spending for the Bristol Integrated Personalised Commissioning Pilot – funded by NHS England
- Further spending on Continuing Care Children’s mental health.
- Further spending from NHS England for IAPT.

Bristol City Council Spend and Budget

	14/15 - Actual Spend	15/16 - Actual Spend	16/17 – Actual Spend	17/18- Actual Spend	18/19 - indicative
CAMHS	864,595	878,516	992,854	897,234	970,620**
Social Care - Positive Behaviour Support Service (PBSS)	30,000	30,000	30,000	30,000	30,000
MTFC	0	93,781	105,255	79,767	72,637
Troubled Families	49,534	72,836	148,000	162,689	162,689
Early Years - Emotional Needs	9,063	12,642	23,708	32,744	32,744
SEN - PBSS	30,000	30,000	30,000	30,000	30,000
Youth Services - Counselling			84,000	84,000	*
	983,192	1,117,775	1,413,817	1,316,434	1,298,690

*The 84K shown here in previous years is incorporated in the CAMHS figure above **

There are other funding sources that include emotional health but these have not been possible to disaggregate such as Healthy Schools Programme, social care or educational support.

Please see the tables below for details of the workforce and activity of our specialist providers in 2017/18:

CAMHS Workforce 2017/18

Specialised CAMHS

Specialised CAMHS		
Position	WTE	NHS Band
Admin & Clerical	0.6	2
Admin & Clerical	2.5	3
HCA	2	3
Admin & Clerical	2.2	4
Assistant Psychologist	2.5	4
Nurse	1	5
Specialist Practitioner	0.8	6
Nurse	3.44	6
Social Worker	1.6	6
Therapist - Social services	0.7	7
Social Worker	0.5	7
Nurse	4.83	7

Psychologist	2.2	7
Nurse manager	0.6	8a
Psychologist	1	8a
Psychologist	0.7	8b
Psychologist	0.6	8c
Psychotherapist	1.8	8a
Psychotherapist	1	8b
Consultant	1.4	

Total WTE = 31.97

Bristol East and Central CAMHS

CAMHS East & Central		
Position	WTE	NHS Band
Admin & Clerical	1	2
Admin & Clerical	2	3
Admin & Clerical	0.5	4
Occupational Therapist	0.8	6
Nurse	3.53	7
Psychologist	2.51	7
Social Worker	2	7
Psychotherapist	2.02	8a
Psychologist	0.8	8b
Consultant Psychiatrist	1.22	

WTE total = 16.38

Bristol North CAMHS

CAMHS North		
Position	WTE	NHS Band
Admin & Clerical	1.65	2
Admin & Clerical	1.33	3
Admin & Clerical	1	4
Nurse	4.2	7
Team Manager	0.5	7
Psychologist	1.8	7
Psychotherapist	2.5	7
Psychologist	2.1	8a
Psychotherapist	1.5	8a
Psychotherapist	1	8b
Art/Music/Drama Therapist	1	8a
Clinical Service Manager	0.5	8a
Consultant Psychiatrist	1.55	

WTE total = 20.63

Bristol South CAMHS

CAMHS South		
Position	WTE	NHS Band
Admin & Clerical	1.6	2
Admin & Clerical	2.6	3
Admin & Clerical	1.81	4
Social Worker	0.6	6
Social Worker	1	7
Nurse	3.2	7
Team Manager	0.5	7
Occupational Therapist	1.8	7
Scientific Therapeutic Therapist	1	A
Psychologist	1.6	7
Psychotherapist	0.9	7
Psychologist	1.63	8a
Psychotherapist	0.5	8b
Psychotherapist	1	8d
Clinical Service Manager	0.5	8a
Trainee Psychiatrist	1	
Consultant Psychiatrist	2	

WTE total = 23.24

CAMHS activity 2017/2018

Total number of referrals for year	1385
Total number accepted	1188
DNA rate	5.80%

Off The Record workforce 2017/18 – Bristol & South Glos

WTE	NHS Band Equivalent
2.86	3
2.2	4
8.6	4/5
15.16	5
6	5/6
2.6	6
1.2	7

0.8	7/8a
1	8b

WTE = 40.42

Off The Record activity 2017/18

Total number of referrals to OTR	1529 (referred to treatment)
Total number seen in CCG services	2710 (1-1 = 590, groups = 60, Wellbeing Practitioner = 109 HUBS/ POP UP = 1951)
DNA rate for CCG funded services	7.3%

Kooth workforce 2017/18 (including staff working in Bristol service)

Kooth staffing and NHS Banding equivalent

WTE	NHS Banding
2	1
1	2
10	3
8.5	4
55.4	5
17.1	6
11.7	7
2	8A

Total WTE = 107

Kooth activity April 1st 2017- March 30th 2018

Total number referrals (registrations)	2,631
Total number YP receiving counselling	552
DNA-	0

5. Risk and Mitigation³²

Risk	Mitigation
Workforce/recruitment: National workforce capacity issues, slow	Workforce Development Plan in place, BNSSG planning underway to support area-wide

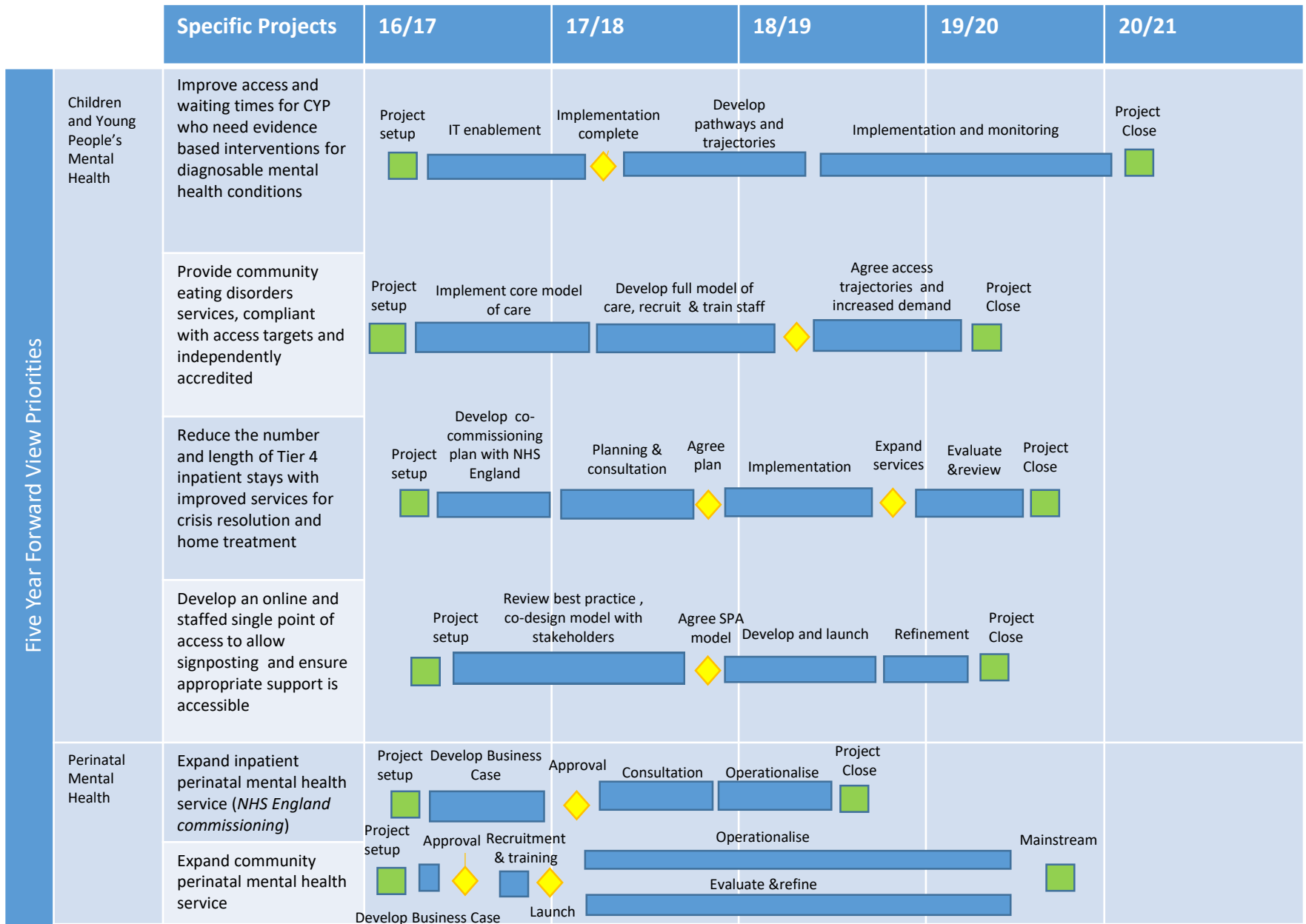
³² NHS England feedback on 2016/17 LTP requested the outline of key risks and mitigating responses in our 2017/18 LTP.NHSE feedback.

recruitment processes within larger organisations	recruitment/sharing of staff, continued participation in IAPT programme, comprehensive planning of projects and programmes.
Austerity: Reduced capacity due to cuts in funding across the wider mental health system including schools, VCS, Local Authorities (including Public Health)	Continue work develop whole-system, whole-city approaches to mental health to ensure resources can be maximised and gaps minimised, e.g.; Thrive and i-Thrive.
Co-ordination of work in schools: Academisation of education system poses challenges for the LA co-ordination of support/initiatives to schools.	Continued Public Health work (restructure allowing) to support whole-school approaches to mental health, support sharing of information and best-practice between schools via area-based Schools' Mental Health Network, support in relation to PSHE curriculum. Continue to work with senior LA and Education leaders to disseminate/share information and influence practice.
Merge of Bristol, North Somerset and South Gloucestershire CCGs; resulting restructure and change in staff roles, integration of services across BNSSG.	Clear inductions/handovers in place to support knowledge and understanding in child mental health commissioning and contract management. Detailed plans to support the integration of services across the STP footprint for CAMHS.

APPENDIX 1

BNSSG STP Children and young people's emotional health plans on a page

Mental Health – Women, Children and Families



Five Year Forward View Priorities

Develop a children and young people’s community eating disorders service

Aim

Deliver Mental Health Five Year Forward View target:

By 2020/21, evidence-based community eating disorder services for children and young people will be in place in all areas, ensuring that 95% of children in need receive treatment within one week for urgent cases, and four weeks for routine cases.

Current State

Estimated incidence of eating Disorders:

- In the UK in 2009, the highest incidence of AN, BN and EDNOS was for girls aged 15-19 yrs – 86 per 100,000
- In 2009, the incidence of eating disorders amongst males, aged 10-19, in the UK was 31 per 100,000
- In 2009, the incidence of eating disorders amongst females, aged 10-19, in the UK was 120 per 100,000 (Micali et al 2013)
- Depression is reported in **50-75%** of people with eating disorders (American Psychiatric Association, 2006)

The following list reflects the numbers of referrals received in Quarter 2 and Quarter 3, 2016/17:

Teams	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
CIT	2	1	1	1	3	1	9
Bristol East & Central CAMHS			1	1			2
Bristol North CAMHS		1	1	1			3
Bristol South CAMHS		1	2		4		7
South Glos CAMHS	3	1		2	2		8
AWP area Total	5	4	5	5	9	1	29
North Somerset [Mark please add]	4	3	2	1	5	1	16
BNSSG Total							45

Currently not all children and young people can be seen within waiting time targets

Objectives

- To see CYP within 7 (urgent) or 28 days (less urgent) from referral
- Reduce tier 4 occupied bed days
- See CYP in a clear care pathway from point of referral
- Deliver evidence-based interventions incl. family based treatment, paediatric and dietetic input
- Deliver excellent information to CYP and their families and CYP Professionals
- Deliver effective early treatment and interventions
- Deliver expert hub across BNSSG offering consistency of care
- Dovetail CRHTT interventions with ED home treatment requirements

Risks

- Service alignment with two providers
- Inequitable resources and wide variation in referrals for ED across BNSSG.
- CEDS implementation in B and SG will also be contingent on wider system change
- Ability to recruit appropriately skilled clinicians
- Access to paediatric and dietetic interventions incl. acute admission and review for physical safety
- Liaison with 3 acute trusts and age boundary 0-16 yrs or 16-18 yrs
- North Somerset has no Primary Mental Health work stream to enhance Primary Support

Projects

Training & staff development:

- Ensuring sufficient staff are skilled and competent in delivering the family based approach for single session and multi family group therapy. Ensure individual therapies are available as part of the pathway of care
- Ensuring we use existing skills & competencies within locality teams in the CEDS
- Virtual ED BNSSG peer support hub for advice and reference

Enhance primary care support

- Ensure GPs, schools, Public health colleagues are sufficiently skilled and aware of how to recognise and intervene at an early stage, and clear on the need to refer to specialist CAMHS
- Work with public health to dovetail with their initiatives for early intervention in ED
- Ensure the Primary Mental Health work stream is available and skilled to offer consultation, training and information to Primary care (Bristol and South Glos only)

Early Intervention

- Ensure the primary mental health specialists are skilled and available to offer early intervention support and consultation to schools as appropriate

Further Intervention

- Ensure the model is sufficiently staffed with the appropriately skilled clinicians to offer therapies locally, supported by the Ed Lead, paediatric and dietetic time, consultant psychiatry time
- Ensure all cyp are directed to the ED team from referral point so that interventions begin at first point of contact, by a skilled clinician and ‘hand offs’ are avoided
- Ensure continuity and consistency of care
- Ensure referrals to tier 4 are scrutinised and all other options of care are exhausted prior to escalation to tier 4
- Links with Riverside in patient unit
- Scoping out of hours and home treatment options when we have a crisis team available
- Ensuring transition to adult mental health where appropriate, is smooth and care is continuous

Participation

- Ensuring we have young people and families working alongside us in these project areas to develop services which listen to their need

Future progress:

We have set up meetings to gather the clinical staff from locality teams and to create the ‘hub’ from which the service will operate. We have appointed additional clinical staff to support the service and there will be 5 training days from April 2017 to learn the family based model within the family therapy clinics and join as a team. This will include paediatric and dietetic colleagues. This is currently Bristol /South Glos and not BNSSG wide

Whilst Emotional Health Transformation funding will assist, full delivery is dependent upon availability of additional funding

Outcomes

- Clearer referral routes and a better understanding of how to ask for help in their local areas
- A reduction in the need for: transfer to adult services, long periods of treatment & in patient admissions
- More involvement of CYP in commissioning services to meet their needs
- Improved knowledge and training for all those working with cyp, including a better knowledge of how to recognise eating disorders & how to access appropriate evidence based care when needed
- Improved CYP and Family experience

Improve access and waiting times for CYP who need evidence based interventions for diagnosable mental health conditions

Aim: To improve access and waiting times for children and young people (CYP) who need evidence based interventions for diagnosable mental health conditions

Drivers

Improving Access to Mental Health Services by 2020 (2014): Outlined a first set of mental health access and waiting time standards for 2015/16 and an ambition to introduce access and waiting time standards across all mental health services between 2016 and 2020. **Five Year Forward View (2015):** “We want new waiting time standards to have improved so that 95% of people referred for psychological therapies start treatment within 6 weeks and psychosis within 2 weeks. We also want to expand access standards to cover a comprehensive range of mental health services including children’s services, eating disorders and bipolar.” **Future In Mind (2015):** An ambition for all CYP having timely access to clinically effective mental health support when they need it. **Access & Waiting Time Standard for C&YP with Eating Disorder (2015):** Guidance on establishing and maintaining an eating disorder service including standard of treatment within 1 week for urgent and 4 weeks for other cases. **Local CAMHS Transformation Plans** detailing local response.

CAMHS eating disorder treatment standard achievement (October 2016)

Bristol - Urgent: 0% Other: 11%
 South Glos. - Urgent: 0% Other: 0%
 North Somerset - Urgent: 100% Other: 100%

Current Core CAMHS (excluding eating disorders) 18 weeks referral to treatment waiting times

Bristol 73% (ytd as at Month 5, 16/17)
 South Glos. 48% (ytd as at Month 5, 16/17)
 North Somerset 72% (ytd as at Month 7, 16/17)

CAPA performance

Choice appointments within 8 weeks

Bristol 93% (ytd as at Month 5, 16/17)
 South Glos. 83% (ytd as at Month 5, 16/17)
 North Somerset 42%(ytd as at Month 7, 16/17)

Partnership appointments within subsequent 10 weeks

Bristol 87% (ytd as at Month 5, 16/17)
 South Glos. 70% (ytd as at Month 5, 16/17)
 North Somerset: 30% (ytd as at Month 7, 16/17)

These are approximate numbers as these figures are not captured reliably.

Objectives

- To fully utilise any additional access and waiting list reduction funding
- To meet NHS Mandate to both improving access and shortening waiting times to provide parity with physical health
- To meet Eating Disorder Access and Waiting Standard (2015)
- To implement Local Transformation Plans
- To meet future CAMHS access and waiting standards

Risks

- National requirements unachievable within current resource. Bristol and South Gloucestershire submitted a business case for 2017/18, outcome currently unknown
- Service alignment as North Somerset has a different CAMHS provider to Bristol and South Gloucestershire
- Capacity unable to meet increasing demand
- Quality of data from discrepancies with information management technology across BNSSG
- Lack of dedicated crisis management team in North Somerset, small pilot in Bristol and South Gloucestershire

Activity description

This project will be led, managed and developed by the BNSSG Emotional Health and Wellbeing Steering Group which is a partnership of providers and commissioners, with the responsibility for coordinating development of children’s emotional wellbeing and mental health services across BNSSG. The project group meets monthly and is chaired by each CCG in turn. Key aims include:

- Responding to the needs of CYP and families
- A more accessible service
- Using the right clinicians and the right intervention at the right time

Development areas

To alleviate the pressure on resources in locality teams who can manage their current waiting lists more easily

- Triage review regarding first response to referrals to ensure CYP receive the appropriate support from the outset, sign posting safely and effectively, offering good advice and one off contact and know when we can close an episode of care following this brief contact.
- Target possible one- off appointments advocated by Bloom (2001). The change of perspective from therapy being seen as a long term event to that of a possible one-off session, from which patients can manage their own care,
- Telephone consultation, targeting those who are referred with a lower level of risk, or where the need is unsure
- Parental support
- On line counselling

Key themes of this work will be:

- Establish sound baseline data and develop challenging but achievable improvement trajectories
- Coordinated development of CYP IAPT programme
- Coordinated development of workforce strategy
- Co-production of model and materials with CYP and a range of professionals
- Digital delivery

A well-established eating disorder project group, fully aligned to the wider Emotional Health and Wellbeing Steering Group, is coordinating an area response to access and waiting standard already in place.

The partnership work will be fully integrated into planned South West Strategic Clinical Network work streams:

- Looking at the southwest as a whole and then using data to support benchmarking
- Getting a fuller understanding about the providers systems for managing referrals, recording activity and outcomes
- Understanding what is working well and what the challenges are.
- Developing local and area wide solutions to these challenges via a regional footprint

Whilst Emotional Health Transformation funding will assist, full delivery is dependent upon availability of additional funding

Outcomes

- Every CYP who is referred to an NHS commissioned service will receive signposting and support regardless of whether their referral is accepted
- Current eating disorder and future mental health access and waiting time standards are achieved
- Every child who meets referral criteria will receive the right care, at the right time and whenever possible in the right place.

Develop an online and staffed single point of access to allow signposting and ensure appropriate support is accessible

Aim: Develop an online and staffed single point of access (SPA) across BNSSG to allow signposting and ensure appropriate support is accessible

Current State

The Departments of Health and Education published the 5 year 'Future in Mind' strategy in 2015. This requires us to:

- Enabling single points of access and One-Stop-Shop services to increasingly become a key part of the local offer, harnessing the vital contribution of the voluntary sector
- Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kitemarking scheme in order to guide young people and their parents in respect of the quality of the different offers
- Enabling clear and safe access to high quality information and online support for children, young people and parents/carers, for example through a national, branded web-based portal

In Bristol and South Glos, CAMHS have a SPA in place.

CAMHS activity (2015/16):

Bristol referrals: 1514 referrals received. 938 accepted (61% accepted/79% nationally)

South Glos referrals: 819 referrals. 475 accepted (58% accepted /79% nationally)

North Somerset: 1183 referrals received. 634 accepted (54%accepted/79% nationally)

National CAMHS benchmarking shows that the expected number of referrals based on our populations would be:

Bristol: 3173

South Glos: 1787

North Somerset: 1372

Objectives

- Ensure no referral is declined without offering further signposting and support
- Allow CYP, families and professionals to easily access signposting and support
- Support and advice available 24/7
- Online, searchable and up to date

Risks

- North Somerset has a different CAMHS provider to Bristol and South Gloucestershire
- Concern that opening up referral routes will lead to a significant increase in demand

Projects

This project will be developed and managed by a partnership of providers and commissioners, with the responsibility for delivering a coordinated SPA.

Bristol and South Gloucestershire: CAMHS service specification from 1st April 2017 includes the following:

- Single Point of Entry in each Local Authority area – to targeted and specialist services with pre-referral telephone / email advice / liaison.
- Single Point of Entry (SPE) and First Assessment will be informed by the Bristol pilot of referral pathway into CAMHS through First Response.
- Accept referrals from schools, health professionals and self-referral, via a single point of access which will be developed with each local authority.
- In cases where referrals are found to be inappropriate, with consent, refer or signpost the child / young person and their family / carers to other services through the single point of access.
- The provider will provide a referral and advice line with appropriate knowledge and skills within each area's First Response / First Point / NS Single point of access so that those thinking about referring can have a discussion prior to the referral.

North Somerset CAMHS service specification includes the following:

- Single Point of Entry (SPE) into Specialist Community Children's Services
- Accept referrals from schools, health professionals. Self referrals are currently not accepted.
- In cases where referrals are found to be inappropriate, with consent, refer or signpost the child / young person and their family / carers to other services.
- The provider provides advice with appropriate knowledge and skills within each service so that those thinking about referring can have a discussion prior to the referral.

Key themes in this work will be:

- Co-production of model and materials with children and young people, and a range of professionals
- Digital delivery
- Learning from Single Point of Access/ Joint Triage in North Bristol and other areas
- Development of new model and implement.

Outcomes

- Every CYP who is referred to an NHS commissioned service will receive signposting and support regardless of whether their referral is accepted.
- Professionals across the wider system will know how to access support and advice

Reduce the number and length of Tier 4 CAMHS inpatient stays with improved services for crisis resolution and home treatment

Aim: Reduce the number and length of Tier 4 CAMHS inpatient stays for children and young people (CYP) with improved services for crisis resolution and home treatment.

Current State

NHS England commission 9 beds at AWP's Tier 4 Riverside Unit in Bristol that generally serves BNSSG. In the context of the wider transformation of emotional health, we plan to change the way we support and care for more complex cases.

The Departments of Health and Education published the 5 year 'Future in Mind' strategy in 2015. This requires us to:

- Ensure the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented
- Implement clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care
- Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour
- By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge

The Five Year Forward View for Mental Health has set us the following ambitions:

- As a result of the investment in community based eating disorder teams, it is expected that use of specialist in-patient beds for CYP with an eating disorder should reduce substantially.
- By 2020/21, in-patient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements.
- Inappropriate use of beds in paediatric and adult wards will be eliminated.
- All general in-patient units for CYP will move to be commissioned on a 'place-basis' by localities, so that they are integrated into local pathways. As a result, the use of in-patient beds should reduce overall, with more significant reductions possible in certain specialised beds.

Objectives

- Minimise Tier 4 admissions
- Eliminate OOA placements for non-clinical reasons
- Reduce clinical reasons for OOA placements
- Reduce length of stay in Tier 4
- Release savings which can be invested in system wide work

Risks

- Rising demand for complex care and interventions
- Recruitment in the context of national shortages of skilled staff
- Two different core CAMHS providers across patch
- Delay in national guidance release
- Capacity in stakeholders to fully engage

Projects

Development of this project in more detail is dependent on our local NHS England Specialised Commissioning colleagues receiving national guidance which is currently delayed.

The stages of this project will include:

- Audit and analysis of current Tier 4 admissions
- Identify themes, especially for OOA placements
- Identify vulnerable groups of CYP at risk of admission
- Develop a model of out of hours/ crisis resolution and home treatment service
- Agree joint commissioning approach
- Recruit and implement model
- Dovetail with adult mental health service developments to support delivery of out of hours intensive support
- Develop mechanism for CYP Community Care Treatment Reviews.

Currently there is a Partnership Outreach pilot with the voluntary sector in Bristol and South Gloucestershire that assesses and supports CYP who attend Emergency Departments following self-harm also undertake some intensive work for those at risk of Tier 4 admission and to allow early discharge. Learning from Partnership Outreach Team pilot will support future service model. This pilot model is currently being evaluated.

There appears to be three main groups of CYP who are being admitted to Tier 4:

1. CYP with eating disorders
2. CYP with challenging behaviour with autistic spectrum conditions
3. CYP who self-harm, can have challenging behaviour and can have attachment/trauma issues

Bristol and South Gloucestershire have intensive Positive Behaviour Support service so few children with Learning disabilities are admitted.

We will do further work to understand the characteristics and needs of these groups in more detail. This will inform the pathways we commission.

Key themes in this work will be:

- Co-production of new models of care and pathways with CYP, and a range of professionals
- Consistency and transparency of pathways across BNSSG
- Principle of care as close to home as possible
- Delivery of Care and Treatment Review approach for children and young people with a learning disability and/or Autism
- Explore intensive behaviour support for CYP with Autism

Whilst Emotional Health Transformation funding will assist, full delivery is dependent upon availability of additional funding

Outcomes

- Reduce the number of Tier 4 admissions for CYP across BNSSG CCGs
- Develop a crisis resolution and home treatment service to support CYP at home
- Minimise the disruption to education and family life by out of area placements
- Improve outcomes for CYP through staying in local area.

APPENDIX 2

AWP Bristol and South Gloucestershire children and young people's emotional health joint workforce plan

Comprehensive Child & Adolescent Mental Health Services:

Integrated Workforce Strategy

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1. About this workforce plan

1.1. Bristol and South Gloucestershire Emotional Health & Wellbeing

This workforce strategy is a live document that reflects our high level priorities and actions across the wider workforce and system. This plan is a joint agency approach to the range of issues currently facing staff who support children and young people's (CYP) emotional health and provide signposting, interventions and treatments.

It has been developed with reference to Health Education England's Mental Health Workforce Strategy and borrows from its model of the five pillars:

- Increasing productivity (including system drivers, targeted interventions, digitally delivered therapies, efficiency gains)
- Increasing attractiveness and reducing attrition (including the importance of staff wellbeing and the correlation between workforce wellbeing and outcomes is key)
- New staff (in Bristol and South Gloucestershire we are focusing on IAPT therapists)
- New roles
- New skills (including staff from non- mental health areas)

It also reflects other national policy drivers:

Five Year Forward View for Mental Health (2015): "We want new waiting time standards to have improved so that 95% of people referred for psychological therapies start treatment within 6 weeks and psychosis within 2 weeks. We also want to expand access standards to cover a comprehensive range of mental health services including children's services, eating disorders and bipolar."

Future in Mind (2015): An ambition for all CYP having timely access to clinically effective mental health support when they need it.

Access & Waiting Time Standard for C&YP with Eating Disorder (2015): Guidance on establishing and maintaining an eating disorder service including standard of treatment within 1 week for urgent and 4 weeks for other cases.

Improving Access to Mental Health Services by 2020 (2014): Outlined a first set of mental health access and waiting time standards for 2015/16 and an ambition to introduce access and waiting time standards across all mental health services between 2016 and 2020.

This plan also links closely with our local Sustainability and Transformation Plan (STP) and contributes to the Integrated Assessment Framework. Our STP covers Bristol, North Somerset and South Gloucestershire. The key elements in the plan relation to this area are:

- Priority across BNSSG to improve access and waiting times for children and young people who need evidence based interventions for diagnosable mental health conditions, providing parity of esteem with physical services
- Building resilience through the delivery of training to non-specialist workforces to improve capacity and capability to support children and young people in community settings
- Services are part of the children and young people's Improving Access to Psychological Therapies Collaborative, but this needs to be developed in both specialist and wider children and young people's workforce
- Work towards a sustainable 24/7 urgent and emergency mental health service
- Provide community eating disorder services, compliant with access targets and independently accredited
- Improve access to and quality of perinatal and infant mental health care

- Deliver improved access to mental health support to children and young people at risk of or in the early stages of criminal justice involvement
- Ensure data quality and transparency - increase digital maturity to support interoperability of healthcare records

We want to explore building capacity and capability in our local health and social care economy to ensure we have the right numbers of frontline staff, supervisors and skills in the right place. This will include expanding provision in online and group services as well as out of hours and 24/7 provision where appropriate.

To date, CCGs have made investing in and developing our provider workforces a key plank of our transformation plans. We recognise the increasing demand for services, as well as a desire and need for services to be delivered differently.

This means we will take a multi-pronged approach to increasing capacity and capability, recognising the messages we have heard from CYP about how they want services to be delivered.

We anticipate that in the future, a wider range of professionals will recognise the pivotal role they play in supporting CYP. How services are delivered will also change and include more digital delivering, services out of hours and in a variety of locations. We need to ensure our workforce is ready and equipped to deal with challenges this may bring.

This plan should also be read in conjunction with NHS Bristol and South Gloucestershire CCG's transformation plans, which are available here:

<https://www.bristolccg.nhs.uk/your-health-local-services/help-and-support/young-peoples-emotional-health/>

https://www.southgloucestershireccg.nhs.uk/media/medialibrary/2016/10/sgccg_EHWP_transformation_plan_311016.pdf

The BNSSG Emotional Health and Wellbeing Transformation and STP Steering Group has the responsibility for developing the plan and meets monthly.

It is intended that this workforce strategy is a developmental document and that future versions will take into account learning from the National CYP Mental Health and Wellbeing Programme and the application of the Comprehensive CAMHS integrated workforce planning tool (CHIMAT). Bristol, North Somerset and South Gloucestershire are participating in this programme.

1.2. Positioning of the plan

The plan covers the period 2017-2020 and will support the delivery of the Emotional Health Wellbeing Strategy for Bristol and South Gloucestershire, and CAMHS Transformation Plans for BNSSG CCGs, as well as enabling Bristol and South Gloucestershire CAMHS to deliver the requirement of '*Future in Mind*'.

The meaning of Comprehensive CAMHS as it is used within this document:

The Integrated Comprehensive CAMHS model for BSG uses the framework of universal, targeted and specialist levels of service to meet the comprehensive mental health and psychological well-being needs of children and young people.

Four Tier model: National Service Framework for children, young people and maternity services (DH, 2004) based on a solid body of earlier work (HAS, 1995).

With Children in Mind: The final report of the CAMHS Review (2008)

Universal services work with all children and young people. They promote and support mental health and psychological well-being through the environment they create and the relationships they have with children and young people. They include Early Years' providers and settings such as child-minders and nurseries, schools, colleges, youth and leisure services and primary health care services such as GPs, midwives and health visitors.

Targeted services are engaged to work with children and young people who have specific needs – for example, learning difficulties or disabilities, school attendance problems, family difficulties, physical illness or behaviour difficulties. Within this group of services we also include CAMHS delivered to targeted groups of children, such as those in care Off the Record and Youth Offending Services,

Specialist services work with children and young people with complex, severe and/or persistent needs, reflecting the needs rather than necessarily the 'specialist' skills required to meet those needs. This includes CAMHS at Tiers 3 and 4 of the conceptual framework (though there is overlap here as some Tier 3 services could also be included in the 'targeted' category). It also includes services across education, social care and youth offending that work with children and young people with the highest levels of need – for example, in pupil referral units (PRU), special schools, children's homes, intensive foster care and other residential/ Tier 4 inpatient or secure settings. Early intervention in Psychosis and adult mental health transitions are included in this category.

1.3. The BSG model: service and scope

The vision and the subsequent delivery of our integrated model is predicated on effective partnership working to ensure that the wide range of services are all involved in supporting children's emotional wellbeing and mental health within the different levels of service. The integrated service model builds targeted and specialist services on top of universal services by drawing down knowledge, skills and resources around the child, young person and family/carer.

The conceptualisation of the integrated model is built on integrated practice, increasing participation of parents and children: seeking views and experience to inform service design and delivery, improved continuity and consistency of care, using the evidence base to improve and monitor outcomes, deliver quality and cost effective interventions.

Data is key to help us understand our population, its needs and the workforce capacity and capability to meet those needs; mindful that the draft CAMHS needs assessment gives prevalence and incidence rates using the four tier model which has been used for over a decade to conceptualise the planning and delivery of mental health services.

The data from children's services mapping provides bench-marked information reported against the four tier model. Currently the configuration of the largest provider of targeted and specialist CAMHS to BSG does correspond to the four tier model, providing community services at Tier 2 and 3 and In-patient services at Tier 4.

As discussed in section 4, Bristol and South Gloucestershire service delivery will be using the Thrive model of delivery.

1.4. The recruitment and retention of staff in targeted and specialist CAMHS

Recent investment proposed in the CAMHS Transformation Plans for BNSSG CCG mean that effective recruitment, development of new job roles and the retention of skilled staff are all vital. Therefore, action plans created around recruitment and retention are incorporated into this Integrated Workforce Plan.

BSG CAMHS needs to be aware that across the Comprehensive CAMHS workforce we still need to do more to recruit staff that matches our population profile, specifically in terms of gender, ethnicity, belief and sexuality.

Education and training

Common across all strands of current children's policy is the need to ensure that all those working with children and families have the necessary values, competences, skills and on-going learning and development to enable them to recognise and respond to the identified mental health needs of children.. A wide suite of policy and practice guidance, strategy and public inquiries have set the context for the learning and development needs of professionals who work with children who have mental health problems.

The vision of all future learning and development should facilitate the development of a unified culture for CAMHS with true inter-agency working.

The education and professional development provided for staff must be accessible and useful at all levels from unqualified support staff to professionally qualified workers. The structure within which professional development will be provided will therefore need to be flexible and based upon a common core framework of knowledge, skills and attitudes:

<http://www.chimat.org.uk/camhstool>

1.5. Continuum of education & training

Most importantly children, their families and carers expect those professionals working to address their needs to be adequately trained and to possess the necessary skills, competences and knowledge to provide effective care and treatment. It is now widely acknowledged that the development of a competent and capable children's workforce is a long-term strategy. The Self Assessed Skills Audit Tool (Nixon & Walker 2011) was developed to be used as part of the Integrated Workforce Planning Tool, providing organisations, teams and individuals with a process and tool to support the initial, albeit significant step of gathering self-assessed information, not objectively measured, mapping the usage of the identified skills and highlighting any training gaps. Organisations can use the information gathered to respond effectively and flexibly to education and training needs as they emerge and to inform current and future education and learning commissioning and provision.

Learning and development for those who work with children and young people must be consistent with wider children's workforce strategy. CAMHS learning and development should be commissioned, provided and evaluated in an interagency context. Wherever possible, learning and development in child and adolescent mental health must fit seamlessly with broader children and young people's workforce training initiatives. This is currently a gap in this plan as it is not integrated with wider plans and it will need to be part of BSG transformation plans.

Workforce development in CAMHS is not only about skills and competences, but also about creating a shared understanding, shared vision and effective partnerships.

1.6. Children and Young People's Improving Access to Psychological Therapies

CYP IAPT continues to be a focus in BSG CAMHS for transformation and future service delivery.

BSG CAMHS was successful in being part of phase 3 of the CYP IAPT program. It has obtained funding for leadership, cognitive behaviour therapy (CBT), systemic family therapy, eating disorders and parenting training. This includes trainees and supervisors.

One of the key outcomes of CYP IAPT is to achieve greater service access particularly for hard to reach groups. BSG CAMHS has partnered with Off the Record, a local voluntary sector service to develop greater integration also to look at creative ways of improving access and reducing stigma. CYP IAPT (Improving Access to Psychological Therapies) attempts to address a number of key challenges. It aims to transform existing mental health services for children and young people so that they have improved access to the best possible psychological services in a way that they find acceptable and relevant.

It focuses on embedding therapies that have been proven to work across services, making sure that everyone involved in the services, not just those who are being directly trained by the project, use intensive (session-by-session) outcome monitoring and works to incorporate the views of children and young people in service design and delivery.

There are three major components of the project:

- 1) Training for practitioners, supervisors and service managers/leads.
- 2) Collaborative practice of evidence-based therapies, using patient-reported outcomes.
- 3) The transformation of all CAMHS services in England, linking research evidence, patient preferences and values, and clinician observations into an improved model of care delivery.

One of the goals of CYP IAPT is to build supportive learning networks by linking outstanding Higher Education Institutions (HEIs) with the transformation of CAMHS services in collaborative which stretch across regional boundaries. Our partners in this are Exeter University, Off the Record and Bristol City Council.

In Bristol and South Gloucestershire we are hopeful that it will be associated with a substantial improvement in outcomes for families. Both CCGs have assured necessary backfill contributions in 2016/17.

CYP IAPT training

The CYP IAPT programme has provided training in a range of evidence based skills including supervision. The numbers of staff who have undertaken each element of the training are in the table below.

Table 3.17: CYP IAPT training numbers (CAMHS only)

	Completed	In progress
CBT Practitioners	4	
CBT Supervisor	1	
Leadership	2	1
Systemic Family Practice Eating Disorders	2	1
Systemic Family Practice Self-harm/Conduct/Depression/Self Harm		2
SFP Supervisor ED	2	1
SFP Supervisor C/D/SH	1	
Parenting		1
Parenting Supervisor	1	

1.7. Seven principles of comprehensive CAMHS integrated workforce planning

This plan uses the 5 principles set out in the draft Health Education England Integrated Workforce Planning Guidance as the basis for its action plan.

Workforce design and planning

Having effective Workforce Design and Development practices in place combining need, service models to meet that need and workforce consequences across all agencies is fundamental to enable services to be staffed appropriately over the coming years.

Recruitment & retention

For mental health services to grow and develop, it is vital to recruit and retain good quality staff that reflects the make-up of the community they serve. Currently, mental health is not seen as an attractive place to work. We need to tackle this stigma by showing that it actually provides intellectual stimulus, good career opportunities, a fair rate of pay for the job and good support networks including a family friendly working environment.

If there are insufficient staff, we will continue to waste resources on agency and locum staffing, we will be unable to provide effective services for users and their careers and government targets will not be achieved.

New ways of working

New ways of working are essential because services are changing, are largely multi-disciplinary team based, with a need to provide a clear pathway for the service user and carer. The pressure from demand for services and insufficient supply of professionally qualified staff mean that traditional practice must be reviewed to ensure that the best use is being made of highly trained professionals.

It is important that all staff, in whatever sector or setting, look at the functions they perform and consider alternative ways that some of these can be delivered.

New roles

We need to recruit from a different pool of people if we are realistically to expand the workforce to the extent required. This may involve targeting people aged 25-60 who do not have GCSEs or graduates, particularly in health and social sciences. Many of these potential recruits do not want to enter the traditional professions, but with the appropriate training and supervision could take on important roles in services to support and release time from professionally qualified staff based on an analysis of the capabilities required.

Leadership

Having effective leadership in place at all levels across all agencies is crucial to facilitating the engagement of both staff and organisations in modernising mental health services.

Education, training and other learning opportunities

Numbers are necessary, but not sufficient. A well-educated, capable and supervised workforce committed to continuing learning is key to delivering effective services, which are valued by service users and their supporters.

Developing the skill mix, capability and competences

Commissioners and providers of services develop the skill mix, capability and competences of staff to deliver all the assessment and treatment components of comprehensive CAMHS.

1.8. Clinical skills audit

NHS Bristol and South Gloucestershire CCGs commissioned South Central West Commissioning Support Unit (SCW) to carry out a skills audit in the main two providers, CAMHS and Off The Record. Utilising a template developed by clinical staff in the National CAMHS Service back in 2011, SCW worked collaboratively with CAMHS clinicians to update the template to make it relevant, reflective of NICE guidelines and fit for purpose in 2016. The tool covered 197 skill/activity areas with a self-assessment on; level of skill, use of skill, interest and confidence.

The audit was rolled out to community CAMHS staff in May 2016 and completed by 80 of a possible 126 identified respondents, and then to Off The Record staff in October 2016 and completed by 18 out of a possible 34 respondents.

Of the 197 skills included in the audit, 194 are used by at least one member of CAMHS staff on a frequent basis. This one statistic alone demonstrates the huge diversity of skills within the workforce, and the incredible resources in the team employed to support the health and wellbeing of young people in our community.

From the data, SCW have drawn together a series of reports that provide:

- an overview of the skills across the team and how frequently they are being used. This report provides a snap shot of skills that can be broken down into smaller teams that shows a pattern of skills mix and usage of those skills in the current service. It gives an objective overview of skills and usage of those skills at this point in time, and how these might differ between locality teams.
- an overview of areas where clinicians have indicated 'no' or a 'low' level of skill, and how frequently these skills are applied. This report demonstrates that with a few anomalies, clinicians who are not skilled generally do not apply these skills. The anomalies however provide a point of discussion and exploration with clinical team managers.
- an overview of areas where clinicians have indicated they are highly skilled, and how frequently these skills are applied. Again this report demonstrates that with a few anomalies, area of high skills are frequently employed by clinicians. Anomalies where clinicians are not using skills, especially if pressure points have been highlighted elsewhere can be explored with clinical team managers.
- a comparison of skills and confidence in skills. Generally there is a very high correlation between confidence and skills, but where there are anomalies; the data allows us to ask the right questions.
- an indication of interest in skills areas where clinicians are not currently involved. These are areas where clinicians have expressed an interest in gaining additional skills. This will aid any future workforce plan in helping to identify where we can develop within the service, and where we may need to source those skills through recruitment.

AWP have already undertaken critical training as a result of these reports, and Off The Record have recognised the need for development of skills in the development of safety plans, self-harm and systemic work, including family therapy. They have also recognised their strengths in other key areas such as systems approaches and client needs led practice and are keen to support other providers in these areas. AWP have further commissioned the use of the audit in the Riverside residential unit, recognising its value in understanding our current workforce and shaping training and workforce development plans.

Using these reports, SCW in partnership with AWP are now engaging with Clinical Team Managers to explore the narrative behind the data. This narrative will help us establish and understand in greater detail where our workforce are in terms of their current skills, identifying strengths, priorities for development, risks and opportunities. This will then feed into shaping our service critical training needs and longer term workforce planning. Feedback from clinical team managers will be collated by AWP and shared with commissioners in the new year, collaboratively working to develop a workforce to meet the needs of young people.

2. Local population profile and mental health needs of children and young people

Further information is available on the Bristol and South Gloucestershire Local Authority websites, as part of the Joint Strategic Needs Assessments:

<https://www.bristol.gov.uk/policies-plans-strategies/joint-strategic-needs-assessment-jsna>

3. Whole system provision

3.1. Other services

A wide range of professionals, clinical and non-clinical, are involved in supporting the emotional health and wellbeing of children and young people. This includes:

- Schools and early years settings, sixth forms and colleges (independent and state provision)
- Primary care, including GPs, practice nurses and other staff
- Universal services, such as health visitors and school nurses
- Local authority services such as parenting and behavior support
- Social care, including social workers
- Services for looked after children or those on the edge of care
- Youth justice, including YOT
- Criminal justice staff
- Other health professionals, such as sexual health nurses
- Voluntary and community organisations

There are also other NHS commissioned services in addition to CAMHS, including Off The Record (Bristol and South Gloucestershire and Kooth (Bristol)).

Off the Record

Aims and objectives of service

- To empower and support young people age 11-18 via the provision of targeted mental health early intervention in order to enable improved emotional health and wellbeing; to build resilience, gain confidence and find solutions to their problems.
- To offer a varied and stepped menu of evidence-based/best practice interventions and services utilising a variety of therapeutic and engagement approaches, online and face to face, in line with the identified needs of each individual young person.
- To employ the principles of community development and youth work in order to engage and involve young people in the development, running and evaluation of the service.

Kooth

Currently a 12 month pilot in Bristol from 1st September 2016, www.kooth.com is a free online service offering emotional and mental health support and interventions for children and young people aged 11 to 18. Young people sign in safely and anonymously to have a "drop-in" chat with a counsellor or therapist or book a one-to-one session.

Kooth's counsellors and therapists are available until 10pm, 365 days a year. Young people can talk to one another anonymously on the forums and keep an on line journal. Evidence suggests that Kooth can help children and young people with a range of emotional and psychological problems.

3.2. CAMHS service description

The service is delivered by four locality teams, and additional specialist teams which cover all areas. The service uses outcome measures to support them in using the most effective therapy.

The CAMHS teams can offer many different treatment options, depending on the difficulties being experienced and the type of problem including:

- Consultation (to a professional, or parents and carers of the child)

- Individual talking therapies
- Young people's and/or parent/ carers groups
- Family therapy and family based treatment
- Cognitive behavioural therapy
- Child Psychotherapy
- Medication
- Art or play therapy
- Diagnostic assessment
- Consultant psychiatry

Age range served: The service is provided to children and young people aged 0 to 18th birthday.

Current workforce (2015/16):

Bristol CAMHS

Be Safe

Position	WTE	NHS Band
Admin & Clerical	0.6	Band 4
Assistant Psychologist	0.5	Band 5
Psychologist	0.55	Band 8a
Psychotherapist	1.1	Band 8b

WTE total = 2.75

Bristol East and Central CAMHS

Position	WTE	NHS Band
Admin & Clerical	1.49	2
Admin & Clerical	2.25	3
Admin & Clerical	1.5 (0.5 = CIT)	4
Nurse band	1.00	6
Nurse band	1.8	7
PMHS/PIMHS	2.8	7
Clinical Psychologist	1.71	7
Family Therapist	1.35	8a
Psychotherapist	1.00	8a
Psychologist	0.6	8a
Psychologist	0.61	8c
Psychiatrist consultant	1.6	

WTE total = 17.71

Bristol North CAMHS

Position	WTE	NHS Band
Admin & Clerical	1.37	2
Admin & Clerical	2.24	3
Admin & Clerical	0.8	4
Psychologist	1.9	7
Nurse	1.3	7
PMHS/PIMHS	3.6	7
Psychologist	1.6	8a
Psychologist	0.7	8b
Psychotherapist	0.9	8a
Psychotherapist	1.0	8b
PMHS	1.0	8a
Psychiatrist Consultant	0.6	

WTE total = 17.01

Bristol South CAMHS

Position	WTE	NHS Band
Admin & Clerical	1.6	2
Admin & Clerical	2.6	3
Admin & Clerical	1.81	4
Occupational Therapist	0.6	7
Psychologist	3.25	7
Nurse	1.79	7
PMHS/PIMHS	3.42	7
Psychologist	0.63	8a
Family Therapist	0.7	8a
Psychotherapist	1.09	8b
Psychotherapist	1.0	8d
Nurse	1.0	8a
Psychiatrist consultant	2.4	

WTE total = 21.89

Deliberate Self Harm

Position	WTE	NHS Band
Admin & Clerical	0.6	3
Nurse	3.8	7
Nurse Manager	0.4	8a

WTE total = 4.8

Thinking Allowed

Position	WTE	NHS Band
Admin & Clerical	0.8	3
Psychologist	2.4	7
Psychologist	0.6	8c
Psychotherapist	0.8	8a

WTE total = 4.06

South Gloucestershire CAMHS

Position	WTE	NHS Band
Admin & Clerical	2.95	3
Admin & Clerical	1	4
Family therapist	1.13	8a
Family therapist	.8	7
Nurse	1.45	8a
PMHS/PIMHS	6.34	7
Psychologist	1.68	8a
Psychologist	1.8	7
Psychotherapist	.6	8a
Psychotherapist	.7	7
Psychiatrist Consultant	2.4	

WTE total = 20.85

Core functions

All staff working in targeted and specialist CAMH services are required to be competent in the core functions (National Workforce Programme & Skills for Health). The core functions include competencies in:

- Effective communication and engagement
- Assessment
- Safeguarding and welfare
- Care coordination

- Health promotion
- Supporting transitions
- Multi agency working
- Sharing information
- Professional development

4. Our workforce future

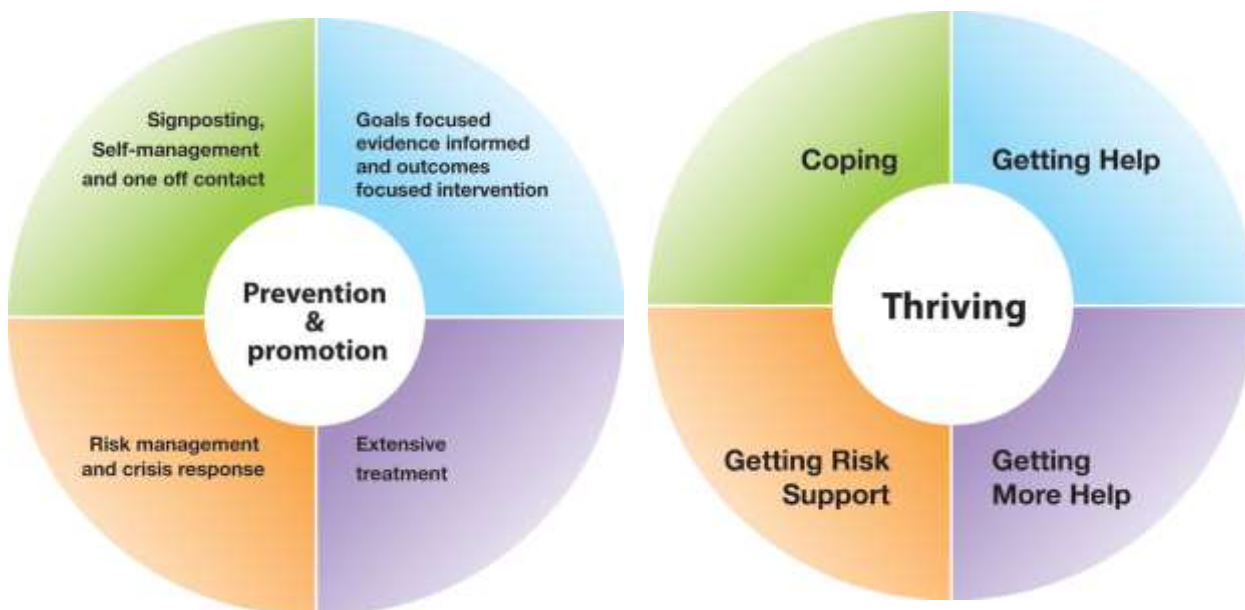
4.1. Model in Bristol and South Gloucestershire

The Anna Freud Centre working with the Tavistock and Portman NHS Foundation Trust have been working to consider what CAMHS should look like in the future and in November 2014 proposed the THRIVE model which is described below. This supports our vision of a patient and family centred approach and matches the aspiration of delivering a service which is user friendly, transparent and easily accessed and understood.

The THRIVE model (The AFC-Tavistock model for CAMHS); proposes to replace the tiered model with a conceptualisation that addresses the key issues outlined above and is aligned to emerging thinking on payment systems, quality improvement and performance management. The model outlines groups of children and young people and the sort of support they may need and tries to draw a clearer distinction between treatment on the one hand and support on the other. Rather than an escalator model of increasing severity or complexity, we suggest a model that seeks to identify somewhat resource-homogenous groups (it is appreciated that there will be large variations in need within each group) who share a conceptual framework as to their current needs and choices.

The **THRIVE** model below conceptualises four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of prevention and promotion initiatives in the community.

The image to the left describes the input that offered for each group; that to the right describes the state of being of people in that group - using language informed by consultation with young people and parents with experience of service users.



Each of the four groupings is distinct in terms of:

- Needs and/or choices of the individuals within each group⁶
- Skill mix required to meet these needs
- Dominant metaphor used to describe needs (wellbeing, ill health, support)
- Resources required to meet the needs and/or choices of people in that group

The groups are not distinguished by severity of need or type of problem.

The middle designation of “thriving” is included to indicate the wider community needs of the population supported by prevention and promotion initiatives.

The emphasis is away from what services have to traditionally offer, moving towards a service which can be flexible and offer children and families what they need at that particular point in time and in a timely manner.

4.2. Coping

- Building resilience for the wider community through excellent availability of information and awareness

4.3. Getting help

As services and evidence develop nationally, we anticipate that there will be more resources for self-care and guided support. We will also encourage staff to raise awareness of support for parents, such as www.minded.com.

The wider workforce will be actively engaged with this as they signpost and support children and young people. They will need to understand the underlying principles and effectiveness of these approaches, such as manualised interventions delivered by staff with lower levels of specialist clinical skills. Digital technology will play a large role in this, both as it reflects what CYP tell us they want and also as it can be highly cost-effective. This will also require professionals to have a good working knowledge of digital culture and how to work with people online, for example managing safeguarding.

CAMHS at this level are provided by professionals working in universal services who are in a position to:

- Identify mental health problems early in their development
- Offer general advice
- Pursue opportunities for mental health promotion and prevention

Current action to support schools in promoting resilience and prevention of mental health problems (Future in Mind):

- The Department for Education (DfE) is leading work to improve the quality of teaching about mental health within Personal, Social, Health, and Economic (PSHE) lessons in schools, and has commissioned the PSHE Association to produce guidance for schools in teaching about mental health safely and effectively, which will be available in spring 2015. Alongside the guidance will be a series of lesson plans covering key stages 1-4 (5-16 year olds). For older pupils, they will address such topics as self-harm and eating disorders, as well as issues directly concerned with school life, such as managing anxiety and stress around exams.
- DfE is developing an evidence-based schools counselling strategy to encourage more and better use of counsellors in schools, with practical and evidence-based advice to ensure quality provision, that improves children’s outcomes and achieves value for money. This will be published in spring 2015.
- DfE has invited schools, colleges and organisations to bid for a £3.5 million character education grant fund for local projects.
- School nurses lead and deliver the Healthy Child Programme (HCP) 5-19 and are equipped to work at community, family and individual levels. They can play a crucial role in supporting the emotional and mental health needs of school-aged children. School nursing services are universal and young people see them as non-stigmatising.
- Inspection is a key lever to drive improvement. The new draft Ofsted inspection framework ‘Better Inspection for All’ includes a new judgement on personal development, behaviour and welfare of children and learners.

Primary Mental Health workforce

The primary purpose of the Primary Mental Health Specialist (PMHS) role is to link outside organisations such as Schools and Early Help to CAMHS and to support the mental and emotional well-being of young people in education. They provide regular consultation and training to schools and other frontline professionals.

PMHS services to Schools, Social Care, Early Help, School Nurses, Healthy Weight Nurses, Brook Sexual Health:

- Consultation, which may involve discussing a particular child who has raised concerns.
- Provide information and advice about when and how to refer to CAMHS or other services.
- Professionals can call for a telephone consultation, or it may be possible for PMHS to visit the school in person / arrange a face to face meeting with a professional.
- Offer regular on-going consultation session in person, frequency negotiated with each organisation within the boundaries of the PMHS core offer.
- Attend Team Around Family meetings or similar meeting for particular cases, by arrangement and with previous case discussion.
- Direct face to face contact with children and young people for assessment and intervention where appropriate
- The PMHS team are also able to meet specific training needs identified. This may be individualised to local need or part of wider training. The PMHS team are currently involved in the Cascade training for Bristol schools

CASCADE training for schools and other professionals (Bristol only)

The Anna Freud Centre brings together mental health leads in Schools and CAMHS to embed long term collaboration and integrated working. The training comprises of two workshops delivered at least 6 weeks apart. The workshops are for education and mental health professionals and aim to bring together representatives from up to 10 schools and their local CAMHS service, building stronger links and communication between these professionals.

The workshop takes a blended learning approach, drawing on evidence-based approaches to both training and system transformation. Focusing on schools and CAMHS work in partnership to embed learning as part of sustainable organisational change in order to improve mental health and resilience for all children, young people and their families within the locality.

The workshops use case studies and cover content around depression, anxiety, school approaches to fostering resilience and the use of outcome measures.

The aim is to embed long term, sustainable and locally-owned collaboration between schools and CAMHS and includes:

- Clarity on remit, roles and responsibilities of partner organisations
- Agreed best use of key points of contact in schools and CAMHS
- Structures to support shared planning and collaborative working
- Common approach to outcome measures for children and young people
- Ability to continue to learn and draw on best practice
- Development of integrated working to promote rapid and better access to support
- Evidence based approach to intervention

Aims of the training

- Develop a shared view of strengths and limitations and capabilities and capacities of education and mental health professionals
- Increase knowledge of resources to support mental health of children and young people
- Ensure more effective use of existing resources
- Improved joint working between education and mental health professionals

4.4. Getting more help

This group of children and young people would need face to face contact of an evidenced based intervention.

CAMHS is already both trained and continuing to train staff in evidence based practice under the CYP IAPT programme and the pathways of care will become clearer in the future (see below). We need to include children and young people with difficulties that fall within NICE guidance and support those with a greater need but where NICE and the evidence base is less clear.

4.5. Getting risk support

The THRIVE model suggests that there needs to be an explicit recognition of the needs of children, young people and families where there is no current health treatment available, but they remain at risk to themselves or others. This group of children may present with risky behaviours many times to CAMHS and other services with no diagnosable mental illness applicable to their needs and behaviours. THRIVE recommends that all agencies work seamlessly together to provide the continuity of care necessary. Safety plans need to be clear and achievable with sign up to support young people, from all aspects of their lives.

5. Next steps

5.1. Developing care pathways

One of the key issues for Bristol and South Gloucestershire is achieving consistency of provision across the piece, and clarifying the delivery model against a range of presenting needs. The following pathways are being considered as the way of setting out how services should be delivered to meet those needs.

- Eating disorders
- Self-harm and emotional dysregulation
- Depression and anxiety
- ADHD
- ASC
- Tics and Tourettes
- Infant mental health
- Attachment disorders
- Trauma
- Primary mental health

Pathway development will build on the 'hub and spoke' approach as appropriate, in order to maximise use of specialist skills.

The Community Eating Disorder Service, currently in early progress, is an example of how we will build on existing skills and competencies to that ensure those who have the specialist knowledge can take a central role in the coordination and delivery of an evidence based model. All referrals for eating disorders will be directed into this hub and timely intervention and consistency of good clinical practice for all will be a priority.

In order to achieve this for all children and young people we need to ensure we have the correct workforce with leadership a key objective. This can be achieved by continuing to gather workforce information and to upskill staff through CYP IAPT. There will then be a clearer picture of where additional training will be required beyond the CYP IAPT programme.

BSG has been engaging more robustly with the CYP IAPT programme and CAMHS have developed a CYP IAPT steering group which will ensure the appropriate staff can access the training so that all teams have a good mix of all the evidence based approaches.

There are difficulties in sending large numbers on intensive training programmes as backfill is not easily available. A robust recruitment drive for backfill is necessary in advance of any training so that teams do not struggle to provide cover for the duration.

The steering group consists of a member of each team and this group will be responsible for ensuring the CYP IAPT programme is monitored and reviewed.

5.2. The job-ready population

- In addition to the CYP IAPT programme all staff will be developed in terms of skills and competencies through good quality supervision and CPD
- It is vital that we support staff on return from training and in particular, once back in full time role, the clinical models will be embedded in team practice for each particular care pathway.
- Recruiting staff from other healthcare employers within or outside the NHS
- International recruitment for all specialties and hard to recruit to posts
- Succession planning for staff groups to develop into new or more skilled roles; through good CPD and forward thinking
- Retention strategies to keep skilled staff; ensuring CPD and opportunities across the service are available & encourages staff to stay
- Effective workforce utilization; enabling staff to change role or team as appropriate and hours to suit where the service can offer this.
- Utilisation of bank staff, locums, contract and temporary staff to increase supplies in period of high demand.
- Widening access schemes
- Offering incentives to stay or return

5.3. New supply

Increasing the supply of workforce through:

- Recruiting from non-healthcare workforce to boost economy supply
- Recruitment of newly qualified staff from: undergraduates, assistant practitioners, and any others on preceptorships
- Offering clinical placements to trainees in the range of psychological therapies
- Offering secondments
- Offering short term contracts to boost new supply
- Widening access schemes – equality and inclusion agenda
- Making use of apprentices; offering structured training leading to a nationally recognised qualification. This can provide a route into a variety of roles and encourage young school leavers to enter further training whilst supporting workforce development.

5.4. New ways of working

Enhancing supply through development, modernisation, and new methods of working and new roles.by:

- Introducing the role of support workers/assistant practitioners
- Development of advanced practitioners
- Development of AHPs roles
- Modernisation of services
- Developing the existing workforce much quicker than the long lead times of some professional education.
- Including multi-agency and multi-professional posts
- Introducing productive time efficiency measures
- Regular training needs analysis (TNA)

APPENDIX 3

Children and young people's emotional health Tier 4 Co-commissioning plan



Children and Young People's Emotional Health – BNSSG and BANES CCG and NHS England collaborative commissioning plan for inpatient and daycase treatment

December 2016

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By 2020/21, in-patient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements. Inappropriate use of beds in paediatric and adult wards will be eliminated. All general in-patient units for children and young people will move to be commissioned on a 'place-basis' by localities, so that they are integrated into local pathways. As a result, the use of in-patient beds should reduce overall, with more significant reductions possible in certain specialised beds.

By 2020/21, inappropriate placements to in-patient beds for children and young people will be eliminated: including both placements to inappropriate settings and to inappropriate locations far from the family home (out of area treatments).

A combination of the different activities to deliver transformation, such as increasing the number of children receiving evidence-based treatment in the community and the development of new models of care (see chapter 9), is expected to lead to reduced use of in-patient beds for children and young people across all settings, with savings to reinvest in local mental health services. Investment to pump-prime 24/7 crisis resolution and home treatment services should further release money currently within the specialist commissioning budget that can be redeployed to achieve further improvements in access and waiting times in mental health services.

In parallel, NHS England will transform the model of commissioning so that general in-patient units are commissioned by localities on a place basis (whether alone, as part of an STP or another group covering a defined geography), to align incentives and ensure that efficiencies delivered are reinvested in communities. As a first step, all CCGs are expected to develop collaborative commissioning plans with NHS England's specialised commissioning teams by December 2016. These plans will include locally agreed trajectories for aligning in-patient beds to meet local need, and where there are reductions releasing resources to be redeployed in community-based services.

1 INTRODUCTION

The aim of this work is to reduce the number and length of Tier 4 CAMHS inpatient stays for children and young people (CYP) and improve services for crisis resolution and home treatment.

This Tier 4 co-commissioning plan is a live document that reflects our high level priorities and actions across the spectrum of issues relating to inpatient and day case beds for CYP across BNSSG and BANES

This plan is a joint agency approach to the range of issues currently facing CYP, their families and staff who work with those CYP who need more intensive support than that provided by core CAMHS and other NHS funded services.

This plan also links closely with our local **Sustainability and Transformation Plan (STP)** and contributes to the Integrated Assessment Framework. Our STP covers Bristol, North Somerset and South Gloucestershire. The key elements in the plan relation to this area are:

- Priority across BNSSG to improve access and waiting times for children and young people who need evidence based interventions for diagnosable mental health conditions, providing parity of esteem with physical services
- Building resilience through the delivery of training to non-specialist workforces to improve capacity and capability to support children and young people in community settings
- Services are part of the children and young people's Improving Access to Psychological Therapies Collaborative, but this needs to be developed in both specialist and wider children and young people's workforce
- Work towards a sustainable 24/7 urgent and emergency mental health service
- Provide community eating disorder services, compliant with access targets and independently accredited
- Improve access to and quality of perinatal and infant mental health care
- Deliver improved access to mental health support to children and young people at risk of or in the early stages of criminal justice involvement
- Ensure data quality and transparency - increase digital maturity to support interoperability of healthcare records

2 CURRENT STATE

NHS England currently commissions 9 inpatient beds plus day case beds (number under review) at AWP's generic Tier 4 Riverside Unit in Bristol that generally serves BNSSG. In the context of the wider transformation of emotional health, we plan to change the way we support and care for more complex cases.

Bristol and South Gloucestershire CCG and NHS England have recently reprocurd CAMHS community provision alongside CAMHS inpatient provision with the result of the same provider and specifications that includes joint out of hours psychiatric provision across the services.

The Departments of Health and Education published the 5 year 'Future in Mind' strategy in 2015. This requires us to:

- Ensure the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented
- Implement clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care
- Include appropriate mental health and behavioural assessment in admission gateways for inpatient care for young people with learning disabilities and/or challenging behaviour

- By co-commissioning community mental health and inpatient care between local areas and NHS England to ensure smooth care pathways to prevent inappropriate admission and facilitate safe and timely discharge

The Five Year Forward View for Mental Health has set us the following ambitions:

- As a result of the investment in community based eating disorder teams, it is expected that use of specialist in-patient beds for children and young people with an eating disorder should reduce substantially
- By 2020/21, in-patient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements
- Inappropriate use of beds in paediatric and adult wards will be eliminated
- All general in-patient units for children and young people will move to be commissioned on a 'place-basis' by localities, so that they are integrated into local pathways. As a result, the use of in-patient beds should reduce overall, with more significant reductions possible in certain specialised beds

3 OBJECTIVES

- Minimise Tier 4 admissions
- Eliminate OOA placements for non-clinical reasons
- Reduce clinical reasons for OOA placements
- Reduce length of stay in Tier 4
- Release savings which potentially can be invested in system wide work

Key themes in this work will be:

- Co-production of new models of care and pathways with CYP, their families and a range of stakeholders/professionals
- Consistency and transparency of pathways across BNSSG and BANES
- Principle of care as close to home as possible
- Delivery of Care and Treatment Review approach for children and young people with a learning disability and/or Autism.

Outcomes will include:

- Reduce the number of Tier 4 admissions for CYP across BNSSG and BANES CCGs

- Develop a crisis resolution and home treatment services to support CYP at home (in place in BANES)
- Minimise the disruption to education and family life by out of area placements
- Improve outcomes for CYP through staying in local area.

4 RISKS

- Rising demand for complex care, reviews and interventions
- Recruitment in the context of national shortages of skilled staff
- BANES has a different STP footprint to BNSSG
- Three different core CAMHS providers across patch
- Delay in national guidance release
- Capacity in stakeholders to fully engage

5 TIER 4 CAMHS WORKFORCE

In Bristol we have the Riverside Unit which provides **Tier 4 daycase and inpatient services**. The unit has 9 inpatient beds and day case beds and although a national provision generally covers the BNSSG and BANES footprint.

Bristol and South Gloucestershire CCG and NHS England have recently recommissioned community children's health services including CAMHS and Tier 4 through a joint procurement process. Out of hours on call psychiatry cover is jointly commissioned and jointly provided. Sirona has been awarded the contracts for both Tier 4 and CAMHS as prime provider with sub-contract with AWP.

Staff have told us that the issue of insufficient capacity in core CAMHS means the Bristol / South Gloucestershire Partnership Outreach Team pilot are unable to provide sufficient step down for children and young people with the community teams. It also means teams are more likely to refer into Tier 4.

In terms of workforce, we anticipate that this will require more capacity and capability to provide **crisis resolution and home treatment teams**. This will involve staff having the right skills and also have the right job plans, including working outside of the traditional working week.

6 NEXT STEPS

Development of this project in more detail is dependent on our local NHS England Specialised Commissioning colleagues receiving national guidance which is currently delayed.

The stages of this project will include:

- Audit and analysis of current Tier 4 admissions
- Identify themes, especially for OOA placements
- Identify vulnerable groups of CYP at risk of admission
- Develop a model of out of hours/ crisis resolution and home treatment service
- Agree joint commissioning approach
- Recruit staff and implement model
- Dovetail with adult mental health service developments to support delivery of out of hours intensive support

Currently there is a Partnership Outreach pilot with the voluntary sector in Bristol and South Gloucestershire that assesses and supports CYP who attend Emergency Departments following self-harm, they also undertake some intensive work for those who are at risk of Tier 4 admission and to allow early discharge. Learning from the Partnership Outreach Team pilot will support the future service model. This pilot model is currently being externally evaluated.

There appears to be three main broad groups of CYP who are being admitted to Tier 4:

1. CYP with eating disorders
2. CYP with challenging behaviour with autistic spectrum conditions
3. CYP who self-harm, can have challenging behaviour and can have attachment/trauma issues

We will do further work to understand the characteristics and needs of these three groups in more detail. This will inform the pathways we commission.

Bristol and South Gloucestershire have jointly commissioned intensive Positive Behaviour Support service with the local authorities so few children with Learning disabilities are admitted to Tier 4.

Work is underway to remodel and recruit to a new eating disorders service across BNSSG.

Bristol and South Gloucestershire CCG are bidding for funding to pilot an approach for children with autistic spectrum conditions without learning disabilities at risk of Tier 4 inpatient.

Bristol CCG are also bidding for funding to deliver personal health budgets for children in care /care leavers with mental health problems

Bristol, South Gloucestershire and North Somerset are moving towards one single commissioning voice with one senior management structure.

APPENDIX 4

Community Forensic Child and Adolescent Mental Health Service Specification

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	C11/S/c
Service	Community Forensic Child and Adolescent Mental Health Service (including Secure Outreach)
Commissioner Lead	<i>For local completion</i>
Provider Lead	<i>For local completion</i>

1. Scope
<p>1.1 Prescribed Specialised Service</p> <p>This service specification covers the provision of Community Forensic Child and Adolescent Mental Health Service (including Secure Outreach)</p> <p>1.2 Description</p> <p>1.2.1 This service specification describes a Tier 4 community-based forensic Child and Adolescent Mental Health Service model that will be delivered within a clearly defined geographical area at Regional and sub-regional level.</p> <p>1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners</p> <p>1.3.1 NHS England commissions Tier 4 Child and Adolescent Mental Health (CAMHS) services provided by Specialist Child and Adolescent Mental Health Centres. The range of Tier 4 services commissioned by NHS England includes inpatient care and associated non-admitted care including forensic outreach when delivered as part of a provider network.</p> <p>1.3.2 CCGs commission CAMHS for children requiring care in Tier 1, Tier 2 or Tier 3 services.</p>

2 Care Pathway and Clinical Dependencies

2.1 Care Pathway

- 2.1.1 Future in Mind (2015) emphasised the need for ‘improved care for children and young people in crisis so they are treated in the right place, at the right time and as close to home as possible’. This includes ‘implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.
- 2.1.2 This service specification will focus on the functions required of a specialist mental health service to mediate transitions into and out of secure in-patient care. It is recognised that such a function requires a broad remit comprising full understanding of all forms of formal and less formal secure care in which young people from a given geographical catchment may be located. Such a service should support the prevention of admission to all secure settings when a meaningful alternative is feasible.
- 2.1.3 Secure mental health in-patient provision forms only a part of a range of formal secure settings for young people in England; the majority of young people in secure environments are detained either on remand or following sentence in secure youth justice settings (Young Offender Institutions, Secure Training Centres or Secure Children’s Homes) or alternatively under the Children Act (1989 and 2004) on welfare grounds. ‘Less formal’ secure care refers to a range of other settings which are not classified as ‘secure’ but which may support high risk and complex young people by the provision of high levels of continual staff supervision.
- 2.1.4 There are currently two broadly distinguishable clinical groups of young people in secure mental in-patient provision (‘forensic’ and ‘complex non-forensic’); such clinical groups are not necessarily mutually exclusive and there frequently is considerable overlap between them. There are three distinct forms of secure in-patient provision for young people
- **Medium secure** settings accommodate young people with mental and neurodevelopmental disorders (including learning disability and autism) who present with the highest levels of risk of harm to others (i.e. ‘forensic’ concerns) including those who have committed grave crimes. In such settings there are prescribed stringent levels of physical security and high levels of relational and procedural security. Young people admitted to medium secure settings frequently have longer durations of stay than young people in other inpatient settings.
 - **Low secure** settings accommodate young people with mental and neurodevelopmental disorders (in particular learning disability and autism) at lower, but nevertheless significant levels of physical, relational and procedural security. Young people in such settings may belong to one of two groups: those with ‘forensic’ presentations involving significant risk of harm to others and those with ‘complex non-

forensic' presentations principally associated with challenging behaviour, self-harm and vulnerability. Young people admitted to low secure settings (as is the case for those admitted to medium secure settings) frequently have longer durations of stay than young people in other inpatient settings.

- **Psychiatric intensive care units (PICUs)** for young people allow for containment of short-term behavioural disturbance which cannot be contained within an open adolescent in-patient unit or where such behavioural disturbance is associated with mental health concerns in other non-mental health settings. Young people in such settings may belong to the 'forensic' or 'complex non-forensic' groups. Levels of physical, relational and procedural security in PICUs is similar to those in low security but there would be fewer facilities (e.g. educational and recreational settings) to support a young person over a sustained period of time than is the case within medium and low secure units

2.1.5 A secure outreach service needs to be familiar with the needs and differing care-pathways which exist for young people with 'forensic' and 'complex non-forensic' presentations. It is anticipated that such a service would have direct clinical involvement with the 'forensic' group who currently present particular challenges to generic local CAMHS and other services. Whilst such a service would necessarily need to understand the needs of the 'non-forensic' population and provide advice and consultation where necessary, it is envisaged that direct clinical involvement may not be required routinely as such presentations at entry into, or discharge, from secure care are more likely to fall into the day-to-day remit of existing non-secure ('Tier 4') in-patient units or community CAMHS provision. A secure outreach service needs to be flexible in its approach as many presentations do not divide neatly into 'forensic' and 'non-forensic' groups.

2.2 Service Requirements and Functions

2.2.1 The service is a tertiary referral service for CAMHS teams, CAMHS/Youth Offending Team (YOT) link workers and neurodisability services for young people and other agencies. The team will be accessible to all agencies (e.g. social services, YOTs, prisons, courts, solicitors, education, health commissioners etc.) that may have contact with young people exhibiting risky behaviours or young people in the youth justice system who have mental health difficulties. For this reason, initial contacts about possible referrals will be welcomed from all agencies and responses to initial contact from referrer will be made within 5 working days of receipt

The catchment for each service should be 'regional' in the sense that it covers a population and/or geographical area for a total population of about 2.5 million. It is likely that the catchments of some services working either in densely or sparsely populated areas or in areas with particularly high levels of deprivation will need to be organised accordingly.

2.2.2 Service functions include

- facilitation of smooth transitions for young people between services and agencies working with young people and between children's and adult services
- coordination of, and liaison with, mental health services across community and secure settings, and ensuring that care is provided in line with the welfare principles of the Children Act (1989 and 2004) and Code of Practice 2015 to the Mental Health Act (as amended 2007)
- specialist support for local services to enhance delivery of responsive child-centred care in high risk cases through multiagency care-planning and promotion of user engagement in care and wider service provision
- reduction and management of the potential risks posed by the young person to others and self through individualised treatment plans and clinical risk assessment and management processes; this will frequently be achieved in collaboration with other agencies
- specialist mental health assessment (including forensic assessment where appropriate, and access to timely assessment where undiagnosed learning disability or autism is suspected), Case-formulation and intervention in high risk cases where there is a need for specialist opinion to ensure that young people presenting high risk of harm to others or self are managed in the most appropriate way
- in collaboration with other agencies, where appropriate, provision of evidence-based treatment for complex high risk cases, through a wide range of interventions to address individual's mental health, welfare and educational needs
- development of joint working arrangements with CAMHS and other children's services (including community learning disability and autism services) to support the management of high risk and complex cases
- informing and developing strategic links between local provision and regional and national specialist services
- Facilitation of transition into, and out of, secure settings for young people, providing support, advice and practical input as required, follow-up of cases where young people move out of area, facilitating, where appropriate, return from secure custodial, welfare or mental health placements; the service will take a proactive role around the 'forensic' group of young people; adopting a facilitative role with less direct involvement for the 'complex challenging behaviour' group who are likely to be better known to and followed up by Tier 4 and CAMHS outreach teams
- Community intervention to prevent admission to in-patient settings where appropriate alternatives exist or where in-patient admission is unlikely to prove successful. This should include close adherence to the 'Transforming Care' agenda and engagement with the CETR process in cases of learning disability, autism or both.
- Strong emphasis on liaison with all agencies to promote working arrangements and facilitate access to mental health assessment and intervention
- Liaison and advice to youth offending teams; courts and the legal system as a resource for general advice, liaison, formal consultation and, on occasions, specialist assessment and management advice to

courts and the youth justice process (e.g.: potential for diversion, fitness to appear/plead; risk assessment in cases with clear mental health/neurodisability neurodevelopmental components, recommendations for appropriate disposal and follow-up)

- Formation of strong links with services providing mental health in-reach into youth justice or welfare secure settings within catchment and with agencies such as children's social care and education who may be placing young people with complex needs in highly supervised other settings
- Develop effective strategic partnerships, particularly with children's social care, education and the youth justice system, that successfully influence appropriate multi-agency developments to cater for other needs of complex, high risk young people (e.g. services for young people with sexually harmful behaviours, mental health in-reach to local secure welfare or custodial settings and involvement in criminal justice liaison and diversion teams).
- Identification of existing gaps in local and regional service provision and leadership in identifying remedial action.
- Provision of training to practitioners from all agencies in relation to areas within the service's specialist remit (e.g. principles of working with high risk and complexity, risk assessment and management, understanding the interface between different legislative frameworks in particular The Mental Health Act, The Mental Capacity Act, The Children Act, Education Act and SEND Reforms, and Youth Justice.)

2.3 Referrals

2.3.1 The team will seek to make itself accessible to any professional who wishes to make initial contact or enquiries regarding a young person giving cause for concern and about whom there are questions regarding his/her mental health ('the referrer'). This will reduce risk of referrals not being made, delays in identification of need and potential disengagement by young people from services. The service must be sufficiently accessible at point of referral so that all cases requiring specialist input are identified. Discussion and formal consultation with referrers should be undertaken by experienced members of the team and not delegated elsewhere. There should be very clear expectation of meaningful engagement and joint working with the specialist outreach team from a child's local CAMHS team for any child referred by agencies other than CAMHS.

2.3.2 The service will have broad and inclusive criteria for initial contact with the team; flexibility should apply in some cases to age of young person depending on need and appropriateness of ongoing input beyond their eighteenth birthday. The team does not necessarily expect that a young person at referral will have a previously diagnosed mental health difficulty.

2.3.3 The referral process has been put in place to ensure

- specialist assessments and interventions are only undertaken when

absolutely necessary

- local services are supported to continue their work with identified young people and are encouraged to do this in situations where they might not have felt able to do so
- young people receive input at a level commensurate with their needs and with their potential for risk of harm to others or themselves

2.3.4 Referral Criteria are deliberately broad covering all young under 18 about whom there are questions regarding mental health or neurodevelopmental difficulties including learning disability and autism who:

- present high risk of harm towards others and about whom there is major family or professional concern
- and/or are in contact with the youth justice system
- OR about whom advice about the suitability of an appropriate secure setting is being sought because of complexity of presentation and severe, recurrent self-harm and or challenging behaviour which cannot be managed elsewhere; in such cases, where non-secure in-patient services or locality CAMHS teams are usually extensively involved, the input from the secure outreach service is likely to be advisory or consultative rather than requiring direct clinical involvement

2.3.5 Referral Process

- The referrer will undertake an initial short verbal discussion (either face to face or by phone) with a designated member of the service. The outcome of this initial discussion will result in feedback to the referrer and agreement about further action: a) no further input required (not within referral remit) or mediation of referral to more appropriate service b) referral accepted for further, more detailed formal consultation.
- If the referrer is not from a local CAMHS team and the referral is accepted for further input after an initial discussion, the secure outreach team will usually always discuss the referral with the young person's local CAMHS team. This will facilitate a clear joint approach to the referral from relevant mental health providers and, wherever possible, joint assessment and working can be undertaken.

2.3.6 Possible Referral Outcomes

Once contact has been made with the service there are a number of possible outcomes. These are as follows:

- Referral not accepted
- Referral accepted for either brief advice (including signposting/facilitation of access to more appropriate services) or more detailed formal consultation with referrer/local network regarding young person's presentation
- Formal consultation requires pre-arranged in-depth case discussion and should include prior provision of background documentary information

by the referrer. There is initial agreement that such discussion takes place on the basis that the outreach service has not had direct clinical input with the young person in question and that advice/recommendations are provided in line with general management principles.

- At the end of the formal consultation a course of action will be agreed between referrer and community forensic CAMHS secure outreach clinician. This may result in
 - a. no further current input required
 - b. referrer and outreach service clinician agree initial formulation and local plan of action and that direct input not immediately required; secure outreach team to keep case open and seek progress update before closing or becoming directly involved
 - c. Outreach team agree to become directly clinically involved usually in conjunction with referrer.
- The forensic CAMHS outreach team will always summarise formal consultation and its agreed outcome in writing to the referrer.
- Following formal consultation referral accepted for specialist assessment and clinical input as required. This outcome requires the home team and network to remain involved with the case (e.g. by providing a care/case coordinator) and usually to participate in ongoing risk-management in conjunction with the outreach team. Following the assessment, the secure outreach team will remain involved, as appropriate, to support the local network to manage the case and to provide specific intervention. This will include in some cases facilitation of admission for secure in-patient care with relevant providers (with which the secure outreach service will be well-acquainted) and support for the referrer and local services within the formal NHS England referral process. Written feedback to referrer outlining details of assessment and recommendations will be provided to referrer and relevant others including family/carers and/or those with parental responsibility.

2.3.7 Contact with the case will not automatically end if the young person in question moves out of catchment into specialist residential, custodial, educational or secure mental health in-patient provision. Indeed, the secure outreach team may be the CAMHS team best placed to follow the young person through any out of county placement and ensure that the young person's needs continue to be met and that transition back to the home area can be facilitated.

2.4 Discharge and Care-Planning

2.4.1 Referrers will retain overall clinical responsibility for young people they refer and assume a case coordination role irrespective of level of outreach team involvement. In this way the service local to the child remains linked with the child's progress and can ensure local case management. Referring services must identify a case coordinator who will remain in contact with the case throughout the period of involvement from the specialist secure outreach team.

2.4.2 Any discharge from the service, irrespective of level of input required (whether short or longer term, consultative or involving direct clinical assessment and intervention), should be undertaken in consultation with the referrer and the child/young person and/or their parent/carer or person with parental responsibility, as appropriate.

2.4.3 The service will ensure rigorous care planning from the point of referral to discharge and ensure that meeting of need and risk management is clearly prioritised. This should take into consideration the needs and wishes of child, young person and family, and the involvement of other professionals. A copy of the discharge planning information will be given to referrers, families/carers or those with parental responsibility, general practitioners and, with the permission of the family, to any other involved professionals.

2.4.4 Children and young people may move to other services and other geographical locations. Such transitions will be planned and monitored as appropriate. This may require liaison and ongoing support for the young person from the service.

2.5 Interventions

2.5.1 Treatment of mental health and neurodevelopmental needs in high risk young people and young offenders is the same as that clearly evidenced for other young people with mental health difficulties.

2.5.2 The team is required to be competent in ensuring that such treatments are delivered when required in a wide variety of different settings and that professionals in such settings are adequately supported to do this.

2.5.3 In addition, it is necessary for the team to have wide experience of interventions or support packages which may be specifically of value in young people with offending or challenging behaviours. Whilst the team may not itself deliver such interventions, it will frequently be asked to provide clear opinion with regard to the best course of action in individual cases. Specialist knowledge of different types of residential and educational settings or the applicability of different therapeutic interventions (such as Multi-Systemic Therapy, Dialectical Behaviour Therapy, Treatment Foster Care or treatment of sexually harmful behaviours) in such situations is necessary.

2.5.4 In all situations, reasonable adjustments should be made for children and young people with learning disability, autism or both and adapted treatment programmes should be available.

2.6 Staffing

2.6.1 The secure outreach team will be multidisciplinary and will have specialist mental health and forensic experience in the assessment and treatment

needs of complex high-risk young people. In particular, the service will have specialist understanding of statutory mental health, welfare, youth justice and educational processes and understanding of the interfaces between them. It must be familiar with the needs of young people with neurodevelopmental disorders, including learning disability and autism. The emphasis should be on a small, highly experienced and active team whose members are equipped to provide authoritative specialist support to local generic networks.

2.6.2 Secure outreach Community FCAMHS team members should include combination of some of the following:

- Consultant psychiatrist (s) (wherever possible dual trained Forensic and CAMHS; otherwise clearly demonstrating the required clinical competencies formalised with a dual training)
- Senior grade clinical psychologist(s) with appropriate forensic experience
- Clinical nurse specialist/senior mental health practitioner(s) (at least Band 7)
- Other relevant specialist professionals (e.g. forensic psychologist, social worker) with appropriate experience in this area
- Dedicated team administration

2.6.3 The function of the specialist team combines support for generic child and adolescent services and specialist clinical assessment, formulation and intervention skills. The role of the consultant psychiatrist is essential given the specialist knowledge of the Mental Health Act required in this work. Psychology support is also crucial given the frequent need for structured psychometric cognitive and other psychological assessments as well as consideration of appropriate interventions. The administrator's role is central and requires a wide-range of skills and coordination of a peripatetic team.

2.6.4 Staffing levels per catchment will be determined in line with the team's core functions, catchment population and geographical size and levels of deprivation.

2.7 Co-located Services

2.7.1 Geographical colocation within existing CAMHS provision is highly advisable. This reinforces the fact that such services constitute a part of CAMHS provision and that their primary concern is to be part of an overall care pathway for children and young people with mental health or learning difficulties. Such an arrangement also facilitates access and allows meaningful feedback whilst preventing isolation of a specialist service. Premises should be available to the team to undertake clinical assessments as they are available within other CAMH services. However, it is likely that the team will need to exercise considerable flexibility to ensure that the best assessment outcome is achieved for the child and his/her family; clearly this will involve proximity to residential provision but

will require attention to the need for privacy and confidentiality and putting the young person at ease.

2.7.2 As a result, the team is likely to be peripatetic but should retain a clearly defined team base. It must provide outreach across each region/sub region and ensure that there is appropriate coverage to meet the population needs according to population density, geographical distribution and levels of deprivation. The services are to be:

- Located within providers with existing broad-based CAMHS provision
- Regionally located and provided on a network model to ensure there is consistent and equitable nationwide coverage.

2.8 Interdependence with other Services

2.8.1 Community Forensic CAMHS Secure outreach teams necessarily must be expert in liaising and establishing good working relationships with a wide variety of agencies and institutions. This is essential if they are to ensure the best outcomes for the young people with whom they have contact. The teams must be capable of advising, supporting and challenging such agencies and institutions as appropriate. At times their role in high risk cases will involve the containment of anxiety whilst at others it will involve the injection of concern where risks were hitherto poorly recognised and addressed.

2.8.2 Community FCAMHS Secure outreach teams will also provide education within the NHS and beyond to raise and maintain awareness of the needs of young people with high risk and complex presentations and needs.

2.8.3 All community FCAMHS teams secure outreach services should be adept at working across agencies and institutions operating not only locally but also at regional and national levels

2.8.4 It is expected that all community FCAMHS teams secure outreach services will actively contribute to a national clinical network (yet to be developed) which will ensure parity of provision and determination of uniform clinical standards and monitoring/evaluation. This network should also ensure continuity of provision for young people if they move between placements in different regions although it would be expected that the child's home-based service would maintain contact with the child and his/her family.

2.9 Interdependent Services

2.9.1 At National Level:

- Nationally recognised providers of specialist secure adolescent medium and low secure in-patient care for young people with mental or neurodevelopmental disorders, including learning disability or autism

- Youth justice custodial settings (Young Offender Institutions (YOIs), Secure Training Centres (STCs) or secure children's homes)
- Secure welfare settings
- Other community FCAMHS providers
- Other providers of highly specialist residential or educational care for young people

2.9.2 At Regional and Local Levels:

- Local establishments providing secure mental health or neurodisability or other inpatient care for young people or those providing other secure care on youth justice or welfare grounds
- Commissioners of CAMHS (including Learning Disability and neurodevelopmental) services
- Public health
- Senior managers in children's social care in different local authorities
- Youth justice (YOT) services and youth and crown courts
- NHS and independent providers of non-secure in-patient care
- Providers of residential care
- Providers of special education
- Police, in particular senior officers responsible for youth justice, but also teams particularly involved with young people (e.g. child abuse investigation units)
- 3rd sector organisations working with young people, particularly those who are hard to engage
- Crown Prosecution Service, in particular decision-makers in relation to youth crime
- Safeguarding leads in all organisations (e.g. named and designated professionals, local authority and education safeguarding leads)
- All services working with children and young people (e.g. CAMHS, social care, education, substance misuse, youth justice)
- Adult mental health and forensic mental health services (including those for people with neurodevelopmental difficulties, including learning disability and autism)

3 Population Covered and Population Needs

3.1 Population Covered By This Specification

3.1.1 The service outlined in this specification is for young people ordinarily resident in England.

3.1.2 Specifically, the secure outreach service is commissioned to provide and deliver high quality mental health liaison, assessment and intervention for high risk young people with complex needs living within catchment (or belonging to that catchment but placed elsewhere) who meet the following criteria:

- under 18 years old at the time of referral (no lower age threshold for

access to the service although most referrals will be for 10 to 18 year olds)

- presenting with severe disorders of conduct and emotion, neuropsychological deficits, or serious mental health problems and/or neurodevelopmental disorders (including learning disability or autism) with/without learning difficulties or where there are legitimate concerns about the existence of such disorders
- usually involved in dangerous, high-risk behaviours whether they are in contact with the youth justice system or not. This will include young people who present a high risk to others through such behaviours as fire setting, physical assault and sexual offending.
- in exceptional cases, are not high risk (not primarily dangerous to others) but have highly complex needs (including legal complexities) and are causing major concern across agencies

3.2 Population Needs

3.2.1 In England in 2015 there were over 1450 young people in secure settings at any one time. Over 300 of these were in secure mental health settings; the remaining 1100 were in either welfare secure (approximately 100) or youth justice custodial settings (approximately 1000). Young people in all types of secure setting have clearly established significant mental health needs.

3.3 Expected Significant Future Demographic Changes

3.3.1 It is not known what the specific future demographic changes will be however there are significantly larger numbers of high risk young people with complex needs subject to high levels of supervision in a range of residential and special educational settings as well as in everyday community settings where needs and risk may be difficult to manage and therefore not be adequately addressed. 'Transforming Care' proposals sets out a requirement for dynamic registers and better understanding of local populations of children with learning disability, autism or both; such developments should feed into future developments in relation to high risk young people

3.4 Evidence Base

3.4.1 The evidence base is derived from an independent evaluation of the regional community FCAMHS service in the Thames Valley (Public Health Resource Unit, 2006) and subsequent re-evaluation of a second service replicating the service model across Hampshire and the Isle of Wight (Solutions in Public health, 2011). Both evaluations were supported by the Department of Health. A further national mapping exercise (Dent, Peto, Griffin and Hindley, 2013) identified significant disparity in provision (with many areas not having access to specialist FCAMHS) and heterogeneity of commissioning arrangements.

4 Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

4.1.1 The expected outcomes of the service support the national ambition to reduce numbers of inpatient admissions and lengths of stay; reduce variations in service availability and access and improve the experience of patients, families and carers using mental health services.

4.1.2 The expected outcome for this service include

- the provision for a specific geographical catchment of clinical consultation and specialist assessment, case formulation and interventions for young people with very complex needs across a variety of secure, custodial, residential and community settings.
- Flexibility in approach ensuring that all appropriately identified young people from the catchment receive the same quality of input and follow-up irrespective of their geographical location or the nature of their current placement
- The provision of a range of strategic, service development and training functions the maintenance of strong links with and between all agencies and services locally including children's social care, youth justice, education and third sector providers secure or specialist residential settings;
- Assessments delivered in the child's local area/current residential placement or in a setting appropriate to the child and family's needs
- Effective formulation of the needs of high risk young people with decisions on placement based on individual need rather than systemic constraints
- Appropriate access and transition to, and discharge from all forms of secure services for young people with highly complex needs.
- Admission to secure inpatient settings only undertaken when clearly indicated.
- Provision of safe, timely and effective (evidence based / best practice) assessment and intervention across the different stages of the care pathway.
- Admission of children and young people with learning disability and/or autism will be in line with 'Transforming Care' policy and 'Community Care, Education and Treatment Reviews' (CETRs) prior to any admission are actively supported
- Improved mental health and well-being by identifying and addressing the mental health needs of high risk young people in a range of secure, residential and community settings
- Minimisation of risk of harm to self and others
- An individualised, developmentally-appropriate framework of care that includes the young person and family/carers in decision making and provides for their needs.
- Principles of safe guarding children are embedded within the everyday practice of the service.
- Supplementation of local provision across agencies with specific specialist

input and case-formulation relating to the understanding and management of high risk cases

- Service accessible to all young people from an identified geographical catchment regardless of disability, sex, race, gender or current geographical location Promotion and support of young people's development
- Promotion of attachment, achievement of developmental potential, healthy family functioning and continuity of care wherever possible
- Inclusion of young people with neurodevelopmental disorders particularly learning disability and autism.

4.2 NHS Outcomes Framework Domains

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

4.3 Outcome indicators

The service will be subject to a formal independent evaluation after 12 months to be commissioned by NHS England; this will inform the on-going development of formal outcome measures. outcome and activity measures are subject to further development

No.	Indicator	Data source	Domain(s)	CQC Key Question
Clinical Outcomes				
101	Number of referrals received by the team.	Provider	1, 2, 3, 4, 5	safe, effective, caring, responsive
102	% of referrals	Provider	1, 2, 3, 5	safe,

	leading to indirect case involvement only.			effective, caring, responsive
103	% of referrals that lead to direct clinical involvement	Provider	1, 2, 3, 5	safe, effective, caring, responsive
104	% of cases with ongoing mental health involvement as part of an integrated care plan	Provider	2, 3, 4, 5	safe, effective, caring
105	% of cases with formal indirect contact accessing feedback from referrer or other professional.	Provider	2, 3, 4	safe, effective, caring
106	% of cases where reduced length of stay has resulted from active involvement in and facilitation of discharge from inpatient care	Provider	2,3,4,5	safe, effective, caring, responsive
Patient Outcomes				
201	% of cases with direct clinical contact receiving feedback	Provider	2, 3, 4	safe, effective, caring
202	Provision of service-related information for young people and families/carers and professionals.	Provider	2, 3, 4	safe, effective, caring
Structure & Process				
301	Forensic MDT membership	Self-declaration	1, 2, 3, 5	safe, effective responsive caring
302	Service infrastructure	Self-declaration	1, 2, 3, 5	safe, effective

				responsive caring
303	Provision of cross agency training	Self-declaration	2, 3, 4, 5	Safe, effective, caring
304	There are agreed patient pathways as per the service specification.	Self-declaration	1, 3, 5	Safe, effective, caring
305	There are agreed clinical protocols/guidelines.	Self-declaration	1, 3, 5	Safe, effective, caring
306	Data collection	Self-declaration	2, 3	Safe, effective, caring

4.3.1 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

4.3.2 Applicable CQUIN goals are set out in Schedule 4D

5 Applicable Service Standards

5.1 Applicable Obligatory National Standards

5.1.1 The service must deliver services, comply to and work within the requirements of

- Mental Health Act 1983, as amended 2007
- Mental Health Act Code of Practice 2015
- Human Rights Act 1998
- The Children Act 1989 and 2004
- Criminal Justice Act 1998
- Criminal Justice Act 2003
- DoH Offender Mental Health Pathway 2005
- Mental Capacity Act 2005
- The Autism Act 2009
- Transforming Care for People with Learning Disabilities – Building the Right Support
- Working Together to Safeguard Children (2010) and relevant subsequent legislation

5.2 Other Applicable National Standards to be met by Commissioned Providers

5.2.1 The service is required to comply with the following national standards, guidance, frameworks and legislation as listed below:

- NICE guidelines for a range of disorders occurring in children and adolescents (e.g. psychosis and conduct disorder)
- National Service Framework for Children, Young People and Maternity Services (2004)
- Code of Practice: See Think Act (Department of Health 2010).
- Every Child Matters in the Health Service (DoH, 2006)
- New Horizons for Mental Health (DoH, 2009)
- DoH/YJB Information Sharing Guidance
- Future in Mind (DoH and DfE, 2014)
- Supporting people with a Learning Disability and/or Autism who Display Behaviour that Challenges, including those with a Mental Health Condition: Service Model for Commissioners of Health and Social Care Services ('Transforming Care')
- The Evidence Base to Guide Development of Tier 4 CAMHS (Department of Health; Kurtz, Z April 2009)
- Promoting mental health for children held in secure settings: a framework for commissioning services. London: DH, 2007
- Procedure for the Transfer from Custody of Children and Young People to and from Hospital under the Mental Health Act 1983 in England (DoH, June 2011)
- Information Sharing - Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government, March 2015)
- UN Convention on the Rights of Persons with Disabilities
- Healthcare standards for children and young people in secure settings (2013) Intercollegiate Document (Royal College of Paediatrics and Child Health (RCPCH), Royal College of General Practitioners, Royal College of Nursing; Royal College of Psychiatrists, Royal College of Forensic and Legal Medicine and Faculty of Public Health)
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (DFE March 2015)
- Healthy Children Safer Communities (DoH, 2009)

5.3 Other Applicable Local Standards

Not applicable

6 Designated Providers (if applicable)

Not applicable

7 Abbreviation and Acronyms Explained

7.1 The following abbreviations and acronyms have been used in this

document:

- **CAMHS** Child and Adolescent Mental Health Services
- **CCG** Clinical Commissioning Group
- **CETR** Care education and Treatment Review
- **FCAMHS** Forensic Child and Adolescent Mental Health Services
- **PICU** Psychiatric Intensive Care Unit
- **SCT** Secure Training Centre
- **SEND** Special Educational Needs and Disability
- **YOI** Young Offenders Institute
- **YOT** Youth Offending Team

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