

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

## South Gloucestershire

October 2018 Refresh



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## **1. Introduction**

The South Gloucestershire Children and Young People's Emotional Health and Wellbeing Transformation Plan 2018 provides information on delivery against transformation plans from April 2017 – March 2018 and progress to date in year.

## **2. South Gloucestershire context**

The substantive Children's Community Health Partnership contract commenced 1st April 2017. Sirona Care and Health are the Prime Provider and subcontract to Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) to provide CAMHS community and Off the Record (Bristol) Ltd to provide early interventions and counselling. NHS England hold a separate contract with AWP for the provision of Tier 4 Inpatient Services (Riverside).

AWP are undertaking a programme of transformational change, in terms of clinical pathways, interventions, organisational structure and IT implementation. Partnerships between providers have strengthened.

On 1<sup>st</sup> April 2018, South Gloucestershire CCG merged with Bristol and North Somerset CCG's to form one commissioning organisation across the whole of the BNSSG area. The South Gloucestershire 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.
- 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.

In 2016, the first South Gloucestershire Children and Young People's Mental Health Needs Assessment and South Gloucestershire Children and Young People's Mental Health and Emotional Wellbeing Strategy were published:

(<http://www.southglos.gov.uk/health-and-social-care/staying-healthy/mentalhealth-emotionalwellbeing/young-people-and-mental-health/>). The work from both of these reports supports and informs the 2018-19 transformation plan update.

South Gloucestershire Council published the South Gloucestershire Young People and Families Partnership Plan 2016-2020:  
(<http://www.southglos.gov.uk/documents/CYP-and-Families-Plan.pdf>)

The South Gloucestershire vision for Children and Young People is:

*‘Enabling every child and young person to thrive. Children and young people should have a good start in life, be safe and do as well as they can, while being able to access support when necessary’.*

The plan outlines 15 South Gloucestershire priorities for children, young people and their families and indicators to show if council, education and NHS funded services are making a difference:

#### **FIFTEEN PRIORITIES:**

1. Help children to live in safe and supportive families
2. Ensure that the most vulnerable are protected
3. Improve achievement and close achievement gaps in education
4. Increase numbers of young people participating and engaging effectively in their communities
5. Improve outcomes for children and young people with special educational needs and/or disability
6. Support children to have the best start in life and be ready for learning
7. Support educational settings to improve attendance and develop positive behaviour
8. Encourage physical activity and healthy eating
9. Ensuring young people have a clear route to employment and training so they can participate in a growing economy
10. Minimise the misuse of drugs, alcohol and tobacco
11. Ensure young people and their families have access to the right information and advice to make their own choices
12. Improve social, emotional and mental health and wellbeing for all children and young people
13. Reduce the number of children and young people in poverty and ensure they live in safe, stable and affordable homes
14. Increase engagement and participation, voice and influence of young people.
15. Offer families in need, support at the earliest opportunity

#### **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.

### 3. South Gloucestershire Needs Assessment

The South Gloucestershire CYP needs assessment was outlined in detail in the 2016 LTP plan. Health outcomes information is provided in Appendix 1.

#### Key findings from the South Gloucestershire Children and Young People’s Mental Health Needs Assessment

There are an estimated 64,600 children and young people under the age of 19, representing 24% of the overall population of South Gloucestershire (274,700). Children from black, Asian and minority ethnic groups comprise approximately 5% of the population. There are 129 schools or colleges in the area.

**Table 1 - South Gloucestershire Population Projections, 2012-2037, ONS <sup>1</sup>**

Age Band	2012	2017	2022	2037	% change 2012-2022	% change 2012-2037
0-4	16,200	16,400	16,800	17,000	3.7%	4.9%
5-9	15,200	17,000	17,300	17,700	13.8%	16.4%
10-14	15,200	15,500	17,400	18,100	14.5%	19.1%
15-19	17,700	16,000	16,300	19,000	-7.9%	7.3%

Whilst health outcomes for children and young people are generally good in South Gloucestershire, (see Appendix, Figure 2), approximately 10% of the population of

<sup>1</sup> Source:2012 based sub-national Population Projections, ONS

South Gloucestershire are living within some of the most deprived neighbourhoods in England<sup>2</sup>. Socio-economic disadvantage is a significant risk factor for poor mental health in children and young people, with those growing up in the poorest households at three times greater risk for developing a mental health problem compared to those growing up in less deprived homes.<sup>3</sup> Furthermore, deprivation can underpin a range of other risk factors within the family unit, schools, and communities, touching on every aspect of a child’s future, including their mental health outcomes.<sup>4</sup> Child poverty has been identified as a particular risk factor in South Gloucestershire. Many families are just managing finances and we have concerns for the short to medium term impact of the introduction of Universal Credit in South Gloucestershire. At the time of updating this plan in October 2018, Universal Credit has gone live in South Gloucestershire areas covered by the Horfield Job Centre – Patchway, Filton, Almondsbury, Stoke Gifford, Bradley Stoke, Cribbs Causeway, Severn Beach, Thornbury and Oldbury. Yate and Kingswood job centres will follow in late October 2018.

The Children and Young People’s mental health needs assessment highlights the following as particular local risk factors for inclusion in future service developments and strategy;

<b>Maternal and family</b>	<b>Infant and school age:</b>
Low birth weight Smoking at time of delivery <18s conceptions and teenage mothers Child poverty Parental unemployment Looked after children Lone parent households Long term conditions/disabilities including Autism LGBTQ+ Gypsy and Traveller Domestic abuse Parental alcohol and drug abuse	Learning disabilities Children providing care Children in need due to abuse or neglect School absence Obesity

### **South Gloucestershire Strategy for Children and Young People 0-25 years old with Special Educational Needs and Disabilities (SEND) 2018-2023**

This strategy sets out further information on the school age population and beyond in the area. Based on data from October 2017, the current school population in South Gloucestershire is 39,030 of which primary is 23,326 and secondary is 15,704 including 16-18 year olds. 355 children are known to the 0-25 Social Care team.

For year 12 and 13 there are approximately 5703 young people in total. 4638 (81%) attend FE college, sixth forms in schools and sixth form colleges. 777 (13.6%) are in employment and 1.2% are available for employment. Training has been taken up by

<sup>2</sup> South Glos health profile PHE

<sup>3</sup> CMO 2010 report

<sup>4</sup> Marmot review

19 (0.3%) of the group. The remaining year 12 and 13 are not in education, employment and training, their destination is unknown since leaving school or they are ill or taking up carer roles.

South Gloucestershire has a greater proportion of school age children identified with SEND with an EHC plan than the England national average (3.2% of school age children in South Gloucestershire compared to 2.8% across England). In contrast there is a lower proportion of children identified at SEND support in South Gloucestershire than the national average.

Approximately 45% of children in South Gloucestershire with an EHC plan have their primary need identified as speech, language and communication needs or autism. It is anticipated that the numbers of children with social emotional and mental health needs will increase over the lifespan of this strategy<sup>5</sup>.

### **Mental Health prevalence in South Gloucestershire**

The South Gloucestershire Council Public Health Team has an ongoing process for engagement with local schools to help them support the children and young people in their care. In 2017, CASCADE training was held and a number of positive actions came out of this. Firstly we now have a Mental Health & Emotional Wellbeing lead for all schools in South Gloucestershire. We also have undertaken an audit that charts outcomes and engagement for all schools and has resulted in a RAG rating we use to target our support. We have subsequently followed this up with a questionnaire that asks all school what they currently do, gaps and their willingness to invest in an area wide offer. This is then being followed up at school cluster meetings.

One particular finding is the disparity in the 11+ and 5-11 offers with primary schools feeling they do not get as much support. This is now being addressed and there is a slot in the January 2019 Health and Wellbeing Board meeting to explore this further and resource and implement the recommended solutions.

Future in Mind (2015) and Mental Health Five Year Forward View acknowledge that one in 10 children between the ages of 5 and 16 years old has a diagnosable mental health problem. Subsequent analysis is revising these estimates. In BNSSG the analysis shows that up to 1 in 4 teenagers may have self-injured. One of the key mechanisms for tracking the health and wellbeing of school pupils is the online Emotional Health and Wellbeing Survey. The survey has completed its second cycle in 2017 with approx. 6500 young people completing the questions. The public health team are using the findings to start targeted interventions with schools and this will also contribute to the work around the joint mental health and schools programme CASCADE.

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<sup>5</sup> Source: Strategy for Children & Young People 0-25 years old with Special Educational Needs and Disabilities (SEND) in South Gloucestershire 2018-2023.



## Transition between CYP and Adult MH Services

South Gloucestershire have had a focus on Transition for people with SEND and LD as a whole for the last 18 months. One of the key developments has been the creation of a new 0-25 Transition team to help facilitate and support young people, young adults and their families, partners, providers and communities to find solutions that enable young people to continue to live at home or independently within the community.

The team supports the Local First framework. For further information please click [http://www.southglos.gov.uk/documents/0\\_25-SEND-Transition-Team.pdf](http://www.southglos.gov.uk/documents/0_25-SEND-Transition-Team.pdf)

The Transition Team have produced 4 key transition pathways around EET, Housing, Health and Social that have been designed to promote self-support through our local PFA offer providing key things to consider when planning to prepare to adulthood.

A multi agency transitional operational group meet every 6 months to identify future young people that will need transition support. This group includes professional from adults and children social care teams, Education Officers, Head Teachers, SGS College, Housing, CLDT, Clinical Commissioning Group, Bristol Community Health, CCHP, Avon and Wiltshire Mental Health Recovery team transition, CAMHS transition.

The group will also look more strategically at the transition support needed for the region going forward.

## South Gloucestershire online pupil survey comparison 2015 and 2017

The majority of outcome scores have shown a negative trend between 2015 and 2017.

Measure	2015 score	2017 score
Self-harm	5.0%	6.8%
Currently being bullied	6.6%	9.2%
Stressed	17.5%	22.9%
Good at making friends	81.3%	76.1%
Satisfied with life	73.5%	72.9%
Happy at school	71.4%	61.6%
Confident about the future	88.5%	85.6%

1779 (73%) young people completed the 14 questions which provide a Warwick Edinburgh Mental Health & Well Being Score:

- 65% (1161) scored within 'average' mental health and wellbeing
- 16% (288) scored within 'low' mental health and wellbeing
- 11% (200) scored within 'very low' mental health and wellbeing – an indicator of requiring an intervention to support them



- 7% (130) scored within 'high' mental health and wellbeing.

25% of 2739 (79%) primary aged children completed the 14 questions which provide a Warwick Edinburgh Mental Health & Well Being Score:

- 63.5% (1736) scored within 'average' mental health and wellbeing
- 27% (748) scored within 'high' mental health and wellbeing
- 6.5% (175) scored within 'low' mental health and wellbeing
- 3% (80) scored within 'very low' mental health and wellbeing – an indicator of requiring an intervention to support them.

The South Gloucestershire Children and Young People's Mental Health and Emotional Wellbeing Strategy 2016-2021 has action plans for 7 main areas, based on:

- **Increasing demand** on services due to predicted population growth.
- Children and young people with specific **risk factors** are particularly vulnerable.
- **Significant unmet need** exists at all levels, particularly for those sub-threshold.
- **Preventative services** have a key role in stopping people becoming unwell and promoting positive mental health.
- Services must be **timely** to ensure access is available when needed.
- Services for **16-25 year olds** should be accessible, flexible and based on need.
- A **whole family approach** (including a focus on perinatal and maternal mental health) is crucial.
- **Clear, accessible information** on mental health and available services

National KPI: Improve Access Rate of CYPMH E.H.9

Local analysis of Children and Young People accessing NHS funded mental health support:

CCG	Eligible population estimate 16/17	15/16 actual	16/17 actual	17/18 (30%) est	18/19 (32%) est
South Gloucestershire	4800	1514	1760	2128	2272

#### 4. Participation

Building on the participation around the commissioning process of CYP Mental Health there are three main areas of participation:

- Barnardo's support and facilitate participation in CAMHS and children's community services
- Off the Record have in house peer support and participation forums
- South Gloucestershire public health have led on the distribution of small grants for projects in primary and secondary schools (see report below).

CYP have recently worked with Barnardo's around their priorities for mental health and wellbeing. They highlighted a number of priorities: relationships with professionals, choice of therapy and therapists, 24/7 access to crisis support, thresholds of services, concerns that people were told they were not ill enough for services, improved communication between schools, GPs, CAMHS. More options for feedback to services.

Young people had particular concerns:

- Children with disabilities including CYP with Autism or ADHD are receiving enough support
- It's not only girls – boys need support too
- Involve every secondary school in CYP MH provision
- Reaching ethnic minorities
- Understanding religion
- Let people know they are not the only one
- Reduce stigma
- Professionals to help them with their journey
- Children and Young people are resources for change

They would also like to organise festivals and events, be involved in delivering training – Mind out is a good example, publish newsletters and have fun.

## **5. Transformation plan governance**

The implementation of the transformation plan is driven by the BNSSG Children and Young People's Emotional Health and Wellbeing Transformation and STP Steering Group. This group feeds into the Children's Community Health Partnership (CCHP) monthly contract and performance meeting. The transformation plans also report to the South Gloucestershire CYP Whole System Mental Health & Emotional Health and Wellbeing Group. The Transformation plan and wider strategy and operational issues arising are reviewed within the South Gloucestershire Children, Young People and Families Partnership Board which reports directly to the South Gloucestershire Health and Wellbeing Board.

The core work streams align across Bristol, North Somerset and South Gloucestershire. BNSSG project plans are being monitored.



## **6. What are we planning for 2018/19? New developments for CYP mental health in South Gloucestershire**

### **Mental health promoting school (including FE)**

Through 2016 and 2017 a lot of support has gone into schools but it has been felt that external support and training, whilst useful, do not fully achieve positive culture change in school that is needed to promote positive mental health for our school aged CYP.

To address this, we are working via the Health in Schools programme and supported by a grants programme to help schools develop their own whole school plans for improved mental health and emotional wellbeing. Impact will be measured via online pupil survey data.

### **Addressing Adverse Childhood Experiences (ACEs)**

A multi-agency ACEs Steering Group has convened to drive the local response to ACEs and develop an approach within their own organisations as well as coordinating work across South Gloucestershire as a whole.

South Gloucestershire is one of the first local authorities to take an organised approach to raising awareness of ACEs and to 'get ACEs on the agenda'. An ACE informed approach is being developed, with a focus on recognition, prevention and early intervention across the life course. As a partnership, with leadership from Public Health and others, we are promoting the systems and 'culture' change that is needed to:

- Support and build resilience in families and children who are at risk of exposure to ACEs,
- Recognise the signs and symptoms of ACEs to enable appropriate early intervention
- Recognise the impacts of ACEs already experienced to help people receive support. We will take a co-ordinated strategic and operational approach, and link into existing and emerging strategies including the Early Help Offer and the BNSSG Mental Health strategy.

To drive this work a Specialist Health Improvement Practitioner (SHIP) post specific to ACEs was established. Work to date (March 2018-August 2018) has evolved from the initial project brief and it has predominantly focussed on scoping and mapping the picture of adverse childhood experiences across South Gloucestershire. A short awareness raising workshop was delivered on 23 occasions in team meetings and training events. As part of this workshop, delegates were asked to complete a short exercise asking them a range of questions around their understanding of ACEs and what they need in order to deliver ACE-aware work. 396 people working in South Gloucestershire across sectors (e.g. Education, Voluntary and Social Enterprise sector, Early Years, Social Care and Health) responded to the mapping exercise.

The ACEs Specialist Health Improvement Practitioner (SHIP) post in the Public Health and Wellbeing Division, is working to:

- Gather and interrogate multi-agency data to build a local picture
- Map current services and interventions across the life course
- Develop information and training for staff, elected members and partner agencies
- Mental health in the context of Early Help and SEND strategies.

Two recent significant pieces of work in South Gloucestershire are the development of the Early Help and SEND strategies. Work has taken place to make sure that improving mental health is a theme running through both of these pieces. This has involved the adoption of joint targets and performance measures and more co-ordinated investment.

## **Health & Justice**

The review of mental health support for children and young people involved in the criminal justice system<sup>6</sup> prioritised 3 areas for BNSSG:

- Additional mental health support embedded in the YOS
- 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 for 4 SLT days a week into South Gloucestershire Youth Offending Service, Bristol Youth Offending Service and Vinney Green Secure unit. The South Gloucestershire Youth Offending Team have access to the SLT one day per week, additionally, the current full-time Primary Mental Health Specialist is made up of 2 part time posts each funded from different streams including Health and Justice.

## **Connect 5 training**

Connect 5 is a programme developed by the Royal Society of Public Health (RSPH) to give frontline staff the confidence to have more effective conversations with the public about their mental health and wellbeing. Although this is an all age, across the board initiative, Public Health England and Health Education England funded people to undertake the “train the trainer” courses, one of whom is based within the South Gloucestershire Youth Offending Service and will in turn be delivering this to colleagues within the team in October 2018.

## **Co-ordinated investment across the pathway**

As already referenced, key commissioners of CYP mental health services have been working more closely to co-ordinate their investment to build a single co-ordinated and well-funded care pathway. The key funders of this work are the CCG and South

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<sup>66</sup> NHSE (2016) Review of Health and Justice Pathways for the CAMHS Transformation NHS England South (South West and South Central); A,Hewitt.

Gloucestershire Council including public health and children's services as well as education and schools.

A report on this investment, the care pathway and measurement of impact is being taken to the Health and Well Being Board in January 2019.

### **Better use of data to target support**

Another key development in our local work has been getting much better data to measure impact across the whole care pathway. This ranges from our online pupil survey that gathers data from over 6,000 young people about a number of wellbeing outcomes through to specific service and training service data.

This has been collated into a system scorecard that then reports up to the Children, Young People and Families Partnership in the form of an annual report.

### **Creating a coherent and well understood local CYP mental health offer**

We have had consistent feedback that the local CYP mental health offer and care pathway is not well understood and this continues to be an area that needs addressing. The new Mind You website has addressed this in part but more work is still taking place to simplify the offer. Part of this is working with AWP to make sure the new i-thrive model they are working to in South Gloucestershire and Bristol works alongside the pre-existing structures and local strategy and action plan.

## **7. 2017-18 Delivery of plan and 2018-19 objectives**

<b>7.1 Emotional Health and Wellbeing Primary Care Project</b>	
Expansion of provision of preventative and early intervention emotional health and wellbeing interventions to children in South Gloucestershire.	
<b>Outcomes</b>	Increased CYP understanding of mental health and coping strategies. Improved knowledge, confidence and skills of CYP workforces.
<b>Guidance</b>	<ul style="list-style-type: none"> <li>• DH Future in Mind strategy</li> <li>• South Gloucestershire CYP Mental Health Needs Assessment, Strategy and Action Plan</li> <li>• South Gloucestershire Online Pupil Survey 2017</li> <li>• 'Transforming children and young people's mental health provision: a Green Paper', 2018</li> </ul>
<b>Activity</b>	<p><b>Promoting resilience</b></p> <ul style="list-style-type: none"> <li>• Delivery of resilience workshops in schools – commenced most activity has been in secondary schools but more delivery to 5-11 year old is a future focus.</li> <li>• Rollout of mental health promotion workshops for parents/carers – commenced These sessions have been very well attended and well received across South Gloucestershire. Roll out will be sustained over the coming period.</li> <li>• Launch of school mental health standards scheme in Oct 2017 – pilot commenced. Initially it has been difficult to recruit schools to this scheme but extra resource has now been added and this has</li> </ul>

	<p>resulted in higher levels of engagement.</p> <p><b>Workforce development</b></p> <ul style="list-style-type: none"> <li>• CYP mental health conference for CYP and workforces inc. VCSE – achieved for 2017.</li> <li>• Local schools Time to Change Network established – achieved.</li> <li>• Youth Mental Health First Aid training for all school nurses – achieved.</li> <li>• Youth Mental Health First Aid training for all school mental health leads – commenced.</li> <li>• CASCADE schools and CAMHS partnership improvement workshops – Oct/Nov 2017.</li> <li>• Roll out of mental health improvement training to CYP workforces – commenced.</li> <li>• Identifying mental health lead for every school in South Gloucestershire – completed.</li> <li>• STORM self-harm and suicide prevention training to start in autumn 2018. This is being jointly delivered by a local group of trainers recruited from social care, mental health and voluntary sector partners. These same workforces will be recruited as participants and it is anticipated significant number of the staff working with South Gloucestershire’s most vulnerable young people will be upskilled through this training.</li> </ul> <p><b>Communications</b></p> <ul style="list-style-type: none"> <li>• CYP mental health website, pilot Sept 2017, launch Feb 2018 – commenced The new Mind You website had over 10,000 unique visitors in the first 6 months. The next plans are to build it into the curriculum in a structured way that ensures all CYP and parent/carers are aware of the site, its content and how to access it.</li> <li>• Promoting national mental health campaigns – commenced Children’s Mental Health Week in February of each year.</li> </ul> <p><b>Participation work</b></p> <ul style="list-style-type: none"> <li>• Recruiting young people and parents/carers to help us develop our local web content and a systematic approach to promoting engagement with that content. A series of focus groups took place during the development of the website and the content reflects this. The next stage is to run more groups to gain feedback on the website and then make improvements addressing the feedback. – commenced.</li> </ul>
	<p><b>Knowledge and skills</b></p> <p>There will be a particular focus during 2017-18 in supporting skills and confidence in the workforce to support a child or young person. There will also be work across Early Help and mental health services to ensure that timely professional advice is available.</p>

	We now have a comprehensive and well attended range of training courses for the different workforces that support Children and Young People. We have also recently added more access to supervision session to help these professionals hold risk when working with Children and Young People experiencing mild to moderate mental ill health.
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### Indicators for the Emotional Health and Wellbeing Primary care Project

Local priority	Outcome	KPI	KPI target	2016/7	2017/8
Promoting resilience	Increased CYP understanding of mental health, resilience and coping strategies	Number of CYP attending resilience sessions  % reporting increase in understanding	750	931  74%	1718  92% of Primary school CYP 79% of secondary CYP
Workforce development	Increased knowledge, skills and confidence of professionals in supporting CYP around mental health	Number attending training sessions  % reporting increase in knowledge, skills and confidence	750	950  96%	650*  98%
Communication	People engaged online and at events	Number of unique users online  Number of people engaged at events	1250 unique users online  175 people engaged at events	1002  164	3552  56
Participation work	Participation and engagement of CYP and parents/carers in implementation plans	Public engagement	Ongoing participation work	7 groups. 85 young people	4 groups 21 young people

\* There has been a shift from mainly 90 minute training sessions in 2016/17 to mainly 1 and 2-day courses in 2017/18



## Mind You



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

In February 2018 the Mind You website was launched, a hub for children and young people's mental health and emotional wellbeing in South Gloucestershire. Many local young people, parents and professionals were involved in creating the content and design, and young people from Off the Record and two local schools appear in images on the site. There are sections for primary age children, teenagers, parents/carers and professionals. The young people's areas have A-Zs of common issues, pages detailing local and national services and resources, and a section containing information on looking after their own mental health.

### Small grants programme

Small grants totalling £10,000 were awarded to fourteen schools and youth organisations to develop and deliver mental health promotion activities during Children's Mental Health Week 2018 and beyond. Activities included launching Jigsaw PSHE in five primary schools, resilience workshops, physical training, and 'Connect with respect' sessions. 4000 children and young people took part in activities; 88% said that their understanding of mental health and emotional wellbeing had improved and 84% said that they learned new strategies to build resilience and cope with worries.

### 7.2 Expansion of tier 2 interventions

The expansion of tier 2 interventions is a priority for South Gloucestershire CCG. Additional recurrent funding was agreed by the CCG in addition to the transformation funds and Public Health funding to significantly increase the capacity of Off the Record in South Gloucestershire.

Outcomes	Improved self-reported mental health and wellbeing for clients Consultation and reference for young people and their families
Guidance	Five Year Forward View Public Health Evidence Review South Gloucestershire CYP Mental Health Needs Assessment South Gloucestershire emotional health schools survey 2015
Activity	Off the Record are providing a number of brief interventions from the community Armadillo café and in schools. Art Therapy CBT Counselling Youth Mental Health Practitioner (YMHP).

CBT and YMHP Interventions are being offered to schools on a weekly basis for 6 schools on a 6 week rotational block. These are located across South Gloucestershire. Successfully delivered in all but one secondary school Reasons for this being explored. This will be supported by CASCADE work.

**Data from Off The Record:**

**South Glos CYP – period April 17-March 18 (Up to 19 years)**

- Number of referrals : 900 (new referrals added to IAPTus for South Glos regardless of which services they accessed, if any)
- Number of Young people seen by Wellbeing Practitioner : 245 (this figure includes 99 CYP who were seen via the Youth Mental Health Practitioner pathway)
- Number of young people seen in 1-1 therapies : 277 (1:1, outreach, art, drama and ProReal)
- Number of young people who attended mind aid/ armed: 28
- % of young people reporting improved outcomes following an intervention: 71%
- % of young people who waited longer than 4 weeks for an intervention : 30%.

**Total workforce numbers – please note that this is for Bristol and South Gloucestershire as a whole.**

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

**Resilience lab figures:**

Public Health are funding the Resilience Lab:  
 Weekly Drop-in of a rolling programme of 5 evidence based sessions and whole class resilience interventions.

Total labs delivered - 118  
 Total young people attending - 2340

	<p>% reporting increased knowledge following attendance - 85%</p> <p>Parent Support: weekly parent support drop-in at the Armadillo café was piloted for 8 weeks. This was been offered to all parents of YP 11-15 on the OTR South Glos waiting list who have expressed interest in receiving further support. This provision is continuing to run.</p>
2017-18	<p>Successful SCN bid for non-recurrent funds from NHSE to expand number of locations.</p> <p>Continuation of school interventions rolling programme.</p> <p>Continuation of sessional outcomes monitoring</p>

### 7.3 Community Eating Disorders Pathway

A key project for 2017/18 is the progression of a clinical pathway for community eating disorders across the South Gloucestershire, Bristol and North Somerset areas.

Outcomes	Children and Young People with an Eating Disorder will receive support within 4 weeks for routine cases and 1 week for urgent cases.
Guidance	NICE guidance Eating Disorder CYP IAPT
Activity	<ul style="list-style-type: none"> <li>• Interim development pathway for Eating Disorders – June 2016</li> <li>• Joint action plan for Community Eating Disorder pathway delivery AWP and Weston Area Health Trust – ongoing</li> <li>• Recruitment of transformation manager in AWP – complete</li> <li>• Recruitment to Eating Disorder posts AWP – complete</li> <li>• Enrolment of ED staff in CYP ED IAPT training – completed</li> <li>• Baseline data against waiting times AWP – completed</li> <li>• SUCCEED sessions to help young people have improved body image being piloted in two local secondary schools by the University of the West of England. Complete initial report received.</li> <li>• Programme plan for early intervention to be delivered with new ED transformation manager, Public Health and AWP. Complete</li> <li>• Monthly access and waiting times data – achieved significant improvement. South Glos waits: 1 week = 66.7%, 28 weeks = 66.7%</li> </ul>
2017-18	<ul style="list-style-type: none"> <li>• Finalising clinical pathways.</li> <li>• Finalising CYP and family information.</li> <li>• CYP Eating Disorder conference planning for October 2018.</li> <li>• Full launch of Expert Reference Group.</li> <li>• Collaborative commissioning with NHSE – New models of care to reduce inpatient admissions for CYP ED by further investment in community ED services – home treatment, assertive outreach.</li> <li>• There were three urgent eating disorder referrals of which two started treatment within 1 week. There were 33 routine eating disorder referrals, 66.7% started treatment within four weeks.</li> </ul>

#### 7.4 CAMHS assessment and treatment pathway

A key priority is to reduce waiting times for children and young people in child and adolescent health services.

Outcomes	Reduction in waiting times for routine and acute mental health needs Reduction in referrals for tier 4 services
Guidance	Tier 3 national service specification CYP IAPT programme
Activity	<ul style="list-style-type: none"> <li>Recruitment of additional staff to the core CAMHS team achieved</li> <li>Additional administrative support for the Central Intake Team (single point of access) - achieved</li> <li>Recurrent investment to support CYP in mental health crisis in the emergency department and in the community – subject to BNSSG business case</li> </ul>
2017-18	<ul style="list-style-type: none"> <li>Single point of access – embedded but consolidating</li> <li>Waiting times for routine referrals remain high.</li> <li>Year end performance 62.5% of life threatening referrals assessed within 2/24 hours (although August to March 100%)</li> <li>27.2% of routine referrals assessed within four weeks, 88.2% of routine referrals followed up within eight weeks of assessment.</li> <li>Mitigating actions; strong partnership with Off the Record, launch of iThrive October 2017. Wider workforce training.</li> <li>Operational pressures remain in the team – further recruitment pending outcome of BNSSG business case.</li> <li>CAMHS DNA rates were low at 3.7% (target is 6% maximum). Only 1.9% of appointments were cancelled by the service (target 3% maximum). However only 75.3% of patients were seen within 18 weeks (target 92%)</li> </ul> <p>A business case was approved for £730k recurrent funding, a proportion of which is allocated to South Gloucestershire CAMHS and new trajectories agreed.</p> <p>South Glos CAMHS FTE Clinical 22.8 Admin 4.45 Total 27.25</p>

#### 7.5 Be Safe

Delivery of the Be Safe Project to children under the age of 11 in South Gloucestershire

Outcomes	Reduction in sexually inappropriate behaviours Reduction in community forensic referrals Skill share with families and children and young people professionals
Guidance	Oklahoma University Health Science Programme
Activity	Number of CYP 11 years and their families receiving Be Safe support
17-18	<ul style="list-style-type: none"> <li>South Gloucestershire Council seeking to block purchase support for children 11+</li> </ul>

	<ul style="list-style-type: none"> <li>• Pilot of a complementary service to the current under 11's support, which is aimed at CYP aged 12-17</li> <li>• Be Safe has so far provided advice to professionals in South Gloucestershire who have expressed concern about a young person's harmful sexual behaviour as well as completion of comprehensive assessment reports, delivery of a therapeutic intervention programme where needed and the pilot has also involved a part time (2 days a week) secondment of a member of the Youth Offending Team to Be Safe, allowing the opportunity for co-working of cases and learning and transfer of skills on this issue.</li> </ul>
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### 7.6 CYP Improving Access to Psychological Therapies

Delivering evidence based IAPT interventions.

Outcomes	Number of young people receiving evidence based interventions.
Guidance	National CYP IAPT programme. Details of all CYP IAPT streams are not yet confirmed.
Activity	Increased number of IAPT clinical sessions Number of staff enrolled in trainee and supervisory training across the delivery system CCG backfill costs to cover training posts Non-recurrent investment in autism diagnostics
17-18	Last year of HEE backfill contribution to posts. Allocation of funding direct to AWP to prioritise training needs. Included in wider workforce planning.
18-19	CYP IAPT training is continuing and South Gloucestershire CAMHS will be applying for a number of RTT posts to commence January 2019.  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.

### 7.7 Access to support in a crisis 24/7

Parity of support in a crisis for CYP

Outcomes	Improved experience of support in a crisis
Guidance	Mental Health Five Year Forward view
2017 -18	24/7 crisis support – investment dependent on BNSSG business case Task and finish groups – S136 CYP Emergency department presentation of 16-17 year olds. There were 140 health crisis presentations in ED, however the provider is not currently able to report the number who were assessed within the 2 hour target

## 7.8 Support for the most vulnerable

Wider CYP workforce training	
Outcomes	Enhanced case management approach for CYP with involvement in criminal justice system Robust training to support CYP who self-injure
Guidance	Public Health Wales: Adverse Childhood Experience work Welsh criminal justice board evaluation of enhanced case management approach.
2017 -18	120 multi-agency professionals BNSSG and BaNES attended Trauma and Recovery Training – funded by NHSE Health and Justice Collaborative Commissioning Increased capacity in Youth Offending Services of mental health support worker STORM skills planned for early 2018 – 4 trainers to be trained to roll out programme to 90 South Gloucestershire health and social care staff in 2 years.
	Local authority statutory requirement to outline offer for special education and training provision. <i>‘supporting the emotional, mental health and social development of disabled children and young people and those with special educational needs (this should include extra pastoral support arrangements for listening to the views of pupils and students with SEN and measures to prevent bullying’</i> <sup>7</sup>

## 7.9 Reducing out of area placements

Reduction in out of area inpatient placements	
Outcomes	More CYP treated closer to home or in the community
Guidance	NHSE new models of care
2017 -18	Collaborative commissioning to increase number of inpatient beds in the South West.

## 8. Risks and Mitigations

Risk	Mitigation
<b>Workforce/recruitment:</b> National workforce capacity issues, slow recruitment processes within larger organisations	Workforce Development Plan in place, BNSSG planning underway to support area-wide recruitment/sharing of staff, continued participation in IAPT programme, comprehensive planning of projects and programmes.
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.

<sup>7</sup> Section 4.32 Special Educational Needs and Disability Guidance. 2015. Department for Education, Department for Health.

## 9. 2018/19 and beyond

South Gloucestershire is working across BNSSG STP to ensure the sustainability and improvement of children and young people's mental health services and experiences. BNSSG commissioners and providers are working together to deliver the requirements of 'Future in Mind' and the all age requirements of the Mental Health Five Year Forward View.

### 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.

The *2017-2019 NHS operating planning and contracting guidance*<sup>8</sup> 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.

A Psychiatry Liaison BNSSG project relating to 16 and 17 year olds was completed to increase clarity and more alignment of pathways across BNSSG. There has been training for adult Emergency Department staff. The pathways will be reviewed with future investment.

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

Health 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

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<sup>8</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf>



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.

Furthermore, the South Gloucestershire Strategy for Children & Young People 0-25 years old with Special Educational Needs and Disabilities (SEND)<sup>9</sup> was recently published following engagement and consultation events earlier this year. The Strategy set out details of six main priorities and key themes going forward, which are intended to show how the strategy as a whole will be implemented. Those relating to mental and emotional health and wellbeing are listed below:

**Priority 2 – Timely Identification, assessment and reviews leading to improved outcomes:**

- **2H** – Schools to develop a whole school approach to supporting children with mental health and emotional wellbeing needs. This will include schools having a designated member of staff who links with the primary mental health specialist for schools and a Youth Mental Health First Aider who is able to recognise the signs and symptoms of mental health and provide initial support.
- **2K** – All eligible requests for support from Child and Mental Health Services (CAMHS) are met within nationally required standards with (24 weeks).

**Priority 4 – Plan services and provision to be available within the community:**

- **4I** – Implement a “whole school approach” as part of what is already available to support mental health improvement, with a focus on special schools with resource bases. The scheme includes actions on teaching about mental health and emotional wellbeing, staff wellbeing and training, parents and the school environment and ethos.
- **4P** – Identify pathways for children and families who have social emotional and mental health needs.

**Priority 6 – Support, Training and Development:**

- **6G** – Practitioners will understand and recognise the impact of Adverse Childhood Experiences (ACEs) on development, behaviour, emotional wellbeing and mental

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<sup>9</sup> Source: Strategy for Children & Young People 0-25 years old with Special Educational Needs and Disabilities (SEND) in South Gloucestershire 2018-2023.

health and provide appropriate support which is linked to the Mental Health Strategy.

## 10. Financial summary 2018-19

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

Description	Planned 2018/19 BNSSG CCG - South Gloucestershire
CCHP (Sirona) CAMHS	£1,703,000
<b>Total Block</b>	<b>£1,703,000</b>
<b>Other</b>	
ED and transformation schemes	£741,000
<b>Total Other CAMHS</b>	<b>£741,000</b>
<b>Combined Total</b>	<b>£2,444,000</b>

**NB:** In addition, £1.25 million 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 South Gloucestershire.

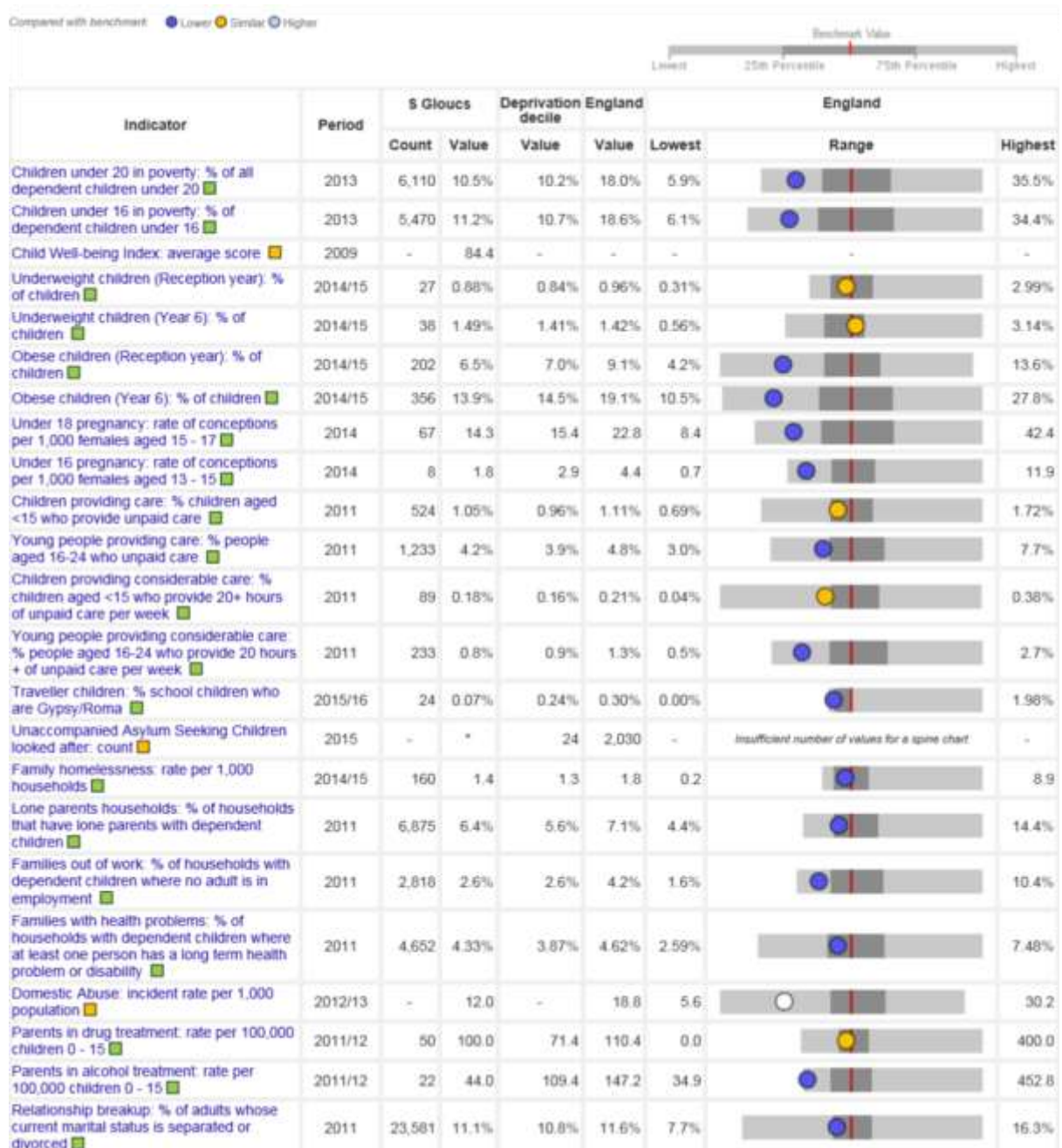
In addition to the above, there will be:

- £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

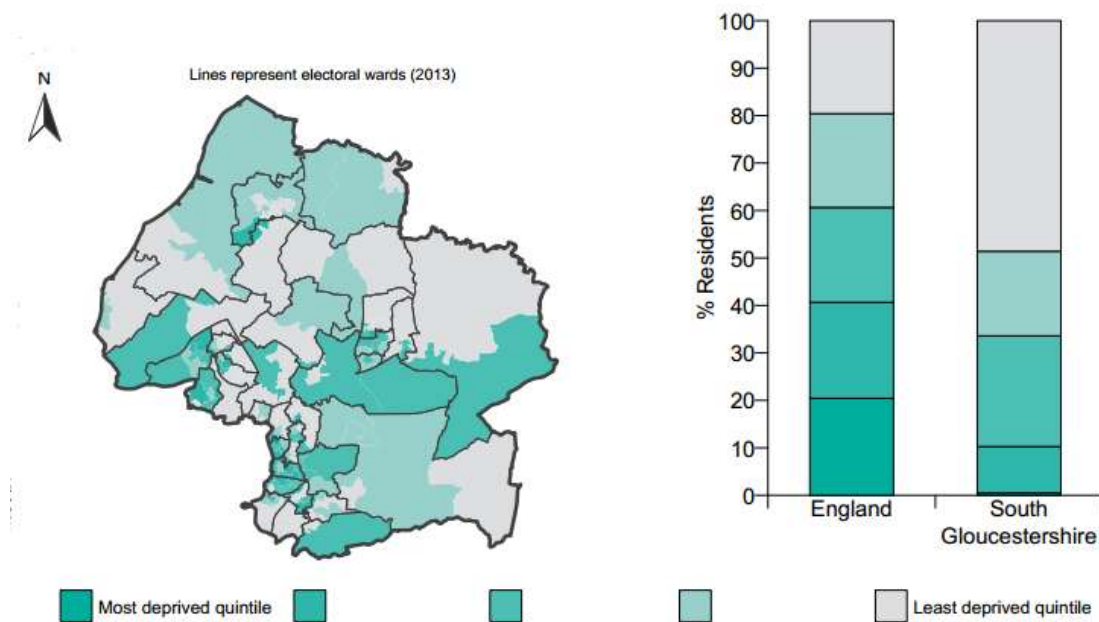


## 11. Appendices

**Figure 1 – Benchmarking report South Gloucestershire compared to England. Key health and social indicators.**



**Figure 2** – The map shows differences in deprivation within South Gloucestershire and the chart shows the percentage of the population who live in areas at each level of deprivation (from Public Health England’s South Gloucestershire Health Profile)



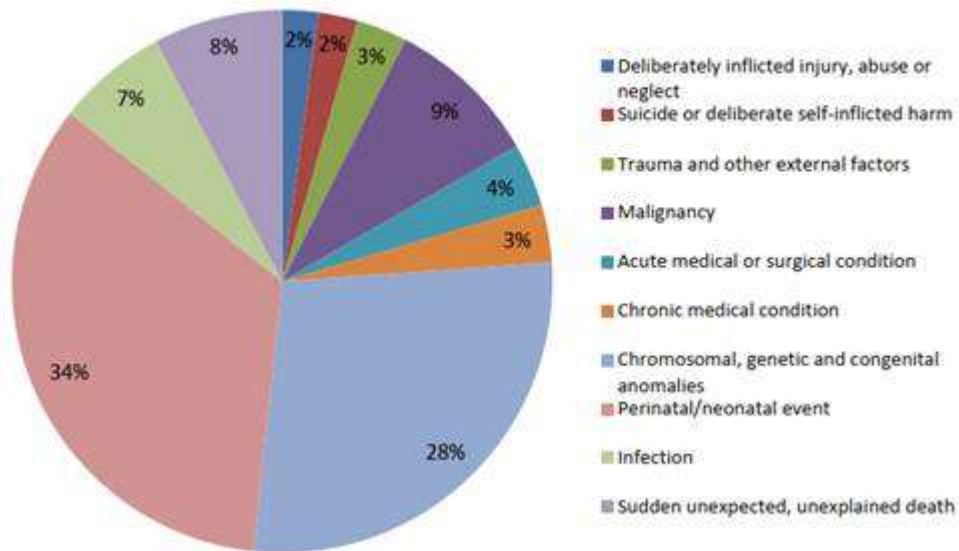
**Figure 3** – shows the prevalence of mental and emotional health disorders in South Gloucestershire compared to England.



**Figure 4** – Information on child deaths, West of England as a whole (not specific to South Gloucestershire)

Child death overview panel, West of England ([https://www.safeguarding-bathnes.org.uk/sites/default/files/woe\\_cdop\\_annual\\_report\\_2016-2017\\_-\\_final.pdf](https://www.safeguarding-bathnes.org.uk/sites/default/files/woe_cdop_annual_report_2016-2017_-_final.pdf)):  
Between 2012 and 2017, 2% of child deaths (<18 year olds who died in the West of England area or of a child residing in the West of England area who has died elsewhere) were due to suicide or deliberate self-inflicted harm. This is equivalent to ~8 to 13 deaths over a five year period across the WoE.

**Figure 6: Notifications by category of death over the 5 year period, 2012-2017**



**STP BNSSG CYP Emotional Health Plans on a page:**



STP CYP-PMH  
emotional health time



STP Plan on Page



STP Plan on Page



STP Plan CYP CEDS  
v1.2.docx



STP Plan on Page  
Tier 4 CAMHS reducti

**AWP Bristol SGlos CYP emotional health joint workforce plan:**



AWP Bristol SGlos  
CYP emotional health

**CYP emotional health Tier 4 Co-commissioning plan:**



CYP\_emotional\_health  
h\_Tier\_4\_co-commiss

FCAMHS Service Specification



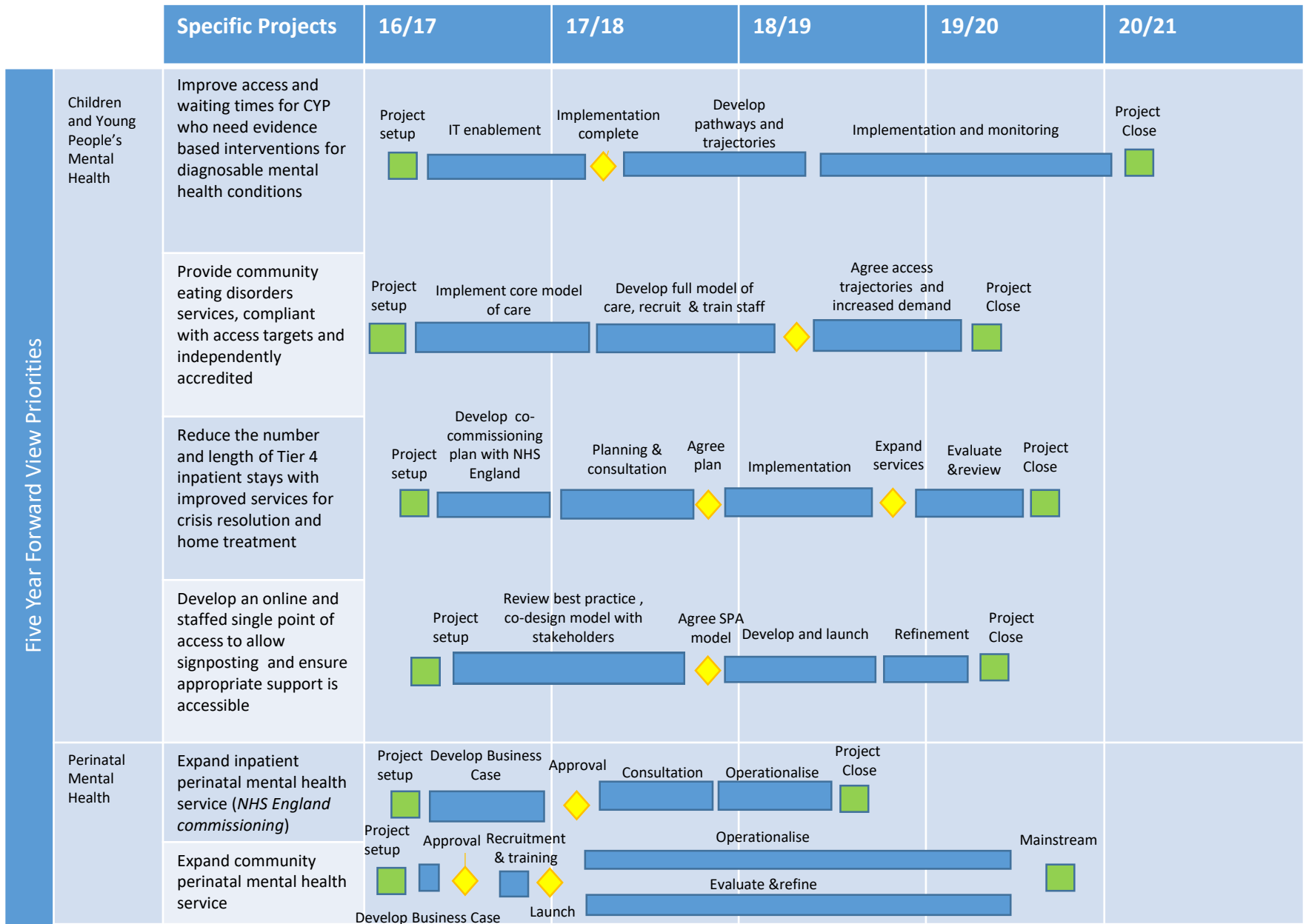
Community Forensic  
Child and Adolescent



## **APPENDIX 1**

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

# Mental Health – Women, Children and Families



## 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
<b>AWP area Total</b>	<b>5</b>	<b>4</b>	<b>5</b>	<b>5</b>	<b>9</b>	<b>1</b>	<b>29</b>
<b>North Somerset [Mark please add]</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>5</b>	<b>1</b>	<b>16</b>
<b>BNSSG Total</b>							<b>45</b>

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 1<sup>st</sup> 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\\_31\\_1016.pdf](https://www.southgloucestershireccg.nhs.uk/media/medialibrary/2016/10/sgccg_EHWP_transformation_plan_31_1016.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](http://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 18<sup>th</sup> birthday.

**Current workforce (2015/16):**

#### **Bristol CAMHS**

##### **Be Safe**

<b>Position</b>	<b>WTE</b>	<b>NHS Band</b>
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**

<b>Position</b>	<b>WTE</b>	<b>NHS Band</b>
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**

<b>Position</b>	<b>WTE</b>	<b>NHS Band</b>
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

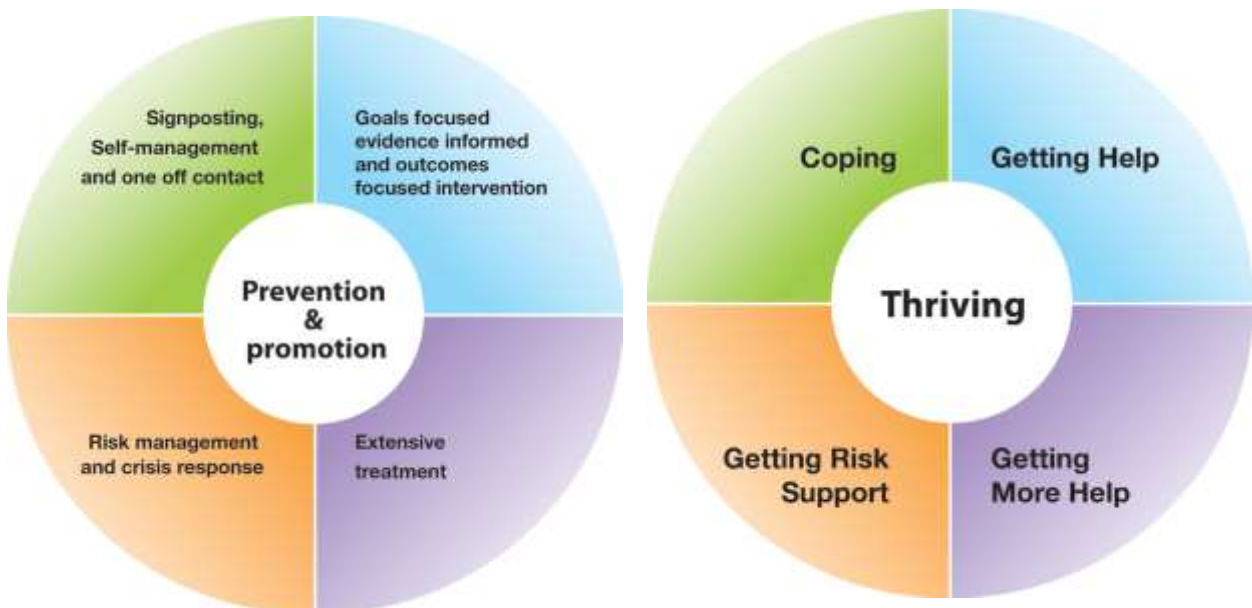
##### 4.1. Model in Bristol and South Gloucestershire

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 group<sup>6</sup>
- 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](http://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**

## Contents

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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

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

<b>1. Scope</b>
<p><b>1.1 Prescribed Specialised Service</b></p> <p>This service specification covers the provision of Community Forensic Child and Adolescent Mental Health Service (including Secure Outreach)</p> <p><b>1.2 Description</b></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><b>1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners</b></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

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

#### 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

<b>No.</b>	<b>Indicator</b>	<b>Data source</b>	<b>Domain(s)</b>	<b>CQC Key Question</b>
<b>Clinical Outcomes</b>				
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
<b>Patient Outcomes</b>				
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
<b>Structure &amp; Process</b>				
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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