

A  
child's  
journey

CAMHS and  
Emotional  
Wellbeing  
Services in  
Kirklees

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A full review of all the impact of emotional wellbeing and mental health services provided in Kirklees for children and young people on safeguarding children and promoting their welfare, commissioned by Kirklees Safeguarding Children Board from Jane Held Consulting Ltd.

October 2016

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## Executive Summary

This report provides an overview of an in-depth review of emotional health and wellbeing and Child and Adolescent Mental Health Services (CAMHS) in Kirklees. The review was commissioned by Kirklees Safeguarding Children Board (KSCB) following a lengthy period of concern about the quality and impact of services for children and young people.

The review took place between April and September 2016 and was presented in initial draft to the Kirklees Safeguarding Children Board on 9<sup>th</sup> September 2016.

The review identifies that there are good plans in place to improve specific CAMHS services but there are still significant challenges to achieve this. There is an ambition and determination on the part of senior leaders to improve CAMHS services overall. The KSCB has identified that improvement needs to be well coordinated, and strongly driven and recognises that it has a crucial role in assuring itself of positive development as the improvement journey progresses.

The review scope was to review all services provided to children to support their emotional health and wellbeing, CAMHS services and related services such as services for children and young people with autistic spectrum disorders. The aims of the review were:

- To understand the experiences and journey of children and young people through CAMHS and ensure that there is a focus on their point of view.
- To ensure that local CAMHS arrangements are safe and meet safeguarding requirements.
- To bring in an external/independent point of view.
- To take into account the whole system and reference tiers 1, 2, 3 and 4.
- To take into account, and learn from, regional and national best practice.
- To report back to inform future commissioning, and recommend changes as appropriate.

The reviewer was asked to follow the child's journey through case file audits and talking to children, young people and families; take into account the experiences of all who are part of the system; establish if the arrangements for individuals meet safeguarding standards; consider and develop core points for future contracting; set the Kirklees service provision in the context of regional and national delivery and identify issues for the Transformation Plan 5 year strategy to address.

The Review addresses the key questions and evaluates services based on what is working well and what needs further development. It has used baseline standards of good practice as identified in *Future in Mind*, the report of the Children and Young People's Mental Health Taskforce. (NHS 2012)

The questions this review addressed are:

- ❖ How are children and young people kept safe at all stages?
- ❖ How effectively are children and young people and families engaged?
- ❖ How effective is the service in terms of access, reach of service provision, knowledge of services within the system, quality of referrals and responses to referrers, families and young people?
- ❖ What is the quality and timeliness of services delivered to children and young people?
- ❖ How well do stakeholders understand current contractual arrangements, thresholds, services and monitoring data?
- ❖ What evidence is there of outcomes from interventions?

## Where we are now.

### What is going well and what is improving.

*“The service saved my life”.*

(Young person interviewed as part of the review).

#### **1. A positive environment for change.**

It is clear that change is already underway in Kirklees. Strategically there is buy in to the principle of a shared approach, with integrated strategic planning and senior manager buy in to the need to work more systemically.

The Transformation Plan is a positive force for change. A significant step forward will be if the Transformation Plan and the new Children’s Plan can share the same narrative, analysis of need, messages, expectations of multi-agency behaviours, priorities and delivery programmes as well as detailed separate service specific plans. The Council as well as the NHS needs to own and “take hold” of this process as core business, and through their direct responsibility for early help (prevention and early intervention) and for emotional health and wellbeing (a current priority in the Council’s plan).

#### **2. A strong start to the delivery of the Transformation Plan.**

There is a real can do approach to the first year of delivery of the Transformation Plan. Delivery is being tightly managed and strongly driven, and there is strong monitoring. Some of the changes made in year 1 of the Transformation plan are already showing improvements. The AskCAMHS service has been very well received, and is very well used, identifying the high level of unmet need there was previously. The crisis team is a good step forward and the focus on extending the availability of the CHEWS emotional health and wellbeing offer positive benefits. The changes that have been made by South West Yorkshire Partnership NHS Foundation Trust (SWYFT) which have been rapid and significant in their scale and impact are also a good sign. However, there is a huge amount still to do

to improve practice and ensure those they serve are fully safeguarded and have their welfare promoted.

### **3. Improvement in waiting times for initial assessments.**

Waiting times are reducing overall for initial assessments although everyone is clear that there is a very long way to go before waiting times reach acceptable levels in the eyes of children, young people and families, or indeed reach the planned new standards.

### **4. Partner agencies are addressing emotional well-being**

There are a growing number of schools providing their own services to promote emotional health and wellbeing. The Stronger Families Programme is investing in additional capacity to address emotional wellbeing and the Youth Offending Services has dedicated clinicians working in the team. Both services are keen to develop better integrated services and to reduce the need for inter-service referrals, and repeat assessments of need.

### **What is going less well.**

*“When I feel really bad, they don’t ask how I am feeling. There is nowhere to go to help me and my mum when I am not feeling well in my head. It takes a very long time in the car to go and see the CAMHS Dr. The room we go in is scary and small. I feel like I am being watched to see how I behave”.*

(Young person interviewed as part of the review).

### **1. A lack of strategic connection resulting in services that are not client centred and miss opportunities for joined up working and joint commissioning.**

Current services are planned for, commissioned and delivered in service centred not “client centred” ways. The approach is structures based rather than needs based or functionally focussed. Service provision is organised in linear ways rather than in either geographically or functionally integrated, linked, or locality based arrangements or through whole life course models. As a consequence children, young people and families experience parallel systems of service delivery and multiple systems to navigate. This limits the opportunities that joint commissioning could bring.

At present, because the wider organisational system does not wholly own child and adolescent mental health services as a key priority, and many of the key national policy drivers do not assist, services are jointly commissioned, but are not strategically connected.

### **2. A lack of co-ordination in early help, intervention and prevention.**

Planning for early help, early intervention and prevention appears to still be insufficiently well coordinated. Although the Transformation Plan and the Council’s Priorities are both

focussed on developing better early help, planning has been happening separately. This has the potential to result in the loss of important opportunities to move services out of the clinic and into the community, and to utilise low cost, no cost community based models of early support.

Early Help, Stronger Families and Children's Services direction of travel is not, as yet integrated into the Transformation Plan and vice versa. To support this effectively, new models of practice need to be developed. These need to be designed to utilise scarce professional skills differently in order to support staff working in universal services and Early Help provision, giving them advice and "skilling them up" to address need themselves rather than refer on. The new schools pilot is a good start and an example of how this can work.

As a consequence services are still very silo'ed organisationally and are largely clinically driven. It is essential that thought is given to developing multi-agency as well as multi-disciplinary teams, perhaps co-located as part of the healthy child developments into school clusters.

### **3. Systems and processes are not yet fit for purpose.**

There are still numerous, complicated, separated, and criteria ridden pathways to access different elements of service. There is a huge amount of referral on, hand-offs from one service to the next, repeat referrals, multiple assessments and too many forms. Huge amounts of time, energy and capacity are diverted into the work of system and process maintenance and silo-based protectionism rather than on direct face to face service provision.

Assessments and referrals, criteria and rationing, and threshold gaming are all creating perverse incentives which drive need upwards. The whole issue of waiting lists and long waits post initial assessment, with odd forms of list management and extremely poor communication to referrers and families is one of the consequences of a hugely complicated incoherent system. It is probable that many staff perceive others as either refusing to manage risk or avoiding it.

### **4. Transitions arrangements are poorly managed and difficult.**

Transitions within and between services are poorly managed and transitions from children's services to adult services extremely difficult. Service gaps occur as a result, particularly in relation to ASD services.

### **5. The attitude and behaviour of the workforce is perceived as unhelpful and current systems reinforce negative behaviours and do not provide adequate support.**

Culturally and behaviourally there is a real mountain to climb. Although there are many skilled dedicated staff, passionate about what they do, who care deeply about the children and young people they work with there are some deeply engrained issues to address.

The specialist services workforce is experienced by others, especially families, as overly professionalised, unconnected, and unhelpful but is also under constant pressure to attach a CAMHS label to a child when their professional view is that it is not needed and universal services can cope. There are many examples of poor attitudes to children, young people and their families and a “do to, not with” approach by most professionals. There are unhelpful behaviours all round, with no sense of collectivism or collective responsibility and accountability. And, most frustratingly (and most likely to cause harm) there is at times a “not my problem approach.” At present there does not appear to be an assertive, hard driven joined up communication strategy or an integrated jointly agreed workforce development strategy. Both would make a significant difference.

The universal services workforce of schools, teachers, GP’s, social workers etc. is confused, unclear, and frustrated by what it perceives as a closed system and service. The workforce lacks confidence in its’ own capacity to respond to and meet emotional health and wellbeing issues, and provide effective prevention and early intervention and looks to “specialists” when specialist input is really not needed. As a consequence referrals become more important than identifying and meeting need, and a refusal to accept a referrals creates anxiety and frustration rather than a creative opportunity to intervene themselves.

There is very limited understanding at the frontline about the strategic direction of travel, the policy context and the vision and ambition for the future. Strategic leaders are not articulating the vision across none NHS services sufficiently clearly. The threshold model is seen as applying to child protection and not to meeting all forms of need. There are no cross discipline common understandings, shared values, principles, behaviours, practice standards or practice models.

#### **6. Over-reliance on a ‘medical model’ of mental health and well-being.**

Services are increasingly specialisation driven, and the labels that can be “attached” to a child carry excessive weight (i.e. give me a label and I’ll get help). This is partially because many of the services are NHS interventions, but overall the culture is one of domination by the medical model of service provision and intervention.

#### **7. No culture of “never do nothing”.**

There is no culture of ensuring that if a service says “no”, or “yes, but not for so many weeks”, there is a sound assessment of the impact of that on the child’s welfare. There are no systems to ensure interim support whilst waiting for a service or being referred elsewhere. Once an initial assessment has been done some services do ensure interim

measures are in place but that is not consistent. There is no culture of “never do nothing” in Kirklees. Whilst there is no evidence the risks of this are directly harming children, the data still shows the demand is for specialist services (Tier 2 and 3) and growing, which may be a direct consequence of not responding early or quickly.

#### **8. Too much variation in quality of knowledge and practice across services.**

The quality of practice is very variable in every agency and service. Staff tend to focus on the single service they are there to provide rather than the child’s story, and on the issue or presenting problem rather than focussed on the whole child and their social, emotional, physical, and environmental context and family. Practitioners also tend to either focus too much on adults or too much on the child. There is too little understanding of infant and early childhood mental health (resilience and emotional wellbeing) or of early help services for very young children and families to improve resilience. Perinatal mental health services are now getting some investment but specialist advice to Children’s Centres is, for example, missing. Adult services often do not understand or take account of their client’s needs as parents or of the impact of their client’s needs on their children.

#### **10. A lack of adequate support for families.**

Families experience episodic interventions, which are often very short. There are often no post intervention plans or step down support. No one “holds” the family (except maybe schools) through the family’s journey of changing needs. Staff need systems and processes which support them, alongside the training and skills to wrap services round a child and their family, not pass them on.

#### **10. Lack of evidence base to inform best practice.**

The evidence base used to inform practice and frontline non specialist understanding of the issues is very variable and access to advice remains limited and allied to referral systems.

#### **11. Significant gaps in service delivery and workforce development.**

The gaps in service brought to the review’s attention include the need to:

- Increase and extend PHSE.
- Develop more services to address and support the needs of children who are looked after including building on moves to provide rapid access to support, targeted services for foster carers and residential staff, advice to schools and priority access to CAMHS.
- Provide training and support to staff working with young people to help them understand and respond better to adolescence behaviour and development, (what’s normal, what’s a worry and needs some support, what requires medical help) and address risk taking behaviours.
- Improve the join up between disabled children’s services and other services.

- Develop the availability of psychological support for children with complex conditions.

## **12. Resource pressures**

Whilst the transformation budget was clearly identified in Year One, it will be part of the CCG baseline budget in year two onwards which constitutes a significant risk in the face of competing priorities for both the Council and the CCG's.

## **What the Review tells us.**

This analysis sets out the review's overall findings of what is working well and working not so well against the standards of what good looks like in terms of:

- Putting children, young people and families first and service design second
- Speedy, flexible, person centred, needs based services
- High support to increase skills in universal services
- Responding early and quickly and flexibly
- Simplicity
- Specialist advice, accessible consultation, advice and input 24/7
- Meeting children, young people and families where they are by "coming out of the clinic into the community"

Kirklees SCB are to be congratulated for taking the decision to review services as thoroughly as they have. This is an ideal time to use this review to inform the next stages of strategic planning and service improvement in Children's Services, as well as year 2 of the Transformation Plan.

## **Key Messages.**

### **Transformation Planning**

What the review tells us is that a road map of improvement is in place, the direction of travel is good and is based in good well researched and evidenced rationale. The Transformation Plan priorities are right, delivery is on track, and the risks are understood. An attempt has been made to put the needs of children, young people and families first and design services round them, but the dislocation between the Transformation Plan and the Council's early help approach has not, until recently, been helping with this.

### **Safeguarding and Risk**

There are strong signs of positive change and impact but children and young people are still not consistently well served across the whole system and are not consistently well safeguarded. In some parts of the system significant risks are associated with difficulties of

access and waiting times, and by an absence of early help and coordinated support during periods of waiting. Children, young people and families indicated that an appointments based system did not always suit their need for immediate support.

### **The Journey of the Child**

When young people did get through all the stages and into treatment a significant number those the review heard from valued it very highly. However, the journey of the child or young person through the system is one of long waits, lack of support, confusing and often hard to understand processes, with lots of handoffs from one service or professional to another, lots of hoops to jump through and lots of assessments. Often children and young people felt their lives were less important than their diagnosis or condition to the professionals working with them. Help is slow to come, and usually only when there is a crisis or things have deteriorated a significant amount. Services are still inflexible, slow to respond and shaped to fit service need not the needs of the children, young people and families using them.

### **System issues**

The system is over complex and needs radical simplification. It is currently not fit for purpose. It needs to focus on, put value on and invest in activity that builds resilience and improves children and young people's emotional health and well-being. A list of action points are provided in the Recommendations for Change section of this Executive Summary.

### **Workforce Skills and Development**

One of the most significant challenges and barriers to future developments is the variability in skills, and the gaps in competence, understanding and training of a large multi-agency workforce. Cultures and behaviours are unhelpful and a major workforce development programme will be needed to develop a shared culture of both social and medical model interventions being integrated into one form of practice

### **Data**

One of the questions that is currently unclear and that the review has highlighted is exactly what data the KSCB wishes to use to assure itself of the quality of emotional health and wellbeing services and CAHMS and what difference they are making to the safeguarding and promotion of welfare of vulnerable children and young people in Kirklees.

## **What needs to happen.**

### **Recommendations for change.**

1. The system is over complex and needs radical simplification. It needs to focus on, put value on and invest in activity that:
  - builds resilience and improves children and young people’s emotional health and wellbeing,
  - provides extensive development of early help services,
  - focus on developing advice and learning support, consultancy and other forms of skilling up a universal workforce
  - designs services to meet children and young people “where they are” and reduce clinic use
  - provides a range of rapid 24/7 forms of advice and support (such as helplines, internet guidance and access to out of hours advice and support services)
  - creates flexible resources that allow for support to be bespoke to meet an individual’s assessed needs at any point, and reduces overdependence on clinical services (including peer support groups)
2. KSCB should support and challenge the partners to develop and agree a shared set of priorities, values, principles and behaviours, (underpinned by a common language) which are used to underpin all strategic and operational planning for children as well as embedded in workforce standards and competencies.
3. KSCB should establish a programme of monitoring, evaluating and assuring itself of the progress being made in delivering the Transformation Plan in particular with regard to the child’s journey through the system, and the degree to which the system is consistently safeguarding children and young people and promoting their welfare. This should not replicate the work of the Integrated Commissioning Board but provide sustained scrutiny and a high level of challenge.
4. KSCB should consider working with the Integrated Commissioning Board in designing a suite of impact and outcome measures and a rolling programme of audit activity to test the impact delivering the Transformation Plan has had and what difference it is making.
5. This review report should be used to inform the Second Year Transformation Plan and the development of the specification for the new Tierless Services and each stage of the tender process. The criteria for what a “good service” looks like should be applied to tender evaluation.
6. Thought should be given to whether KSCB or the Integrated Commissioning Board should support an “experts by experience” advisory group to add to the level of scrutiny and challenge, assist in audits and quality assurance activity.

7. KSCB should look to its partners and particularly the Health and Wellbeing Board, which leads on joint workforce issues) to develop a joint workforce development programme to improve the skills of all frontline staff
8. KSCB should work with the other Boards to develop a major communication programme about the transformation programme and what is changing, why.
9. KSB should robustly assure itself over the next 12 months that the development of the early help system is integrated into the second year of the Transformation Plan priorities and delivery plan (and vice versa).
10. KSCB should look to partners to think creatively about where and how services can be integrated and ask challenging questions as to why not, for example whether the SPA could and should be integrated into the developing single point of access for children's services.
11. KSCB should take a high profile interest in supporting and challenging the development of a coherent and simple system, and should ensure existing systems are reviewed, revised, simplified and agreed on a multi-agency basis.
12. KSCB should ensure that access to services within the new tier-less system uses the same threshold tool, continuum of need, risk sensible models, and assessment tools as the rest of the early help and children's services system.
13. KSCB should develop a "Never Do Nothing" policy with a simple tool for assessing risk.

## Conclusion.

*"The service should be client centred, not about meeting the staff needs; it should be open minded about its client's illness and not prescriptive. It needs to be accessible and welcoming".*

(Parent interviewed as part of the review)

The Review concludes that there is still much work to be done to fulfil this parent's vision. However, there is a coherent and effective transformation plan in place to drive improvement in Children's Emotional Health, Wellbeing and Mental Health Services. It will be important to maintain the momentum created by the introduction of the Transformation Plan and the workforce will need significant support to implement lasting change. All partners, Senior Management and frontline staff will fully need to embrace system change

and focus on improving outcomes, particularly in terms of developing a coherent early help offer and healthy child programme, which is integrated with early help for emotional health, wellbeing and CAMHS services. A key opportunity will be to actively engage with children, young people and their families to create services that are truly tailor- made and client-led.

**Jane Held Consulting Ltd**

**September 2016**

## Introduction

This report provides an overview of an in-depth review of emotional health and wellbeing and Child and Adolescent Mental Health Services (CAMHS) in Kirklees. The review was commissioned by Kirklees Safeguarding Children Board (KSCB) following a lengthy period of concern and a number of issues raised about the quality and impact of services for children and young people.

The review took place between April and September 2016 and was presented to the Kirklees Safeguarding Children Board on 9<sup>th</sup> September 2016. The review demonstrates that there are good plans in place to improve specific CAMHS services but there are still significant challenges to address. There is an ambition and determination on the part of senior leaders to improve CAMHS services overall. The KSCB has identified that this needs to be well coordinated, and strongly driven, and the Board has a crucial role in assuring itself of the improvements as the improvement journey progresses.

Many individuals contributed to the review freely of their time and knowledge and the Review Team is grateful to all of them. The Review was well supported by the KSCB Business Unit and, in particular Arifa Batool. The joint commissioner, Tom Brailsford was invaluable in providing expert support, and information and the Reference Group helped support the work with insight and thought. Finally the contribution of those children and young people who contributed to the reference group, met with the Reviewer, or submitted evidence was particularly valuable. This Report is for them, and for all the children and young people of the area. Their futures are what this Review holds in mind.

## Background

Services to support the emotional health and wellbeing of children and young people, and address their mental health needs have been the subject of concern at a national as well as regional and local level for a significant period of time. This is not restricted to the NHS. Underlying the business of Children's Services, from early years to adulthood, across all services, is the emotional health and wellbeing of children and young people.

The context in Kirklees was and remains similar to most other areas of England. Whilst the context is the same, the quality of services had been of concern for a number of years. Historically, access to services was extremely difficult and waiting lists were extremely long. From 2013-2016, mental, emotional health and wellbeing was identified as a joint priority between the Health and Wellbeing Board (HWB) and the Children's Trust with the HWB taking the lead.

From 2014 providers were identifying and raising their own concerns with commissioners. A series of formal meetings took place between commissioners, providers and the local authority from 2014 onwards.

By then significant concerns were being expressed by many agencies, as well as by parents and their children about the poor quality of the service, the waiting times and difficulties of access and the absence of transparency or accountability for the services provided. The local press covered the issues raised. Too many children, young people and families were being let down, and receiving a sub-standard service, too many waited for too long and too many received no service despite needing help and support.

At the time, the risk a child or young person could be seriously harmed as a consequence of receiving no service, waiting too long for a service or receiving a poor service was understood to be significant and growing. In July 2015 council representatives and NHS Commissioners met again to further consider the situation. A number of summits were held over that period. Urgent steps were taken by the commissioners to address the immediate concerns but the degree to which improvement was needed required further consideration.

The KSCB on behalf of all partners, in the light of the concerns, agreed to commission this review in September 2015, with a view to work beginning in 2016 following the finalisation of the Kirklees Transformation Plan. For a variety of sound reasons the Review did not begin until April 2016 and covered a period when the initial priority changes in the plan was beginning to be implemented. Leadership in the local authority also changed over this period. The review therefore took place during a period of transition, and service reconfiguration.

The concerns were such that the Council simultaneously decided to undertake an ad-hoc Scrutiny Review. The panel met between October 2015 and March 2016. This Review has had access to the draft report of that exercise. The exercise was designed to

- Develop an understanding of the services provided by CAMHS and its current performance in line with national requirements.
- Scrutinise the CAMHS Transformation plan and its supporting action plan.
- Seek the views of service users.
- Consider benchmarking information nationally on the provision of CAMHS services.

The panel noted the positive indications that the Transformation Plan would improve transparency as well as service quality particularly in relation to referrals and waiting times. They recommended further attention be paid to referral processes, and the development of pathways to access CAMHS and within and between services. Communicating the changes was another area of development they recommended<sup>1</sup>. This review has built on the work of the Scrutiny Panel rather than seek to replicate it.

It would be fair to say that during the review public confidence was still not high, and the evidence is that that most people outside the “CAMHS” world are broadly unaware of much of the change that is happening or planned. As a consequence the qualitative data had to be interpreted within that context, balancing expressed views with service user, organisational and operational reality, underpinned by the quantitative data on impact that was available by the end of Quarter 1 of 2016/17.

## Methodology

The review scope was to review all services provided to children to support their emotional health and wellbeing, CAMHS services and related services such as services for children and young people with autistic spectrum disorders. The Terms of Reference for the Review are attached as Appendix A. The aims of the review were:

- To understand the experiences and journey of children and young people through CAMHS and ensure that there is a focus on their point of view.
- To ensure that local CAMHS arrangements are safe and meet safeguarding requirements.
- To bring in an external/independent point of view.
- To take into account the whole system and reference Tiers 1, 2, 3 and 4. Noting the time frame it would be useful if the review took note of any issues particularly identified re options for children and young people, referrals and communications within schools (Tier 1), CHEWS (Tier 2) and NHS England (Tier 4) as needed. Further work may be identified by the LSCB.
- To take into account, and learn from, regional and national best practice.
- To report back to inform future commissioning, and recommend changes as appropriate.

The Review was led by a multi-agency review steering and reference group who between them had a skill mix of sufficient knowledge of children’s experiences and perspectives, Safeguarding, LAC, mental health, and CAMHS. The group met three out of four planned times due to delays with timetabling the interviews and focus groups. The group was chaired by the KSCB Independent Chair. A young person joined the Review Steering Group for its last meeting.

The Reviewer was asked to follow the child’s journey through case file audits and talking to children/young people and families. They were tasked to take into account the experiences of all who are part of the system; establish if the arrangements for individuals meet safeguarding standards; consider and develop core points for future contracting; set the Kirklees service provision in the context of regional and national delivery and identify issues for the Transformation Plan 5 year strategy to address.

Appendix B sets out, in full, the various elements and stages of the review. The baseline for the work comprised The Children Act 1989, the Children Act 2004, the Children and Families Act 2014 and Working Together 2015. *Future in Mind* was a key reference document.

There were five core elements to the Review:

- A call for evidence
- A literature review by a national expert in CAMHS policy
- A file audit
- Data analysis
- Focus Groups and 1:1 interviews.

The Review addresses the key questions and evaluates services based on what is working well and what needs further development. It has used baseline standards of good practice as identified in *Future in Mind*, the report of the Children and Young People's Mental Health Taskforce. (NHS 2012)

Overall the process went reasonably well. All three services that had case files audited provided random files, and none were "tidied up" for audit. A huge amount of evidence was generated, with significant reading (over 70 documents were read). Everyone who participated in the focus groups was willing to engage, openness and self-awareness and gave generously of their time. Individuals provided a lot of follow up documentation and the call for evidence produced rich, thoughtful information about their views and their experiences.

The review was hard to coordinate so there were some hiccups along the way. There were no experts by experience on the Review Steering Group, a limited number of clinicians and practitioners were available for focus groups, timetabling was challenging and one steering group meeting had to be cancelled as a consequence.

Unfortunately the review actually met with very few children and young people, and those that were involved were looked after by the local authority. A small number of children and young people contributed through two focus groups, and the views of other young people were solicited in a range of ways including through schools and a Call for Evidence. It was a matter of some frustration to the reviewer, and indicative of some of the challenges faced in working with and through children, young people and families in the future that the numbers of children and young people involved in the focus groups was very limited although a larger number replied to the call for evidence.

Similarly the review only met with a small group of parents, all from one group, Parents of Children with Additional Needs (PCAN).

## **Prevalence and Policy Context**

One in five mothers will experience mental illness during pregnancy or the first year of a child's life. Early interactions and experiences directly affect the way the brain develops, as does exposure to abuse, domestic violence, drugs, alcohol, and domestic violence. These can trigger physiological changes that impact on a child's social, emotional and cognitive development. If a child falls below the norm during the first years of life, they are unlikely to catch up. Nearly one in four children do not reach the expected level in language and communication skills by the age of five and a fifth fall short in personal, social and emotional development<sup>ii</sup>.

Problems in adolescence can grow as the potential hurdles and challenges to young people's resilience increase. Alongside the physiological change that adolescents experience, the pressures they face from peers, body image, exam stress and social media can impact negatively on their well-being.

Data from the NHS tells us that <sup>iii</sup>half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. One in ten children aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest.

Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison. Yet most children and young people get no support. Even for those that do the average wait for routine appointments for psychological therapy was 32 weeks in 2015/16. A small group need inpatient services but, owing to inequity in provision, they may be sent anywhere in the country, requiring their families to travel long distances

The *National Service Framework for Children*<sup>iv</sup>, published jointly by the Department of Health and the Department for Children Schools and Families in 2004 was a 10 year framework for the development of children's health and social care services including CAHMS services. It created a clear "whole system" approach, recognising that investment in prevention and early intervention, through universal children's services was a crucial element of a whole system approach which meet needs at the right time, in the right way, in the right place (at the right cost).

By 2014 national policy, structural, organisational and economic changes had had a significant impact on CAHMS services, and there was huge variation in the availability and quality of services across the country. Services were fragmented and incoherent in many places as commission became more fragmented and service providers more diverse. The amount of money invested in CAHMS remained at roughly 6% of the overall NHS budget

over the 10 years. In addition the “whole system” intent of the 4-tier model of services in the Framework (tier 1 being universal services and tier 4 being highly specialist and intensive medical treatment services) increasingly focussed on the upper tiers rather

By 2015 it was clear there was a need to re-energise and improve mental health care across the NHS to meet increased demand and improve outcomes. Growing need, increasing waiting lists, an increase in suicide and self-harm, better diagnosis, and better knowledge and understanding of the issues due to social media culminated in a government review and the joint publication of *Future in Mind*<sup>v</sup> by the Department of Health, Department for Education and NHS England in 2015. As the introduction says “*far too many families have experienced poor children’s and adolescent mental health care Norman Lamb MP*”.

The intent was to put children and young people at the heart of services, articulate a clear consensus about the way it can be made easier for children and young people to access high quality care when they need it, break down the complex tiers of service and establish clear responsibility for putting in place a coherent offer of services, through collaborative partnerships. Local commissioners were given responsibility for developing a 5 year Transformation Plan and ring fenced funding made available to support the delivery of the plan in year one. Priorities were meeting access standards, increasing the availability of psychological therapies through improved access (IAPT services), improving the availability of perinatal mental health services and investment in mental health services in schools.

CAMHS are still a key policy issue, and over the period of this review there were a series of publications addressing the national issues that continue to cause concern. The Children’s Commissioner published a review of access to services in May 2016.<sup>vi</sup> In the same month the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness published some concerning data on suicide by children and young people in England in May 2016<sup>vii</sup> as well. In February 2016 *The Five Year Forward View for Mental Health* was published by the Independent Mental Health Taskforce to the NHS in England. Finally, in August 2016 the Education Policy Institute’s Mental Health Commission assessed first year Transformation Plans on 5 key areas, governance; early intervention; ambition; involvement of children and transparency.

The policy challenge is to translate the investment and system change into improved outcomes for children, in a rapidly changing local and national context. It requires more than change to NHS services to have the impact needed. Major investment in a multi-agency workforce is needed if staff is to have the skills to respond early and effectively, and reduce demand for specialist services. Schools and local authority children’s services are critical partners in both planning, investment, development and delivery terms. It is clear from this review that these challenges are being faced in Kirklees as well as elsewhere.

## Services in Kirklees

Strategic responsibility for ensuring there is a comprehensive CAMHS service in Kirklees rests with the two Clinical Commissioning Groups (CCGs) in Kirklees, NHS North Kirklees and Greater Huddersfield. They need to work closely with Kirklees Local Authority Children's Services who share responsibility for this. The Council and the CC's jointly fund a Joint Commissioner for CAMHS. This post holder is a strong, tenacious and determined advocate for the service.

The budget for services rests with both the NHS and the Council. Compared with the rest of Yorkshire and Humberside, investment in Tier 3 (NHS) provision was significantly less in 2014/15.

Additional investment is provided by the NHS under the auspices of the Transformation Plan. Whilst the transformation budget was clearly identified in year one, it will be part of the CCG baseline budget in year two onwards which constitutes a significant risk in the face of competing priorities for both the Council and the CCG's.

### **Service Structure**

In Kirklees services are still organised broadly in four tiers. A tierless service is planned and changes have already taken place to the configuration of the services provided by South West Yorkshire Foundation Trust (SWYFT) and the Children's Emotional Wellbeing Service (CHEWS) as part of year one of the Transformation Plan year one delivery programme. Services are provided as follows:

Advice and treatment of less severe problems. Preventative work provided within a wide range of universal settings (Personal, Health and Social Education for example) and by the third and voluntary sector. Schools, Early Years Services, Youth Work, and other early help services in Kirklees provide a range of services which are not currently explicitly acknowledged as part of the continuum of emotional health, wellbeing and CAMHS provision.

Targeted services in education, social care and health for vulnerable children and young people experiencing behavioural, emotional or mental health difficulties. Schools, early years services, youth work, the youth offending service, services for children with disabilities and additional needs, paediatrics, learning support and educational psychologists and other early help services in Kirklees provide a range of services which support these vulnerable children and are rarely seen as part of tier two services.

Specific targeted services have been commissioned from Northorpe Hall (a third sector provider) in terms of access to advice, support, referrals for short terms psychological interventions (10 week interventions), and the provision of training. Northorpe Hall also provide the Single Point of Access service, **Advice and Support for Kirklees (ASK CAMHS)** introduced as part of the transformation plan changes. Locala (the Community Healthcare

provider in Kirklees) also provides a range of services such as school nurses and community paediatric services.

Services for children and young people with moderate to severe mental health needs provided by specialist services. These are provided by specialist CAMHS services commissioned from South West Yorkshire Foundation Trust (SWYFT) by the CCG's. These services included nursing, psychologists, psychiatrists and therapists. They deal with a range of presenting needs, such as depression, suicidal ideation, self-harm, obsessive-compulsive disorders, severe anxiety, autistic spectrum disorders, psychosis, attention deficit disorder, eating disorders, conduct disorders, and traumatic experiences. They also provide the new multi-disciplinary crisis team.

Services for children and young people with severe and highly complex mental health needs requiring highly specialist in-patient treatment are commissioned by NHS England. There is no such provision locally in Kirklees and so children and young people are referred elsewhere. This includes to Manchester, Leeds, York, Sheffield and Manchester. There is a national shortage of such provision and it can mean children and young people are cared for in inappropriate settings when specialist places are not available. Kirklees has good arrangements for ensuring that anyone in that situation is identified, closely monitored and advocated for to minimise the time spent in the wrong setting but it remains an issue.

#### Strategic Developments within Kirklees

The development of the Kirklees Transformation Plan 2015-2020 involved a wide range of people including parents, children and young people. It was submitted in October 2015, and has been assessed as a good plan, meeting all the assurance criteria in full. The priorities for year one are set out under the 5 *Future in Mind* themes (Appendix D).

The Council and Children's Services have meanwhile been substantially reviewing how their services are organised and provided. The Council's new Corporate Plan 2016 - 2017 *Your Council for You* has placed an emphasis on culture and behaviour as the foundations of good services. This plan includes the priorities in the Joint Health and Wellbeing Strategy to ensure vulnerable people are safe and in control of their own lives.

A new Children's Services Development Board has been established, the Children's Plan 2013-16 is being reviewed and a new plan prepared, and a number of major programmes of work underway which will if coordinated effectively compliment, enhance and be an integrated part of the second year of the Transformation Plan:

- Expanding the Stronger Families Programme
- Introducing additional support for care leavers
- Launching an all age disability services

- Change the way support is provided to children and their families through a focus on early intervention and prevention, and the development of a locality working model (with a central role for schools)
- Redesign service pathways and work towards a single point of assessment.

Kirklees Safeguarding Children Board is supporting and challenging this work, and as this review was concluding, had begun consultation on an Integrated Early Intervention and Prevention strategy and published a new, revised Kirklees Continuum of Need and Response (CoNR) (threshold tool). Supporting this is a “risk sensible model” of identification, assessment and intervention, and a clear early help offer.

## What good looks like

There is ample evidence from research and practice of what good emotional health and wellbeing and CAMHS services look like. As part of the Review, contemporary policy, guidance and best practice was extensively reviewed. The summary of that work is attached as appendix C. As the Review was commissioned to look at the whole scope of emotional health and wellbeing and CAMHS services, it has based its analysis of the evidence in Kirklees on the framework applied by Young Minds. A “whole-system approach” is one which:

- Promotes resilience, prevention and early intervention
- Constantly improves access to effective support
- Cares well for the most vulnerable
- Is accountable and transparent
- Develops the workforce

The National Institute for Clinical Excellence (NICE) sets out evidence based standards for clinical practice, and The Joint Commissioning Panel<sup>viii</sup> set out what good looks like in CAHMS Services in that:

- The care provided should be timely, effective and efficient
- There are clear pathways, advice for universal services, joint and integrated work, 24 hour services and access to emergency provision
- Services reach those least likely to access specialist CAMHS
- There is an appropriate range of services for children and young people with different needs and different ages, including intensive services for those who would otherwise require admission to hospital
- The strategic direction for services is jointly agreed, there is good clinical and managerial leadership and a multi-agency commitment to integrated services
- Services involve children and young people in planning, developing and delivering services

*Future in Mind* sets out how local systems should make it easier for children, young people and families to access help and support, and how to improve the organisation, commissioning and provision of services. The key themes for a good system are:

- Services promote resilience, prevention and early intervention
- Local structures are simplified and deliver a joined up approach
- High quality local information drives improvements in care and standards of performance
- There is a culture of continuous evidence based improvement
- The right investments are made based on need and evidence
- Access to services will improve based on need not on eligibility for a specific tier
- The most vulnerable are cared for
- Services are transparent and accountable
- The workforce is equipped and developed to respond to local need of all types

In undertaking the review we focussed on the degree to which current services meet these themes. In addition during the Review the Local Government Association published *Best start in life – Promoting good emotional wellbeing and mental health for children and young people*.<sup>ix</sup> This contained some key points about how local authorities can best contribute by:

- Ensuring strategic planning is linked to the local Joint strategic needs assessment and priorities emotional wellbeing and mental health
- Focusses on early help (prevention), support and treatment
- Appoints mental health champions in different services
- Recognises and ensures midwives, health visitors and school nurses play a key role
- Taking a life course (pre-birth to adulthood) approach
- Offers both universal support and targeted interventions
- Ensures a joined up partnership approach
- Engages with and listens to children, young people and families
- Monitors and constantly evaluates progress
- Uses clear and consistent messaging

These were helpful additions to the framework for analysing the evidence. In terms of safeguarding, the Review was based on the basic principle that supporting children and young people's emotional wellbeing and mental health safeguards them and promotes their welfare and so is everyone's responsibility, and not just the responsibility of families and specialists in CAMHS.

A good service therefore puts value on

- Putting children, young people and families first and service design second
- Speedy, flexible, person centred, needs based services
- High support to increase skills in universal services
- Responding early and quickly and flexibly

- ▶ Simplicity
- ▶ Specialist advice, accessible consultation, advice and input 24/7
- ▶ Meeting children, young people and families where they are by “coming out of the clinic into the community”

The review tested these facets of what a good service looks like, and in particular whether services were experienced by children and young people as putting them and their welfare first. It also tested whether services were provided in line with *Working Together to Safeguard Children 2015*<sup>x</sup>: protecting them from maltreatment, preventing impairment to their health and welfare, ensuring they grow up in circumstances consistent with the provision of safe and effective care and enabling them to have the best outcomes.

## Data Analysis and Trends

Like every other part of England, demands on services in Kirklees are steadily increasing, more complex cases are rising in number and there has been a rise in routine and emergency referrals to both CHEWS and SWYFT. Demand in April 2015 significantly exceeded capacity. The amount of service commissioned was insufficient in both money and workforce capability terms.

The Transformation Plan included an extensive section on data and the baseline position. This Review has used that baseline data and the quarterly monitoring returns provided by the Integrated Commissioning Group as its source of information. This is not replicated in full here. Current data is available from the Second Year Transformation Plan, published after this review was completed.

The data from 2013/14 indicates that in terms of prevalence 9.6% (2,555) of 5-16 year olds in Kirklees have some form of mental health disorder. The prevalence overall is higher in boys, and is higher in North Kirklees. Services are seeing more than the expected number of young people with an identified eating difficulty. 376 young people between 11 and 17 years entered the youth justice system in 2013/14, and 980 children and young people with autistic spectrum disorders live in the area. In March 2015 there were 620 children looked after by the local authority.

In 2014/15 the CHEWS service received 1,406 referrals. The majority of presenting issues were for behavioural concerns, anxiety and low mood.

Baseline data for the Tier 3 service was harder to obtain and assess in 2015. In the first three months of the 2015 financial year out of 433 referrals, 3 in 7 (43%) were deemed to be inappropriate and turned away. Whether they were inappropriate or not, this constitutes a significant number of children, young people, families and referring professionals who felt significant help was needed, and expected help from a referral. Of 59 emergency referrals only 46% were seen within 24 hours.

Waiting times were significantly outside acceptable limits, with the average wait from referral to treatment being 13 weeks for CHEWS. For tier 3 the waiting time from assessment (for which people had already waited a considerable time) to treatment was 35 weeks. Admissions to tier 4 were reducing in 2014/15 but average lengths of stays stayed the same. Timely access to services for victims of CSE, for children who are looked after, in youth offending services, the child protection system more generally or in receipt of the Stronger Families Programme was a significant issue.

By the end of quarter 1 of 2016/17 the performance data shows there an improvement in waiting times and access to services. Times have fallen to 28 days for a choice appointment (referral to initial assessment) with specialist services. Waiting times for targeted services are 13 weeks after deteriorating to 16 weeks for some time due to an upsurge in demand. The Single Point of Access (SPA) (ASK CAMHS) was implemented in April 2016. It received 773 new support requests between April and June, whilst referrals to specialist services fell. Of the average of 270 referrals into the service a month, 80% lead to a referral and assessment and 40% to a full tier two service.

Early indications are that the SPA is reducing inappropriate referrals to specialist services and support is being appropriately provided by targeted services. Unfortunately, despite the drop in referrals, and the faster waiting time to a choice appointment (an assessment of the most appropriate specialist service), waiting times for a partnership appointment (treatment post assessment) is still averaging between 4-6 months, which is still far too long. In addition the success of diverting cases to CHEWS is having a knock on effect on their capacity.

The delivery of the Transformation Plan by the first quarter of the year (2016/17) was on track. The schools link model was implemented, short term provision in both targeted and specialist provision for vulnerable children (using LAC/CSE and YOT services) in place and investment in "*pillars of parenting*" supported and being rolled out across residential children's homes with plans to extend it to foster carers.

Most significantly the 0-19 Healthy Child programme tender is underway which will incorporate a "tierless" specification that will be expected to be embedded into a new service delivery approach in line with the THRIVE Elaborated model of service (which is organised around the needs and strengths of children and their parents and is clearer about the limitations of what CAMHS can and can't offer). It also includes newly funded ASD provision and learning disability nursing to support a fully cohesive approach to children's emotional health and wellbeing. The specification includes new targets for waiting times across the system in line with the anticipated NHS guidance on access standards.

## Call for Evidence

Following the best practice review a call for evidence was widely distributed. 48 responses were received. The table below sets out the breadth of responses.

The responses were very varied and were, overall, balanced between negative and positive, and the majority were constructive. Frontline social work was marked by its absence in responses (only 3). The material was thoughtful, rich in content and extremely helpful in helping the review understand the reality of the experiences of children, young people, families and professionals in Kirklees.

Source	number
Health Services:	
▪ Locala (school nursing, health visitors, district nurses, therapists and other healthcare professionals)	5
▪ GP's	2
▪ Other Health professionals	6
Schools and Education Services (primary and secondary) comprising	12 in total
▪ Safeguarding, SENCO and pastoral related staff	
▪ Teachers	
▪ head teachers	
▪ Kirklees learning partnership	
Parents	7
Children and young people	3
Children's Services	
▪ Social Work, IRO's, Family support and child protection, corporate parenting	5
▪ Children's Residential Home	1
▪ Commissioning and Health Partnerships	1
▪ Youth Offending Team	3
Third and Voluntary Sector	2
<b>Total</b>	<b>47</b>

The responses from children, young people, and their families were extremely helpful, and moving. Two drawings in particular, as part of a response from a school summed up the significant difference in the experiences they had. One was of the respondent and a CAMHS professional standing hi fiving each other, with the caption "hi five them". The second was of a series of case files round an individual, each marked as a case number. The implication was they felt the person they had seen just treated them as if they were a "case type" rather than a person.

The majority of responses from parents were negative. Parents felt they were not listened to, excluded, and that they did not get the help they needed. One parent said *"Nothing worked well, CAMHS was completely unresponsive to our needs, had no flexibility whatsoever, were completely closed, not open to alternative ideas, dismissive of anything that wasn't ADHD."*

One parent set out in full the situation, the issues, (referral delay, retired GP as family friend helped navigate the system,) the experience of in-patient care, (they did their best but she needed specialist care) the negative experiences (*"communication was dire..."*) and the positive. They said what they would like to see is *"when a GP has promised a referral for that to be done within 48 hours, and early intervention- help and intervention given as early as possible as it will save money in the long run"*

No parent was unreasonable about what they had to say, they tried hard to accentuate what was positive and each showed an understanding of the context. The same parent as above said *"the service should be client centred, not about meeting the staff needs; it should be open minded about its client's illness and not prescriptive. It needs to be accessible and welcoming"*. Another said *"everyone is different and what was offered to my daughter did not work for her. I feel they should have worked wither and us more to overcome her difficulties. Resources are clearly insufficient!"*

Whilst inevitably a call for evidence is self-selecting the collective message from parents was that the service they received was frustrating to access, slow and inappropriate in response, bureaucratic and unhelpful. In addition, parents felt unsupported by the system.

The matter of most concern to the review, on analysis, is the absence of any support, input or interim support to the child or young person, once a referral has been made, before a first appointment, and similarly, before a course of treatment. The safeguarding risks in these circumstances are potentially significant.

Professionals all expressed a variety of concerns about access to services, about delays, and communication challenges. However they also were constructive about the changes they see coming and about options to improve. What was most significant was the way professionals referred to CAMHS and CHEWS as being a service they fought to access that was very clinic based and isolationist rather than an integrated part of the system within which they were working. One said *"the main problem, for the past few years, has been the well-nigh impossibility of getting a referral to CAMHS in the first place. Then, no matter what the level of concern, if the case was accepted it went to level 1 group counselling. We are a highly experienced school, sadly, with mental health issues, and by the time we make a referral the lower level of counselling has been completed internally by our own qualified counsellors. When we refer we need an assessment for level 2"*.

Another said *"The new ASK CAMHS where it is proposed we ring for an initial appointment rather than drown in sheaves of paperwork sounds hopeful"*.

A third said *"the children who have accessed Northorpe Hall have generally found it beneficial and we have begun to see a difference in them....it would be really useful to have feedback or strategies that can be used in school following counselling sessions or at the end*

*of the sessions to continue the support. We understand the need for confidentiality but sometimes have to deal with the fallout of sessions the next day”.*

*More worryingly “when we did have an xx in crisis, year 6, self-harming and researching how to kill herself, I rang CAMHS and Northorpe Hall to see who best to refer to. Neither service knew so in the end the GP and myself referred x to CAMHS who saw X then referred her back to Northorpe. This was very confusing for the parents and the child and disappointing that neither service knew who was best to give help and it delayed the child getting help”.*

Themes from all the responses include

- ▶ Arguments over diagnosis, and diagnosis being the only route to access support.
- ▶ Inflexibility, an unwillingness to listen (on both sides), and a significant number of comments about professional arrogance, exclusivity and dismissiveness.
- ▶ Long waits, with no communication, an absence of support during the waiting and creative solutions to this and a number of individuals who tried alternatives such as private providers after not receiving a service in Kirklees.
- ▶ A significant number of responses relating to the incoherence and complexity of the services, and how hard it was navigating the system.
- ▶ Some commented that because of the difficulties with access it was quicker to go to Accident and Emergency in a crisis putting pressure on paediatric services and the wards.
- ▶ The Children’s Emotional Wellbeing Service (CHEWS) was widely well regarded.
- ▶ A strong view from professionals in other health disciplines that there was an absence of support and they had to “to manage the issues ourselves” in primary and universal settings. Many secondary schools had their own support through specialist staff to work with young people but found it hard to access good advice.
- ▶ Several professionals commented on the importance of adult mental health and commissioning to support parents with parenting capacity challenges, and how it was hard to access such support for parents of children they were working with.
- ▶ A significant number of professional respondents and some young people referred to the importance of the need for the service to “get out of the clinic” and into the community and meet children where they are.
- ▶ The new Single Point of Access (SPA) is seen as a significant improvement.
- ▶ Creative solutions - A range of constructive and good ideas to address issues were suggested.

Respondents identified what was working well as:

- ▶ There was now a fast response for emergency and crisis situations.
- ▶ The ASK CAMHS service provided helpful advice from “duty” staff.
- ▶ Intervention saved our daughter’s life. (Responses 9 and 10)
- ▶ There was increasing flexibility in response to referrals.

What was working less well was:

- The length of waiting times for autistic spectrum disorders and the fact that receipt of a service was diagnosis dependent waits and diagnosis dependent. (Response 7, 8)
- Clinicians were not listening to children, young people or families but were only interested in their own perceptions and analysis. (Response 6, 11, 16, 27)
- In one case a young person found themselves in severe crisis with no support. (Response 17 - this was subsequently rectified)
- Professionals felt wasted time on process chasing and found it frustrating that the provision of support was referral dependent.

Much of the content is similar to responses to consultations, and surveys during 2014 and 2015 as part of the preparation for the Transformation Plan. Should the Board wish to utilise such invaluable learning the call for evidence could be suitably anonymised and used as learning and training material with staff.

## Focus Groups

The Review met with a wide range of individuals in focus groups and in 1:1 interviews. 5 focus groups took place, involving a multi-agency group of front line clinicians and practitioners, a group of front line clinicians from SWYFT, a multi-agency group of middle managers, a small group of young people who were looked after and a group of parents from Parents of Children with Additional Needs (PCAN). Interviews took place on a 1:1 basis with 11 individuals, either in person or by phone.

Everyone was asked their views on the key questions of what the service is like, what is working well, what difference is it making and what needs further development. Different groups had very different levels of knowledge about the Kirklees Transformation Plan and the changes taking place, or planned. Many of the front line staff found it hard to articulate what is making a difference, and expressed a high level of frustration with range of issues depending on which service and role they worked in. Senior leaders were able to talk about the direction of travel more confidently but were less familiar with what it feels like to be a front line practitioner.

A rich variety of views were expressed about the historical position, the current position, and the future. Themes were however remarkably consistent regardless of which group was contributing. People were very positive about:

- The changes to services they knew about or were involved in.
- The policy shifts towards developing better quicker early help.
- Working with and engaging children, young people and families in service developments.
- The possibility of new investment.

- The support they drew from their own colleagues or other parents and carers.
- The attention being given to improving emotional health and wellbeing services and CAMHS.
- Their desire to do a good job by the children and young people they are responsible for and their ambition for real change and improvement.
- Honest reflective thoughtful views about the current situation, the history behind them and the opportunities there are to get it right in the future.

Issues of concern were:

- Access to services.
- Emergency response times and the lack of availability of crisis support.
- Waiting lists and waiting times.
- Complex incoherent impenetrable pathways to referral or services – no commonality of values, principles or language.
- Bureaucratic processes obscuring and preventing quick, flexible, child centred practice.
- Who supports children, young people, parents and carers in distress if they are waiting for a service, or are refused on
- A case driven approach where saying no is perceived as normal.
- A lack of trust that services can do a good job or improve.
- Narrow eligibility criteria, and referral requirements, and constant hand-offs.
- A focus on assessment rather than service provision.
- Service gaps for specific groups (ASD, Head injuries, Conduct disorder in young offenders, transition into adult services)
- Professional arrogance, and a refusal to listen to, respect or accept as valid the views of non-mental health professionals (and vice versa).
- Ignoring the views of parents and carers and young people
- Services designed to “do to” people not “do with them” (whether that is doing to children and young people, to parents and carers, or to professional colleagues).
- An expectation that anything relating to potential emotional distress or mental health issues should be dealt with by specialists.
- Frustration about services being individual case and clinic led and ideas about how to utilise scarce clinical skills better.
- Silo working and differential cultures – the medical model versus the social model being played out strategically, operationally, and systemically.
- The dominance of processes rather than working through and with people.
- Resources and the short sighted nature of a system that drives demand upwards by responding only when the needs are clinical – the absence of investment in prevention, early help, early intervention, and not effectively using shared capacity to do more with less.
- Labelling – and the systematic insistence on organising services around ‘labels’ .

- Strategic gaps between the TP processes and the improvement plans of the council and children's services – "two different planning and service design and delivery worlds".
- A perceived absence of strategic ownership of the issues beyond the narrow world of children and young people – adult health issues dwarf children's and council priorities impact on children's services – no economic argument made despite warm words – risks inherent in maintaining progress.
- The language used – e.g. "I don't know about that, it's not my pathway" rather than, "well that approach to possibly meeting your child's worries is something I do not know about, but I could find out for you".

The focus groups provided a strong platform on which to test the hypotheses drawn up during the evidence gathering, file auditing and data analysis stages of the review. The conclusions reached are grounded in the learning from the many people involved.

## Practice Quality

The quality of practice was tested by undertaking 15 file audits. 5 were selected from each tier of service (early help, CHEWS and SWYFT). The files were selected at random from a list of 10 in each setting, and were seen without any advanced preparation. The audit tool is attached as Appendix E.

Of the 5 files audited in Early Help services (Children's Services) one was very good, (as assessed against the criteria in the tool), two were inadequate, and two were adequate. Whilst the bare minimum basics were in place in all five, two did not demonstrate an adequate service was provided. Only one of the five files demonstrated a whole system approach, with all the partners involved, communicating, working collaboratively and with a joint plan in place. In the others there was very limited engagement with other agencies involved and a significant lack of utilization of the knowledge, skills, insights and experience of other partners in adding to the understanding of and interventions with the child and family. The child's voice was very limited in all but two files.

Whilst all told a story, three out of five focussed primarily on the parent's story and needs. All five showed a circular repeat/referral system in place rather than one lead agency working with others without onward referral or repeat referrals and sporadic incident based interventions. Multiple assessments were also a feature in all five. There was a lack of a coherent child and family centred approach. The quality of both assessment and analysis was variable, and plans were activity rather than outcome focussed in four of the five. An assessment of the degree of safeguarding or emotional health and wellbeing risk of harm or impairment to welfare was missing in all but one file.

Only two files had records of supervision taking place, and the evidence of reflective, evidence based practice was missing in all but one file.

In terms of Tier 2 (CHEWS) all five cases were adequately recorded and the quality of the clinical work good as far as the review could access it (as the confidential sections were not available to the reviewer). The files were easy to access, easy to use and easy to read, unlike the other two systems. Consent was clearly dealt with and a clear story told about the presenting issues, the systematic intervention processes, the rationale, and a closure summary and feedback from both family and young person. All five cases had positive feedback from both the young person and the family.

However the files were primarily clinical in nature, focussing on what the diagnosis/issue was, what the intervention was, and what the end of the intervention was. There was a very limited “story” of the subjects’ life, family, and community, their family life experiences, their history etc. Whilst the presence of other professionals in those children and young people’s lives was noted, there was almost no record of a multi-agency approach, or any common shared plans to support the family with their whole life. The files were also very “client focussed” and, positively, did record the views of the child or young person, but there was very little about the family.

The files were a helpful if stark demonstration of the professional and cultural differences between children’s services and allied professionals and those working in clinical or partially clinical settings. All five demonstrated a linear clinical model of practice (i.e. referral, diagnosis, treatment, referral on or closure) and the detail of the clinician client interactions without any of the wider context. That is not to say that the clinicians and counsellors involved did not know about the context, the story and the child’s lived experience, but there was not the same professional value placed on recording it. As a consequence the service was “acting in isolation” at least from the records, parallel to but not an integrated part of the rest of what was happening in their client’s lives.

Records of supervision were not visible on the files. Appropriate risk assessments were recorded and any risks flagged on the file.

The audit of the SWYFT files was disappointing for managers as all but one of the files were inadequate, and all but one had essential or basic information missing. One file was adequate bordering on good. One file contained information which on discussion with Managers was referred on as for clinical review as a ‘near miss’. Even taking into account the fact that there had been a huge migration of records onto a new system, with accompanying glitches, the files selected did not demonstrate a good quality of practice. The details were discussed in depth with SWYFT managers.

One file demonstrated a deep understanding of the child, their family, their life, their community and their story. It also demonstrated a whole system approach to support and interventions, with the practitioner clearly working within a wider multi-agency professional context and a clear multi-agency plan of intervention and support. Risk assessments were

updated and clear, and told a clear story with strong records of the child's wishes, feelings, views and decisions.

The file which was sent for review demonstrated a very limited understanding of the young person's everyday life and experiences, and did not take into account the additional risks and pressures on them due to their role as a young carer. Poor supervision of the young person by their allocated worker and poor communication between doctors and other members of the multi-disciplinary team meant the degree of suicide risk was seriously underestimated. However the file also demonstrated that the newly established crisis team saw and managed the crisis well.

Again the files demonstrated the significant differences between those professionals working within a social model of practice, and those working within a medical model. This may be one of the most significant challenges and barriers to future developments and a major workforce development programme will be needed to develop a shared culture of both social and medical model interventions being integrated into one form of practice.

## Views of children and young people

Responses from children and young people to the call for evidence and those who attended the focus groups varied significantly. Some rated the support they got very highly, for example *"I would not be alive now if it wasn't for them"*. Some felt that their lives were less important than their diagnosis or condition to the professionals working with them. Others said for example *"it was rubbish – they were not interested in me"*. Another said that *although they offer to listen to you there is (sic) no plans put in place for sessions and you just feel like you are going over the same thing. It would be better if it was like a telephone service where you had access to the number if you were feeling down and wanted to talk, as most of the time when I used to get there I felt ok but when I was feeling low I had to wait until appointment time"*.

One quite young respondent said some very telling things about his experience.

*When I feel really bad, they don't ask how I am feeling. There is nowhere to go to help me and my mum when I am not feeling well in my head. It takes a very long time in the car to go and see the CAMHS Dr. The room we go in is scary and small. I feel like I am being watched to see how I behave. There are little kids toys there and nothing to help me feel ok waiting. There is nothing in the room that makes me feel calm, no tent to lie in like at school. I don't want to leave school to go and see the Dr. I miss lessons and get into trouble. I want to go at the weekend. The Dr uses words and says stuff I don't understand. The Dr does not explain and just tells my mum to give me more tablets. The Dr argues with my mum because the Dr says PDA isn't right, but I don't understand why the Dr says this because it helps me know what is in my head and what it is called"*

Overall the respondents were clear that they were the experts in their own feelings, worries and anxieties and should be treated as such, with their treatment being agreed with them, after being fully explained and properly discussed.

A young person who is doing well after treatment said *“Throughout all stages of therapy I met with all kinds of different approaches and techniques. I felt some worked and some maybe didn’t as much”*.

One 17 year old told us their story – *“I am now 17 years old and am currently in crisis with no support...I was referred to CAMHS in 2011. My GP made 9 referrals in total before I was seen...I saw someone 4 times every 4 weeks and then they left. I waited another 8 months for another appointment, during this time I attempted suicide 4 times ...(story of several years of treatment) I saw someone (recently) Z told me I needed anger management and referred me to CHEWS. She discharged me from CAMHS. I saw someone at CHEWS and they didnt do anything around anger management. They can no longer work with me and I am waiting for CAMHS again. My recommendations are:*

- 1. There needs to be an emergency line to call for advice, help or immediate support.*
- 2. Once they receive a referral they should see you in 1 week.*
- 3. You should not be switched from one worker to another.*
- 4. You should be seen as often as you individually feel you need.*
- 5. CAMHS hospital workers need to learn to listen.*
- 6. NHS and the council should make funding available for respite or residential care for children at the greatest risk.*
- 7. If you are told you have a particular condition then this needs to be confirmed and support offered to you and your family about how to cope with that condition.*

CHEWS collect feedback from the children and young people at the end of the 10 week intervention. The feedback seen by the review was honest, largely positive and constructive.

The young people who had been or were looked after who attended the focus group were unequivocal, uncompromising and very clear about both the positives and the negatives of their experiences on CHEWS and CAHMS services. Comments took the form of stories such as *‘the first counsellor was crap, and would not see me on their own, the second was alright and had known me since I was about three, but they left and the next one was awful and made me worse, keeping going over and over the same things, the one after that could not really connect with me, was trying to help, and got me sectioned, the one after that was alright and the Dr was great, laughing , joking, banter and all that’*

Another young person said that *‘being an inpatient was good, I felt safe, got to know the routine, and there were lots of staff who could spend enough time getting to know me, but I came out too early and I started overdosing again’*

Those who were older were, in general, negative about the transition into adult services, and how bad it was. All the young people in the two focus groups were clear that a system based on how bad things are does not make sense, and that in Kirklees not only is it based on how bad you are, but even when really ill, there is still a long wait for help. Many felt they got more help and support from their mates. The main messages they had for the review were:

- It's important to recruit the right people and have enough of them.
- Staff in homes and foster carers need much better training on mental health.
- Listening does not solve things.
- Too little, too late, too often.
- Make sure everyone who provides mental health services understands about life in care.
- Think ahead, plan for transition.

One school asked a group of students to indicate how good various aspects of their CAMHS experience were out of a maximum of 10. The responses suggest an overall satisfactory experience but dissatisfaction with the waiting time for a referral to be acted on and the perceived inflexibility of CAMHS to their personal situation. However when students did get into the service they indicated that they did feel quite comfortable talking to them. Three main themes emerged from the written responses.

- Students felt they were treated like an abnormal person.
- Students felt pushed to give desirable answers which showed progress was being made.
- Students felt like a case rather than a unique individual with feelings.

The responses overall suggest that students enjoyed differing experiences of CAMHS. When asked what an outstanding service would be like in their view they said that:

CAMHS Counsellors and workers needed to:

- Emphasis you are listening to their concerns and presenting problems, not just writing things down.
- Treat service users how you would like to be treated.
- Show service users greater empathy but do not pretend to understand.
- Give more relevant advice that is personalised to the service user's needs.
- Reduce the intensity level of conversations by making sessions more fun.

The CAMHS service itself should:

- Speed up the referral process.
- Increase the number of sessions for more vulnerable service users.
- Not lose service user contact details or information generally.

- Reduce the size of the waiting list.
- Speed track those with suicidal thoughts.

A group of young people living in a children's residential care setting were also asked by their manager what they felt. Three key points were how hard it was to talk to a stranger about sensitive issues, how little they felt really listened to, and how there was nothing to help at the time one feels low, because you have to wait until the next appointment.

Other material provided to the review included the *Our Voice Report*<sup>xi</sup> and the *Our Voice CHEWS Feedback Report*.<sup>xii</sup> These reports are summaries of engagement activity with children and young people. Young people stated they wanted:

They wanted:

- To be involved in planning and delivering services and activities.
- To have the right adults working with them, who they can trust and talk to in confidence, who are not judgemental and who like young people.
- Support for our parents, carers, sibling and friends so they can support us.
- Provide services in young people friendly venues.
- Venues that are local because transport to travel to clinics is difficult.
- Tell us what we can expect from a service.

Solutions included things that were low cost but would have a high impact and some significant changes. It is clear the emphasis they placed on services was to maximise services provided through social, community based activities and which focus on advice and support. The review saw how this project had informed the development of the Transition Plan and the priorities within it.

## Analysis

The questions this review addressed are:

- ❖ How are children and young people kept safe at all stages?
- ❖ How effectively are children and young people and families engaged?
- ❖ How effective is the service in terms of access, reach of service provision, knowledge of services within the system, quality of referrals and responses to referrers, families and young people?
- ❖ What is the quality and timeliness of services delivered to children and young people?
- ❖ How well do stakeholders understand current contractual arrangements, thresholds, services and monitoring data?
- ❖ What evidence is there of outcomes from interventions?

What is going well and what is improving

It is clear that change is already underway in Kirklees. Strategically there is buy in to the principle of a shared approach, with integrated strategic planning and senior manager buy in to need to work more systemically. The Transformation Plan is a positive force for change, and if the transformation plan and the new Children's Plan share the same narrative, analysis of need, messages, expectations of multi-agency behaviours, priorities and delivery programmes as well as detailed separate service specific plans this will be a significant step forward.

The delivery of the first year of the Transformation Plan and there is a real can do approach. Delivery is being tightly managed and strongly driven, and there is strong monitoring. Some of the changes made in Year 1 of the Transformation plan are already showing improvements. The AskCAMHS service has been very well received, and is very well used, identifying the high level of unmet need there was previously. The crisis team is a good step forward and the focus on extending the availability of the CHEWS emotional health and wellbeing offer positive. The changes being made by SWYFT are also a good sign although there is a huge amount still to do to improve practice and ensure those they serve are fully safeguarded and have their welfare promoted.

Waiting times are reducing overall for initial assessments although no one is denying there is a very long way to go before waiting times reach acceptable levels in the eyes of children, young people and families, or indeed reach the planned new standards.

There are a growing number of schools providing their own services to promote emotional health and wellbeing. The Stronger Families Programme is investing in additional capacity to address emotional wellbeing and the Youth Offending Services has dedicated clinicians working in the team. Both services are keen to develop better integrated services and to reduce the need for inter-service referrals, and repeat assessments of need.

### What is going less well

These are all positive signs but the fact remains that there is still a lot to improve. There are a range of concerns of which the most important strategically is that services are planned for, commissioned and delivered in service centred not "client centred" ways. The approach is structures based not needs based or functionally focussed. There is currently no identifiable clear high level multi-agency strategically owned agreement about a shared vision, ambition, behaviours, language or outcomes, and staff do not have that shared understanding across the system as a consequence.

Service provision is organised in linear ways rather than in either geographically or functionally integrated, linked, or locality based ways, or through whole life course models. As a consequence children, young people and families experience parallel systems of service

delivery and multiple different systems to navigate. This limits the opportunities that joint commissioning could bring.

At present, because the wider organisational system does not wholly own Child and Adolescent Mental Health Services as a key priority, and many of the key national policy drivers do not assist, services are jointly commissioned, but are not strategically connected.

In addition, planning for early help, early intervention and prevention appears to still be insufficiently well coordinated so although the Transformation Plan and the Council's Priorities are both focussed on developing better early help, planning is happening separately, with the potential that some really important opportunities to move services out of the clinic and into the community, and to utilise low cost, no cost community based models of early support could be lost. Early help, stronger families, and whole Children's services direction of travel is not, as yet integrated into the Transformation Plan or vice versa. To support this effectively, new models of practice need to be developed. These need to be designed to utilise scarce professional skills differently to support staff working in universal services and Early Help provision, giving them advice and "skilling them up". The new schools pilot is a good start and an example of how this can work.

As a consequence services are still very silo'ed organisationally and are largely clinically driven. It is essential that thought is given to developing multi-agency as well as multi-disciplinary teams, perhaps co-located as part of the healthy child developments into school clusters.

In terms of systems and processes there is a very real absence of clarity. There are still numerous, complicated, separated, complex and criteria ridden pathways to access different elements of service. There is a huge amount of referral on, hand-offs from one service to the next, repeat referrals, multiple assessments and piles of forms. Huge amounts of time, energy and capacity are diverted into the work of system and process maintenance and silo-based protectionism rather than on direct face to face service provision.

Assessments and referrals, criteria and rationing, and threshold gaming are all creating perverse incentives which drive need upwards. The whole issue of waiting lists and long waits post initial assessment, with odd forms of list management and extremely poor communication to referrers and families is one of the consequences of a hugely complicated incoherent system. It is probable that many staff perceive others as either refusing to manage risk, or avoiding it.

Transitions within and between services are poorly managed and transitions from children's services to adult services extremely difficult. Service gaps occur as a result, particularly in relation to ASD services.

Culturally and behaviourally there is a real mountain to climb. Although there are many skilled, dedicated staff, passionate about what they do, and who care deeply about the children and young people they work with there are some deeply engrained issues to address. There is very limited understanding at the frontline about the strategic direction of travel, the policy context and the vision and ambition for the future. There are no cross discipline common understandings, shared values, principles, behaviours, practice standards or practice models.

The universal services workforce of schools, teachers, GP's, social workers etc. is confused, unclear, and frustrated by what it perceives as a closed system and service.

The specialist services workforce is experienced by others, especially families, as overly professionalised, unconnected, and unhelpful by many but is also under constant pressure to attach a CAHMS label to a child when they think universal services can cope. There are many examples of poor attitudes to children, young people and their families and a "do to, not with" approach by most professionals. There are unhelpful attitudes all round, with no sense of collectivism or collective responsibility and accountability. And, most frustratingly (and most likely to cause harm) is a "not my problem approach." At present there does not appear to be either an assertive, hard driven joined up communication strategy or an integrated jointly agreed workforce development strategy. Both would make a significant difference.

This is accompanied by services that are increasingly specialisation driven, and the labels that can be "attached" to a child carry excessive weight (i.e. give me a label and I'll get help). This is partially because many of the services are NHS interventions, but overall the culture is one of domination by the medical model of service provision and intervention. Alongside this there is no culture of ensuring that if a service says no, or yes but not for so many weeks, there is a sound assessment of the impact of that on the child's welfare, and no systems to ensure interim support whilst waiting for a service or being referred elsewhere. There is no culture of "never do nothing" in Kirklees. Whilst there is no evidence the risks of this are directly harming children, the data still shows the demand is for specialist services (tier two) and growing, which may be a direct consequence.

In terms of practice the quality of practice is very variable in every agency and service. Staff tend to focus on the single service they are there to provide rather than child's story, and on the issue or presenting problem rather than focussed on the whole child and their social, emotional, physical, and environmental context and family. Practitioners tend to either focus too much on adults or too much on the child. There is too little understanding of Infant and early childhood mental health (resilience and emotional wellbeing) or of early help services for very young children and families to improve resilience. Perinatal mental

health services are now getting some investment but specialist advice to children's centres is, for example, missing. Adult services often do not understand or take account of their client's needs as parents or of the impact of their client's needs on their children.

Families experience episodic interventions, which are often very short. There are often no post intervention plans or step down support. No one "holds" the family (except maybe schools) through the family's journey of changing needs. Staff need systems and processes which support them, alongside the training and skills to wrap services round a child and their family, not pass them on.

The evidence base used to inform practice and frontline non specialist understanding of the issues is very variable and access to advice remains limited and allied to referral systems.

The gaps in service brought to the review's attention include the need to:

- increase and extend PHSE,
- Develop more services to address and support the needs of children who are looked after.
- Provide training and support to staff working with young people to help them understand and respond better to adolescence behaviour and development, (what's normal, what's a worry and needs some support, what requires medical help) and address risk taking behaviours
- Improve the join up between disabled children's services and other services
- Develop the availability of psychological support for children with complex conditions

## Conclusions

This analysis sets out the review's overall findings against the standards of what good looks like and how close the current situation is to that in terms of:

- Putting children, young people and families first and service design second
- Speedy, flexible, person centred, needs based services
- High support to increase skills in universal services
- Responding early and quickly and flexibly
- simplicity
- Specialist advice, accessible consultation, advice and input 24/7
- Meeting children, young people and families where they are by "coming out of the clinic into the community"

Kirklees SCB are to be congratulated for taking the decision to review services as thoroughly as they have. This is an ideal time to use this review to inform the next stages of strategic

planning and service improvement in children's services, as well as Year 2 of the Transformation Plan.

What the review tells us is that a road map of improvement in place, the direction of travel is good and is based in good well researched and evidenced rationale. The Transformation Plan priorities are right, delivery is on track, and the risks are understood. An attempt has been made to put the needs of children, young people and families first and design services round them, but the dislocation between the Transformation Plan and the Council's early help approach until recently is not helping with this.

There are early signs of positive change and impact but children and young people are still not consistently well served and are not consistently well safeguarded. Significant risks associated with difficulties of access and waiting times, and absence of early help and coordinated services during periods of waiting. CYPF themselves indicated that an appointments based system did not always suit their need for immediate support.

The journey of the child or young person through the system is one of long waits, without support, confusing and often hard to understand processes, with lots of handoffs from one service or professional to another, lots of hoops to jump through and lots of assessments. Often children and young people felt their lives were less important than their diagnosis or condition to the professionals working with them. Help is slow to come, and usually when there is a crisis or things have deteriorated a significant amount. Services are still inflexible, slow to respond and shaped to fit service need not the needs of the children, young people and families using them. When young people did get through all the stages and into treatment a significant number valued it very highly.

The system is over complex and needs radical simplification. It is currently not fit for purpose. It needs to focus on, put value on and invest in activity that builds resilience and improves children and young people's emotional health and well-being. A list of action points are provided in the Recommendations section below.

One of the most significant challenges and barriers to future developments is the variability in skills, and the gaps in competence, understanding and training of a large multi-agency workforce. Cultures and behaviours are unhelpful and a major workforce development programme will be needed to develop a shared culture of both social and medical model interventions being integrated into one form of practice

One of the questions that is currently unclear and that the review has highlighted is exactly what data the KSCB wishes to use to assure itself of the quality of emotional health and wellbeing services and CAHMS and what difference they are making to the safeguarding and promotion of welfare of vulnerable children and young people in Kirklees.

## **Recommendations**

1. The system is over complex and needs radical simplification. It needs to focus on, put value on and invest in activity that:
  - builds resilience and improves children and young people’s emotional health and wellbeing,
  - provides extensive development of early help services,
  - focus on developing advice and learning support, consultancy and other forms of skilling up a universal workforce
  - designs services to meet children and young people “where they are” and reduce clinic use
  - provides a range of rapid 24/7 forms of advice and support (such as helplines, internet guidance and access to out of hours advice and support services)
  - creates flexible resources that allow for support to be bespoke to meet an individual’s assessed needs at any point, and reduces overdependence on clinical services (including peer support groups)
2. KSCB should support and challenge the partners to develop and agree a shared set of priorities, values, principles and behaviours, (underpinned by a common language) which are used to underpin all strategic and operational planning for children as well as embedded in workforce standards and competencies.
3. KSCB should establish a programme of monitoring, evaluating and assuring itself of the progress being made in delivering the Transformation Plan in particular with regard to the child’s journey through the system, and the degree to which the system is consistently safeguarding children and young people and promoting their welfare. This should not replicate the work of the Integrated Commissioning Board but provide sustained scrutiny and a high level of challenge.
4. KSCB should consider working with the Integrated Commissioning Board in designing a suite of impact and outcome measures and a rolling programme of audit activity to test the impact delivering the Transformation Plan has had and what difference it is making.
5. This review report should be used to inform the Second Year Transformation Plan and the development of the specification for the new Tierless Services and each stage of the tender process. The criteria for what a “good service” looks like should be applied to tender evaluation.
6. Thought should be given to whether KSCB or the Integrated Commissioning Board should support an “experts by experience” advisory group to add to the level of scrutiny and challenge, assist in audits and quality assurance activity.

7. KSCB should look to its partners and particularly the Health and Wellbeing Board, which leads on joint workforce issues) to develop a joint workforce development programme to improve the skills of all frontline staff
8. KSCB should work with the other Boards to develop a major communication programme about the transformation programme and what is changing, why.
9. KSB should robustly assure itself over the next 12 months that the development of the early help system is integrated into the second year of the Transformation Plan priorities and delivery plan (and vice versa).
10. KSCB should look to partners to think creatively about where and how services can be integrated and ask challenging questions as to why not, for example whether the SPA could and should be integrated into the developing single point of access for children's services.
11. KSCB should take a high profile interest in supporting and challenging the development of a coherent and simple system, and should ensure existing systems are reviewed, revised, simplified and agreed on a multi-agency basis.
12. KSCB should ensure that access to services within the new tier-less system uses the same threshold tool, continuum of need, risk sensible models, and assessment tools as the rest of the early help and children's services system.
13. KSCB should develop a "Never Do Nothing" policy with a simple tool for assessing risk.

## Appendix A



### A REVIEW OF THE CHILD'S JOURNEY THROUGH CAMHS IN KIRKLEES

#### Introduction

The CAMHS service has been the subject of significant discussion between partners, and in recent times has also featured in local media. Following a meeting in July involving Commissioners and Council representatives, it was thought appropriate issues should be explored in more detail under the auspices of the Kirklees Safeguarding Children Board (KSCB). KSCB gave agreement to undertaking the review at its meeting in September 2015, with a view to commencing work in 2016 following finalisation of the Transformation Plan. It is therefore proposed that a time-limited group be established, which will undertake a review of CAMHS from a safeguarding perspective, and will report its findings to the Board. It is considered the review should address all levels of service, but in the light of initial assessments of risk and challenges, a significant focus of the work will need to be on intervention services. The existing Transformation Plan will form a key context for aspects of the review.

#### The Aim of the Review:

- To understand the experiences and journey of children and young people through CAMHS and ensure that there is a focus on their point of view
- To ensure that local CAMHS arrangements are safe and meet safeguarding requirements
- To bring in an external/independent point of view
- To take into account the whole system and reference tiers 1, 2, 3 and 4. Noting the time frame it would be useful if the review took note of any issues particularly identified re options for children and young people, referrals and communications within schools (tier 1), Chews (tier 2) and NHS England (tier 4) as needed. Further work may be identified by the LSCB
- To take into account, and learn from, regional and national best practice

- To report back to inform future commissioning, and recommend changes as appropriate

### **Governance, Working Arrangements and Timescale**

A group of professionals will be established under the leadership of an Independent Chair who will have a skill mix of sufficient knowledge of children's experiences and perspectives, safeguarding, LAC, mental health, and CAMHS. The Independent Chair will also have a detailed knowledge of partnership working.

Key Lines of Enquiry will be developed by the working group under the leadership of the Independent Chairperson.

The Independent Chair and working group will report to a Reference Group to be appointed by the Safeguarding Children Board. The Board will agree Terms of Reference for the work.

There will be an expectation placed upon Board members to enable the provision of relevant resources and information to support the review.

It is intended that this work will be concluded within 6 months and report available to the 9<sup>th</sup> of September 2016 KSCB meeting.

### **Terms of reference**

The TOR will include the following:

- How are children and young people kept safe at all stages
- How effectively are children and young people and families engaged
- How effective is the service in terms of access, reach of service provision, knowledge of services within the system, quality of referrals and responses to referrers, families and young people.
- What is the quality and timeliness of services delivered to children and young people
- How well do stakeholders understand current contractual arrangements, thresholds, services and monitoring data
- What evidence is there of outcomes from interventions

### **Review of the Child's Journey – what needs to be included**

- The story of children/young people as developed through case file audits and talking to children/young people and families
- Experiences of all who are part of the system as referrers, signposters, practitioners, commissioners.
- Safety of arrangements for individuals-do arrangements meet safeguarding standards

- Developing core points for future contracting
- Setting the Kirklees service provision in the context of regional and national delivery
- Issues for the Transformation Plan 5 year strategy: the DoH has made it clear it should be a living document so any findings from the CAMHS Review can be incorporated into the Plan.

## Appendix B

### Specification for Review.

The baseline for the work comprises:

- The proposal, the aims of the review and the governance and working arrangements
- The Children Act 1989, the Children Act 2004, the Children and Families Act 2014 and Working Together 2015
- “Future in Mind” as a key reference document and associated NHS documents
- Setting the Kirklees service provision in the context of national and regional delivery
- Material provided by KSCB

### The Work Programme

I will, following an initial set up meeting, undertake the work through 5 stages and work streams. These stages will overlap at times. Meetings of the Review Group and with the Reference group are included in the days estimated. Details of focus groups, case samples, audit methodology and interview content will be agreed with the relevant leads and the review group members involved.

Monthly highlight reports on progress will be provided for the Review Group and the Reference group.

<p><u>Set up phase</u> (March)</p> <p>5 days’ work comprising</p> <ul style="list-style-type: none"> <li>• .5 days on set up and timeline</li> <li>• 2 days on “best practice review”</li> <li>• 1 day document review and call for evidence</li> <li>• 1 day mapping exercise</li> <li>• .5 developing the KLOE</li> </ul>	<ul style="list-style-type: none"> <li>• Finalise the roles and experience required for the group and agree a timeline for the whole review</li> <li>• Undertake a document review and send out a “call for evidence” to the review</li> <li>• Undertake and report on a short review of research and practical examples of what currently constitutes “best in class” practice in CAMHS to use as a baseline for the review</li> <li>• Scope and map the current “system for CAHMS” across all four tiers in Kirklees in the light of the completion of the transformation plan</li> <li>• Develop the key lines of enquiry</li> </ul>
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<p><u>Take evidence</u> (April-June)</p> <p>5 days' work, comprising</p> <ul style="list-style-type: none"> <li>• with three group meetings (1.5 days) two days of focus groups</li> <li>• stakeholder meetings (3.5 days)</li> </ul>	<ul style="list-style-type: none"> <li>• Analyse written evidence</li> <li>• Take oral evidence over three meetings</li> <li>• Meet with a range of focus groups comprising children, young people, families, and professional stakeholders</li> </ul>
<p><u>Audit and review practice</u> (April –June)</p> <p>4 days comprising</p> <ul style="list-style-type: none"> <li>• Audit tool development (.5)</li> <li>• Case file audits (lead plus 3 reviewers) (2)</li> <li>• Interviews (1.5)</li> </ul>	<ul style="list-style-type: none"> <li>• Case file audits – sample from each tier</li> <li>• Interviews (recorded) with either practitioners, line managers, children or parents about their experiences taken from one case from each tier audited</li> </ul>
<p><u>Analysis of performance data and evidence of outcomes and impact</u> (April –June)</p> <p>5 days comprising</p> <ul style="list-style-type: none"> <li>• Data analysis (3)</li> <li>• Interviews (2)</li> </ul>	<ul style="list-style-type: none"> <li>• Review and analysis of all available data sets</li> <li>• Analysis of any impact and outcome data or evidence</li> <li>• Interviews of young people and carers who received a service between 2 years and 6 months ago</li> </ul>
<p><u>Testing hypotheses and conclusions</u> (July-August)</p> <p>4 days comprising drafting and consulting on findings (including at a group meeting</p>	<ul style="list-style-type: none"> <li>• Group meeting to agree initial hypotheses and conclusions</li> <li>• Draft report</li> <li>• Consult on draft with key stakeholders</li> <li>• Group meeting to finalise conclusions and draft</li> </ul>
<p><u>Presentation of Report</u> (September)</p> <p>1 day</p> <p><b>Total Days 25</b></p>	<ul style="list-style-type: none"> <li>• Attend KSCB 9<sup>th</sup> September 2016</li> </ul>

### Outputs and outcomes

You require me to report formally to the KSCB on 9<sup>th</sup> September 2016. The report should set out the “story” of children and young people’s experience, and that of their families, and an analysis of the experience of all those who are “part of the system”. It should evaluate the Kirklees system and services against the relevant standards required for safe practice as well what evidence tells us is good practice. It should make recommendations (based on what is working well, and what needs developed) for how to best build, develop and maintain a positive experience of mental health and wellbeing for children and young people in Kirklees. These recommendations should include any findings that need to be incorporated into the Transformation Plan 5 year strategy and should address any key issues for commissioners as well as service providers

## Appendix C

### **CHILD AND ADOLESCENT MENTAL HEALTH PROVISION**

#### **A summary of contemporary policy, guidance and best practice**

**DAWN REES**

**Independent Consultant**

## **May 24, 2016**

**The background information and analysis of Kirklees' CAMHS has set out some of the work that needs to be undertaken and to build on what we know about what good looks like. The following section sets this out in the context of contemporary policy and guidance.**

### **Definitions**

Mental health has been defined as <sup>1</sup> "A state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Emotional wellbeing has been defined as: "*A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.*"<sup>2</sup> and is often favoured by schools and others whose main contribution is around prevention and health promotion.

### **How do we describe what we mean by mental health in the real world?**

It is helpful to consider emotional and psychological wellbeing and mental health as part of a continuum of need across the life course. Achieving optimal mental wellbeing in the early part of our lives plays an important part in child development. It influences the development of resilience, promoting attachment, the ability to make and sustain meaningful relationships and to grow into adulthood with greater likelihood of having good mental health and resilience throughout our lives. Interruptions to this developmental perspective, unresolved problems and difficulties in self-regulation and managing emotions, behaviour and relationships all have the potential to compromise mental health, or develop into mental illness, in adulthood

Children's mental health and emotional wellbeing is nurtured primarily in the home, but public and voluntary service provision can help support parents and carers in their vital role of promoting emotional wellbeing and supporting children's mental health throughout childhood. A secure parent/child relationship is the key building block for the development of positive attachment and helps in the development of emotional resilience in children.

The school and college environment can enhance children and young people's emotional wellbeing, by building self-esteem, promoting knowledge of the key difficulties experienced in children and young people and by reducing risk taking behaviours, and supporting the development of social and emotional skills through PHSE, a whole-school environment that promotes emotional wellbeing and mental health.

### **Prevalence and impact**

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<sup>1</sup> *ICD-10 Classification of mental and behavioural disorder; Clinical descriptors and diagnostic guidelines*: Geneva. WHO

<sup>2</sup> Ibid.

- 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class
- Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm
- There has been a big increase in the number of young people being admitted to hospital because of self-harm. Over the last ten years this figure has increased by 68%
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time
- Nearly 80,000 children and young people suffer from severe depression
- Over 8,000 children aged under 10 years old suffer from severe depression
- 72% of children in care have behavioural or emotional problems - these are some of the most vulnerable people in our society
- 95% of imprisoned young offenders have a mental health disorder. Many of them are struggling with more than one disorder
- The number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s (9).
- The proportion of young people aged 15-16 with a conduct disorder more than doubled between 1974 and 1999

## **MENTAL DISORDERS**

The figures below are based on the finding of the latest ONS Child and Adolescent Mental Health Survey which was published in 2004

Any figures on the number of children with these disorders are estimates based on the prevalence rates found in this study and demographic data from the 2001 census.

9.6% or nearly 850,000 children and young people aged between 5-16 years have a mental disorder

7.7% or nearly 340,000 children aged 5-10 years have a mental disorder

11.5% or about 510,000 young people aged between 11-16 years have a mental disorder

## **ANXIETY**

3.3% or about 290,000 children and young people have an anxiety disorder

2.2% or about 96,000 children have an anxiety disorder

4.4% or about 195,000 young people have an anxiety disorder

## **DEPRESSION**

0.9% or nearly 80,000 children and young people are seriously depressed

0.2% or about 8,700 aged 5-10 year-olds are seriously depressed.

1.4% or about 62,000 aged 11-16 year-olds are seriously depressed.

## **CONDUCT DISORDERS**

- 5.8% or just over 510,000 children and young people have a conduct disorder
- 4.9% or nearly 215,000 children have a conduct disorder
- 6.6% or just over 290,000 young people have a conduct disorder

## **HYPERKINETIC DISORDER (SEVERE ADHD)**

- 1.5% or just over 132,000 children and young people have severe ADHD
- 1.6% or about 70,000 children have severe ADHD
- 1.4% or about 62,000 young people have severe ADHD<sup>3</sup>

The most common disorders are:

- Conduct disorders, for example defiance, physical and verbal aggression, vandalism
- Emotional disorders, for example phobias, anxiety, depression or obsessive compulsive disorder
- Neurodevelopmental disorders, for example attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorder
- Attachment disorders, for example children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major caregivers
- Substance misuse problems - eating disorders, for example pre-school eating problems, anorexia nervosa and bulimia nervosa
- Post-traumatic stress disorder - psychosis - emerging borderline personality disorder.

## NATIONAL POLICY CONTEXT

Mental health problems in children and young people can have significant effects and impact on school and social relationships and affect life chances

Mental health problems can last a long time. 50% of mental illness in adult life starts before the age of 15 and 75% by the age of 18<sup>4</sup>

There are strong links between social disadvantage and mental health problems in childhood and children and young people in poor households are three times more likely to have mental health problems<sup>5</sup>.

Parental mental illness is associated with increased rates of mental health problems in children and young people, with an estimated one-third to two-thirds of children and young people whose parents have a mental health problem experiencing difficulties themselves

The Mental Health Strategy 2011<sup>6</sup>, the Health and Social Care Act 2012<sup>7</sup> and the Guidelines from the National Institute for Health and Clinical Evidence (See *Appendix*), are the key drivers for the current changes in understanding need, commissioning practice, integration, service provision, early intervention, health promotion, managing crisis, responding to the most vulnerable and managing transition that relate to children and young people with emotional, psychological and mental health needs. It is a challenging agenda.

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<sup>3</sup> [WWW.YOUNGMINDS.ORG.UK](http://WWW.YOUNGMINDS.ORG.UK)

<sup>4</sup> [www.centreformentalhealth.org.uk/pdfs/life\\_chances\\_summary.pdf](http://www.centreformentalhealth.org.uk/pdfs/life_chances_summary.pdf)

<sup>5</sup> Goodman A. et al: *The Long Shadow Cast by childhood physical health and mental health problems on adult life*. *Prac. Natl. Acad Sci* 2011, 108(15), 6032-6037

<sup>6</sup> <https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

<sup>7</sup> <https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets>

The Government publication *Closing the Gap: priorities for essential change in mental health*<sup>8</sup> highlighted 25 areas where it expected to see change, including improving access, reducing stigma, and parity of esteem between physical and mental health, integrated planning and provision, starting early to identify and tackle mental health problems, and improving the quality of life of people with mental health problems.

The Government publication *Future in Mind*<sup>9</sup> examined how to make it easier for children young people and families to access help and support, and how to improve the organisation, commissioning and provision of services and the emerging themes from that report were

- promoting resilience, prevention and early intervention
- local structures will be simplified and deliver a joined up approach
- high quality local information will drive improvements in care and standards of performance
- a culture of continuous evidence based service improvement will emerge
- the right investments will be made based on need and evidence
- access to effective support will improve (a system without tiers)
- the most vulnerable will be cared for
- Accountability and transparency
- The workforce will develop to respond to local need

Its ambitions are that local partnerships will ensure that will implement its recommendations and an online self-assessment tool can help in the development of local transformation planning. <http://bit.ly/1SMOX8s>

The Joint Commissioning Panel (2011)<sup>10</sup> preceded these reports, but helpfully its summary sets out what 'good' looks like in CAMHS

- The care provided should be timely, effective and efficient
- There should be clear pathways, advice to universal services, joint working, reaching out to groups less likely to access specialist CAMHS, 24 hour services, access to emergency provision
- The strategic direction should be jointly agreed and there should be good clinical and managerial leadership, a multi-agency commitment to integrated services that involves young people in planning services.
- There should be an appropriate range of services for children and young people with different needs and different ages, including more intensive services for those that would otherwise require admission to hospital
- There should be a critical mass of staffing (15 wte clinical staff per 100,000 total population for a non-teaching service); range of skills including child and adolescent psychiatrists, clinical psychologists, CAMHS nurses, CBT therapists, child psychotherapists, family therapists, and creative therapists.
- Staff across health and social care should possess a variety of therapeutic skills, including behavioural, cognitive, interpersonal, psychodynamic, pharmacological and systemic approaches.

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<sup>8</sup> *Closing the Gap: priorities for essential change in mental health*: DH (2014)

<sup>9</sup> *Future in Mind*: NHS England (2014)

<sup>10</sup> <http://www.jcpmh.info/wp-content/uploads/10keymsqs-camhs.pdf>

- There should be clear processes for young people who will require intervention and support in adult life and who will move from children's to adult services
  - Outcomes, evaluation and feedback: all services should have a system of routinely collecting patient outcomes, as well as using patient/carer experience, audit and monitoring of adverse events and serious incidents.
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This section highlights some of the critical aspects that should inform contemporary thinking about how to deliver the best comprehensive services for children and family across the spectrum of need. It is divided into eight sections and should guide the reader through the key delivery and commissioning requirements for a modern response to the problems of emotional and psychological health and mental disorders. Each section comes with an example of good practice.

## **1 WORKING TOGETHER**

Since the Children Act 1989, all government documents have stressed the importance of working together and to integrate planning and delivery as far as possible in order to reduce duplication and prevent gaps in provision.

In Liverpool all the key organisations including the NHS and local authority work together to commission services that are joined up, rather than having different services commissioned by different organisations. This makes sure the investment goes where it is needed and young people can get the right care at the right time. Led by Liverpool CCG, the programme covers six key areas – mental health promotion, early intervention and prevention, access, participation, inpatient services and transition to adult services.

## **2 ASSESSING LOCAL NEED TO DETERMINE PROVISION**

The NHS and Social Care Act 2012 and subsequent guidance to commissioners promotes a model of consistent data collection to inform a regular Joint Strategic Needs Assessment that should be linked to commissioning, funding and delivery priorities jointly owned by CCGs and the Local Authority. These priorities should be set and monitored by the multi-agency Health and Wellbeing Board. Undertaking a JSNA is a statutory requirement. <http://bit.ly/1VQmORX>

Achieving a consistent standard of data collection so that it is truly representative of local populations is problematic. It is not unusual to see JSNAs that have not sufficiently taken into account the mental health needs of its black and minority ethnic populations; its young LGBT population; the mental health needs of refugees and asylum seekers; children in households where there is domestic violence; hidden populations. For a comprehensive JSNA to be effective it must actively seek data that is not obvious, and commission it if such data is absent.

## 2.1 Essex County Council<sup>11</sup>

*In 2013 Essex County Council wrote its CAMHS Joint Strategic Needs Assessment (JSNA) for Essex, which includes Southend-on-Sea and Thurrock.*

*Since April 2013 Clinical Commissioning Groups (CCGs), Essex County Council (ECC), Southend-on-Sea Borough Council and Thurrock Council have been responsible for planning, designing and commissioning local health and well-being services on behalf of the Essex population.*

*The JSNA and review it found good quality but fragmented services with an absence of clear care and referral pathways and inconsistent data collection.*

*The findings of the JSNA supported the redesign and remodel of emotional well-being and mental services to address the inequalities in provision for children and young people and to achieve its ambition to commission an integrated emotional well-being and mental health service for children, young people and their families to ensure that the best quality of care and outcomes can be achieved.*

*In order to develop a pan-Essex approach it was critical to take account of the complicated infrastructure with a number of CCGs in North Essex, Mid Essex, West Essex, North East Essex and South Essex. In addition there are two Unitary Authorities Thurrock and Southend-on-Sea and 12 district, borough and city councils. Local authority responsibilities lie with Essex County Council, Thurrock Council and Southend-on-Sea Borough Council.*

*As a result of its JSNA, Essex set up a new joint commissioning forum (JCC), together with the county-wide stakeholder partnership building the opportunity to develop a strategic focus. As a result, Commissioners report that there have been consistently expressed views on how to improve services which will shape future provision.*

## 2.2 Bolton<sup>12</sup>

Bolton's JSNA helpfully clusters its information under the following headings:

- *Implications for commissioning*
- *Who is at risk and why*
- *ONS projections based on 2011 Census*
- *The level of need in the population*
- *Current services in relation to need*

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<sup>11</sup> <http://www.thurrockccg.nhs.uk/document-library/638-essex-camhs-needs-assessment-executive-summary-final-1/file>

<sup>12</sup> <http://www.boltonshealthmatters.org/content/emotional-health-well-being-children-jsna>

- *Projected service use and outcomes measurement*
- *Evidence of what works*
- *Community views*
- *Recommendation for further needs assessment work*

### **3 DELIVERING A PUBLIC HEALTH APPROACH TO EARLY INTERVENTION, PREVENTION AND HEALTH PROMOTION**

The emphasis on early recognition of problems, early help and early intervention is critical to a public health approach for emotional health, wellbeing and mental health. A key factor in developing strong emotional attachments and resilience in infants is the relationship with parents/care-givers. And this starts with high quality ante-natal care, predicting and reducing risk, the recognition of problems with relationships, mental health or substance misuse problems, domestic violence or vulnerable families. A public health approach will incorporate General Practice, Midwifery and Health Visiting in the early years, alongside Children's Centres, pre-school nursery provision and School Nursing in order to identify parents who might need support and monitoring in the ante-natal period (recognising vulnerability, or post-natal depression for example); identifying problems with attachment and responding appropriately (for example, using the Solihull Approach); providing parenting programmes in non-stigmatising settings; targeting support to vulnerable families when children start school.

Factors associated with an increased risk of peri-natal mental illness are<sup>13</sup>:

- History of mental illness
- Psychological disturbance during pregnancy
- Lone parent or poor couple relationship
- Low level of social support
- Recent adverse events
- Socio-economic disadvantage
- Teenage parenthood
- Early emotional trauma/childhood abuse
- Unwanted pregnancy

A peri-natal outcomes indicator will be available in 2018 to inform the NHS and Public Health Outcomes Frameworks <https://www.npeu.ox.ac.uk/research/perinatal-mental-health-indicator-257>

The Early Intervention Foundation report *The Best Start at Home*<sup>14</sup> on what works to improve the quality of parent child interactions from conception to age 5. It emphasises the importance of positive parent-child interaction which serves to enhance good social and emotional skills and “gives the best possible foundation for cognitive development before, during and beyond school years.” Its sister publication in 2016 highlights the importance of providing support to women and

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<sup>13</sup> *Every Child Counts: 2014 NSPCC*

<sup>14</sup> *The Best Start at Home: Early Intervention Foundation 2015*

children where domestic violence features in the household, and the negative impact of domestic violence on child and adolescent mental health.<sup>15</sup>

### 3.1 Birmingham peri-natal mental health

Birmingham Community Healthcare NHS Trust: Improved peri-natal mental health

“Traditionally, maternal mental health issues were addressed during the period, and referral to the GP if needed. However, there was no clear guidance, and training for health visitors was on an ad hoc basis.

The mental health team decided to develop a clear pathway for health visitors to follow during the perinatal period, and up to 12 months, to address this issue.

Four Maternal Mental Health champions were trained to give specific training on identifying mental health issues and supporting mothers with mental ill health during the perinatal period and beyond.

The training was rolled out to all health visitors during 2013/14, and was then provided for all support staff in health visiting teams. The training was also offered to all newly qualified health visitors. In addition, six members of staff were trained to become Promotional Guide Trainers, who were used to provide training to all health visitors about the importance of relationship building and identification of needs during the antenatal period. It was also provided to all student health visitors in the local university as part of their training.

Since this project was initiated, staff stated that having the Perinatal Mental Health Pathway to follow makes them feel more supported.

For mothers, the identification of maternal mental ill health is being picked up at an earlier stage, often in the antenatal period, allowing for care to be planned.

Since the initiation of the Pathway there has been an increase in the number of antenatal visits by health visitors. The earlier identification of perinatal mental health problems results in more timely intervention and de-escalates the need for medical or social care intervention.

Future plans are to increase the number of antenatal visits until every mother receives a visit by the health visitor from 26 weeks of pregnancy”.<sup>16</sup>

### 3.2 The Thrive Model

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<sup>15</sup> <http://www.eif.org.uk/publication/what-works-to-enhance-inter-parental-relationships-and-improve-outcomes-for-children-3/>

<sup>16</sup> *Maternal Mental Health (Perinatal) Health Visitor Programme: 2015. Department of Health*

The conceptual framework THRIVE, developed through the collaboration between the Anna Freud Centre, Tavistock and Portman NHS Foundation Trust, Dartmouth Centre for Healthcare Delivery Science and UCL Partners, has been translated into a model of care called 'i-THRIVE' (implementing THRIVE), which is an integrated, person and needs led approach to delivering mental health services for children, young people and families. A Community of Practice involving 10 sites from across England is now working to implement the model, supported by a team made up of members from the partnership. The collaborative is now supporting sites to use evidence based approaches to implementation and will be learning about the impact on access, waiting times, patient choice and engagement with services. Shared decision making is an important element of the model and a new measure of the quality of the shared decision making process called CollaboRATE will be used, as well as developing tools to support patients and clinicians in the SDM process, called Option Grids. <http://www.annafreud.org/service-improvement/service-improvement-resources/thrive/>

### 3.2 PARENTING PROGRAMMES

Group-based parenting programmes aim to support, educate and train carers to fulfil their parenting role effectively. There is significant variation in the style, structure and content of parenting initiatives in the UK, and by whom they are commissioned. Programmes range from those that aim to support parents in general to cope better with raising a child, to those that work with parents with particular difficulties. The main type of parenting programmes either relate to behaviour (using social learning techniques), or relationships (new skills in listening and communicating). In 2006 NICE published Guidelines on effective parenting programmes <http://bit.ly/1TuNR1a>. Some of the most popular evidence-based parenting programmes include Mellow Parenting, Triple P, Webster Stratton's *The Incredible Years*, and The Wonder Years.

### 3.3 Hertfordshire County Council and Bradford

Hertfordshire County Council and Bradford Metropolitan District Council commissioned Family Links *Welcome to the World* and its *Nurturing Programme* to improve outcomes for vulnerable families. It now has evidence that the programme has reduced the number of referrals to Children's Services and more parents stayed engaged than with other early intervention programmes.

*Welcome to the World and the Nurturing Programme* are used by practitioners in health, social care and education settings to enable parents to become more resilient, caring and confident.

### 3.4 SINGLE POINT OF ACCESS

The development of a single point of access (SPA) for professionals and families for all emotional health, wellbeing and mental health provision is becoming more prevalent across England. In theory it should simplify the route to the right service, at the right time for all those referred. It should reduce the number of inappropriate referrals to other more specialist services, and support the development of knowledge and skills about emotional wellbeing,

behaviour and mental health in universal services. If need is recognised early and responses are simple, easy to access and intuitive, then children, young people and their families should experience responses that are more helpful, less stigmatising and more in tune with how people live their lives.

A SPA model is built on a principle that we all have a responsibility to respond to children and young people's emotional needs. The emotional health, psychological wellbeing and mental health of children and young people is the business of all of us, not just the health sector.

However a SPA is unlikely to deliver a single solution to all system-wide challenges. Instead, it is dependent on a collaborative approach and should strive to improve everyone's understanding of the part they play in helping to build resilience and capacity in families through the provision of information, early support and advice, and brief intervention in universal settings

### **3.5 Nottingham City Single Point of Access**

The Nottingham Single Point of Access pathway draws together the work of current services and professionals from across Nottingham City (such as health, social care, education, youth and play, and voluntary sector services). It helps them to deliver a seamless service with positive outcomes for children and young people. The pathway does not replace current mental health services, but works alongside these services to ensure children and young people receive the most appropriate support at the earliest opportunity. If more specialist assessment or support is needed, the pathway aims to make sure this is carried out by the most appropriate service or services.

The pathway aims to deliver positive outcomes, ensure need is identified and met at the earliest opportunity, prevent the escalation of behavioral, emotional or mental health needs, ensure early assessment and initial intervention that is family focused. The SPA directs referrals to the most appropriate service and manages the demand for more specialist services by reducing the waiting times for intervention by responding to emerging need.

There is one point of referral for this pathway, for all agencies supporting children and young people with behavioural, emotional or mental health needs.

After 18 months this model has been found to significantly reduce referrals to specialist mental health services, and deliver consultation and support to professionals and families. The model enables self-referral.

## **4 FUTURE IN MIND**

### **Universal Provision**

*Future in Mind* proposed that the Tiered model of describing access and provision has lost its utility and that a description of Universal, Targeted and Specialist provision is more appropriate.

Universal provision is that which families can easily access without needing to be referred, for example General Practice, Health Visitors, Midwives, Children's Centres, Playgroups and Nurseries, Schools etc.

Children spend a significant amount of their time in school and college and schools have subsequently noticed a rapid increase in the number of concerns affecting school-aged children, including bullying, the impact of social media, peer pressure and anxiety. The Young Minds survey of head teachers found that two thirds of them made specific reference to concern about the increasing number of young people appearing to be affected by anxiety, depression and self-harm<sup>17</sup>.

Schools provide an appropriate environment in which to nurture ideas about developing mental health resilience through the PHSE curriculum and a whole-school approach to mental health has been found to be effective in reducing anxiety levels in children and young people. Schools that develop a positive ethos, identify and intervene early, and understand the causes of behaviour are better positioned to respond to the emotional and mental health needs of children and young people<sup>18</sup>. This whole-school approach can be enhanced by provision through the school nursing service, the development of peer-support and/or counselling in schools.

#### **4.1 School nursing and school counsellors**

School nurses across England provide regular non-stigmatising and easy to access drop-in sessions for children and young people to discuss their concerns and worries. The Royal College of Nursing has developed a practice toolkit to support school nurses in the provision of mental health services in school  
[https://www2.rcn.org.uk/\\_data/assets/pdf\\_file/0012/201630/003223.pdf](https://www2.rcn.org.uk/_data/assets/pdf_file/0012/201630/003223.pdf)

Many schools independently commission school counsellors and the British Association of Counselling and Psychotherapy has written clear guidelines and an ethical framework for good practice for head teachers and practitioners, which include the need to ensure that school counsellors are trained to work with children and young people, receive regular supervision and are familiar with the local safeguarding procedures.  
<http://youthcounsellinghull.co.uk/resources/BACP%20School%20Counselling%20Good%20Practice.pdf>

The Department of Health and Public Health England has published guidance to support the commissioning of public health provision for school aged children aged 5-19 which should maximise the school nursing team contribution to the public health of school aged children, including emotional health and wellbeing.  
<https://www.gov.uk/government/publications/school-nursing-public-health-services>  
and how to promote the emotional health and wellbeing of children and young people through the school nursing service  
<https://www.gov.uk/government/publications/school-nursing-public-health-services> .

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<sup>17</sup> [http://www.youngminds.org.uk/news/blog/2929\\_headteachers\\_say\\_children\\_s\\_mental\\_health\\_is\\_most\\_worrying\\_concern](http://www.youngminds.org.uk/news/blog/2929_headteachers_say_children_s_mental_health_is_most_worrying_concern)

<sup>18</sup> [http://www.ncb.org.uk/media/1197143/ncb\\_framework\\_for\\_promoting\\_well-being\\_and\\_responding\\_to\\_mental\\_health\\_in\\_schools.pdf](http://www.ncb.org.uk/media/1197143/ncb_framework_for_promoting_well-being_and_responding_to_mental_health_in_schools.pdf)

## 4.2 The Voluntary Sector and Charities

The voluntary sector and charities have always played a significant role in providing easy to access, local and non-stigmatising provision for children, young people and their families. The Place2Be is one of the largest organisations involved with over 250 primary and secondary schools and over 250,000 children and young people, primarily providing counselling and support to school-aged children in school. It is able to evidence improvements in home-life, classroom behaviour, and attainment and school attendance. <https://www.place2be.org.uk/impact-evidence/children-and-young-people/>

Schools, now independent of Local Authority control and as independent commissioners of additional services, can commission a range of services for their pupils and many utilise their Pupil Premium as a method of enhancing the school response to pupil need.

## 5 TARGETED PROVISION

Targeted provision is usually commissioned to provide targeted funded provision for children and young people and their families, who are vulnerable more likely to develop mental health problems. These include children who are looked after by the local authority, those likely to be on the margins of or in the criminal justice system, children and young people living in poverty, or who have been abused, who have learning or physical disability etc.

NHS England has provided a Service Specification<sup>19</sup> for Targeted and Specialist Child and Adolescent Mental Health Services, and the targeted element can be adjusted taking into account local need set out in the local Joint Strategic Needs Assessment.

Targeted services are frequently commissioned to provide for children and young people who already have or who are more vulnerable to developing emotional and mental health problems, for example those involved in the youth justice system, children who are looked after by the local authority, children with a neuro-developmental disorder or who identify as lesbian, gay, transgender or questioning their sexuality. These examples are offered as a proxy for any group of vulnerable young people who are statistically more likely to be so affected. They are often less visible, less likely to access services and more likely to perceive such services as stigmatising.

The Department for Education has published guidelines for

### 5.1 Looked after children

Looked after children have the same health risks as their peers but the extent is often exacerbated due to their previous experiences. Looked after children show significantly higher rates of mental health issues, emotional disorders such as anxiety and depression, hyperactivity and autistic spectrum disorder conditions. The

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<sup>19</sup> <https://www.england.nhs.uk/wp-content/uploads/2015/01/mod-camhs-tier-2-3-spec.pdf>

Royal College of Paediatrics and Child Health provides guidance on the knowledge skills and competencies required of healthcare staff caring for looked after children [http://www.rcpch.ac.uk/system/files/protected/page/Looked%20After%20Children%202015\\_0.pdf](http://www.rcpch.ac.uk/system/files/protected/page/Looked%20After%20Children%202015_0.pdf)

Designated doctors and nurses have specific responsibilities for children and young people who are looked after, and have statutory roles.

In 2014 the Department for Education published statutory guidance on promoting the health and wellbeing of looked after children <https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2>

The Norfolk and Suffolk NHS Mental Health Foundation Trust *Connect* service provides a specialist service for young people up to 18 who are adopted, looked after or in Special Guardianship, Child Arrangement or Kinship Care – and for carers or families. It works closely with Suffolk County Council to ensure that those children in most need are provided with support, psychotherapy and mental health care where necessary.

<http://nsft.nhs.uk/Our-services/Pages/The-Connect-Service-Suffolk.aspx>

## 5.2 Youth Justice

Around 25% of children who offend have very low IQs of less than 70 and 43% of children on community orders have emotional and mental health needs, and the prevalence amongst children in custody is much higher. 60% of children who offend have communication difficulties and, of this group, around half have poor or very poor communication skills and about 33% of all children accessing local drug and substance misuse services are referred from the youth justice system. 27% of children and young people who offend are not in full time education, training or employment at the end of their period of youth justice supervision. Evidence shows that between a third and a half of children in custody have a diagnosable mental health disorder such as depression, which is particularly prevalent in girls. A review of joint inspections undertaken by the Healthcare Commission and HM Inspectorate found that 42% of children and young people have emotional and mental health needs<sup>20</sup>.

In 2014 the Youth Justice Board published guidance on mental health provision in youth justice settings <https://www.gov.uk/government/publications/joint-guidance-on-mental-health-in-the-youth-justice-system> to ensure that the mental health needs of children and young people are properly identified and addressed.

## 5.3 Drop-in Centres for young people

At The Well Centre in Streatham is a youth health centre where young people can drop-in to see a youth worker, counsellor or doctor. No appointment needed, and young people can just turn up to discuss any health concerns or worries in a safe

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<sup>20</sup> <http://www.prisonreformtrust.org.uk/Portals/0/Documents/turningyounglivesaroundFINAL.pdf>

and confidential space. Staff include doctors, youth workers, counsellors, sexual health and advice workers. <http://www.thewellcentre.org/about-us.html>

## 6 SPECIALIST PROVISION

**Specialist provision is specially commissioned to deliver services to the most vulnerable and the most ill and are generally provided through specialist multi-disciplinary teams – often described as ‘the CAMHS team’. Specialist provision also includes inpatient care and the management of transitions to adult services for those children and young people with severe and enduring mental illness.**

Specialist mental health provision is usually delivered by a local Mental Health Trust through a multi-disciplinary team approach, and the specification for such a service is set out by NHS England<sup>21</sup> Normally specialist provision is for more complex problems or for those children and young people with mental disorder. A full range of services should be available, from assessment through to formulation of diagnosis, intervention and treatment with a comprehensive approach to multi-agency working and collaboration often necessary to respond to the complex needs of these children and young people.

Specialist mental health provision for children and young people will involve a child and adolescent psychiatrist in the multi-disciplinary team. Children and young people needing such provision will often have a range of problems for example, self-harm, eating disorders, anxiety and/or depression suicidal ideation, major affective disorders, neuro-developmental disorders and/or co-morbid conditions.

The Crisis Concordat was published by the Department of Health in 2014<sup>22</sup> and is arranged around access to support before crisis occurs, urgent and emergency access to crisis care, the right quality of treatment and care and then recovery and staying well. The Concordat expects that every local authority, health and criminal justice provider will agree to local Mental Health Crisis Declarations that commit to action at a local level to meet the principles of the national concordat.

### 6.1 Early Intervention in Psychosis

Early Intervention in Psychosis Service usually consists of community based, specialist mental health teams designed to help people from the age of 14 upwards who are experiencing symptoms of psychosis for the first time.

Getting help early following the onset of psychotic symptoms is the bedrock of the Early Intervention approach; it can reduce the disruption to a person’s life and help improve their chances of a quicker recovery. Treatments available are evidence

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<sup>21</sup> *ibid.*

<sup>22</sup>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/281242/36353\\_Mental\\_Health\\_Crisis\\_accessible.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf)

based and follow the relevant NICE guidelines<sup>23</sup> (National Institute of Health and Clinical Excellence). They might include individual psychosocial interventions via care coordination, medication and specialized psychological interventions such as cognitive behavioural therapy (CBT) and family therapy. The care and treatment is offered in an atmosphere of hope and optimism. Emphasis is placed upon service users 'maintaining ordinary lives', personal enablement and recovery.

## 6.2 Emergency health assessments s136 Mental Health Act

A Government review of the operation of sections 135 and 136 of the 1983 Mental Health Act, published in 2014, identified a number of issues, in particular the over-use of police cells as places of safety, which evidence shows can have a serious impact on the person concerned, especially young people. It also highlighted that detainees were not necessarily receiving as timely a response from health services as they should, and that there were significant variations in practice across the country.

The Royal College of Psychiatrists has published a Position Statement on its definition of a Place of Safety (Crisis Assessment sites for children and young people aged 18 and under) <http://bit.ly/1UeXVh3>

## 6.3 Increasing Access to Psychological Therapies

The ambition over the next five years for children and young people's mental health is to support CCGs to work with partners to build effective, evidence-based outcome-focused Child and Adolescent Mental Health Services (CAMHS), working in collaboration with children, young people and families. Delivering this national ambition requires local, system wide leadership and ownership, as well as the participation of children, young people and their families.

The government has pledged £1.25 billion by 2020 to support improvements in children and young people's mental health and wellbeing, along with £150 million for eating disorder services.

Young people and parent/carers said they wanted to be empowered to share their own information to inform future therapeutic work, and to help communication and integration between different services. NHS England, young people and parent/carers worked together to develop a *Mental Health Services Passport template*. Each passport is to be created by a young person or parent/carer (for younger children) with the support of their practitioner. The aim of the passport is to help young people using services, or parents with for younger children, to own and communicate their story when moving between different services. It provides a summary of the time in the service which will be owned by the young people or parent/carer to be shared with any future services if and when they wish.

[www.england.nhs.uk/mentalhealth/cyp/iapt](http://www.england.nhs.uk/mentalhealth/cyp/iapt)

## 6.4 Eating Disorders

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<sup>23</sup> <https://www.nice.org.uk/guidance/cg155>

Eating disorders are serious mental health problems. They can have severe psychological, physical and social consequences. Children and young people with eating disorders often have other mental health problems (e.g. anxiety or depression) which also need to be treated in order to get the best outcomes.

It is vital that children and young people with eating disorders and their families and carers can access effective help quickly. Offering evidence-based, high-quality care and support as soon as possible can improve recovery rates, lead to fewer relapses and reduce the need for inpatient admissions. The availability of dedicated community eating disorder services has been shown to improve outcomes and cost effectiveness.

In 2015, the government announced an additional £30m funding a year (recurrent for five years) to support the development of dedicated community eating disorder services. This will also release further general capacity into CAMHS to help young people in mental health crisis or who may be self-harming. The programme will be delivered within the CYP IAPT programme framework which promotes early access to collaborative, effective, evidence-based and outcome-focused treatment.

A new waiting time standard for Eating Disorders has been published by the National Collaborating Centre for Mental Health and NHS England. <http://bit.ly/1TyvEje>

## 6.5 Learning Disability<sup>24</sup>

The prevalence of mental health problems in people with learning disabilities is estimated to be 36% compared to 10% in the general population. Frequently this is exacerbated by behavioural disorders, and is frequently associated with co-morbid conditions. Children and young people with learning disability must have the same access to specialist child and adolescent mental health services and not be excluded because of their learning disability.

Reasonable adjustments should be made to general services to ensure that children and young people with learning disability have access to assessment and treatment and clear pathways should be developed to ensure that the needs of these children and young people are considered and their special needs incorporated into mainstream planning.

The Special Education Needs and Disabilities reforms require services to work together to support the needs of children and young people with learning disabilities, develop Education Health and Care Plans to ensure that services are joined up. It also includes the potential of utilising Personalised Budgets to give greater freedom for families to commission their own services and support, tailored to the needs of the individual child.<sup>25</sup>

## 7 MANAGING TRANSITIONS

Moving from a child-centred mental health service to an adult mental health service is a

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<sup>24</sup> <http://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf>

<sup>25</sup> <https://www.nspcc.org.uk/globalassets/documents/research-reports/guide-safeguarding-managing-risk-personal-budgets.pdf>

daunting prospect and NHS England has produced guidelines for safely planning and negotiating the transition stage. <https://www.england.nhs.uk/wp-content/uploads/2015/01/mod-transt-camhs-spec.pdf>

Transitions should be planned well in advance and involve the young person and their family. For many CAMHS users, the transition from CAMHS to Adult Mental Health Services (AMHS) is poorly planned, poorly executed and poorly experienced. A large number of young people with mental health problems fall through the care gap and don't transition from CAMHS to AMHS. Those who transition successfully experience an improvement in their mental health.

There is international concern about young people who get 'lost' during their move from CAMHS to AMHS. Disruption of care during transition may adversely affect the health, wellbeing and potential of this vulnerable group.

Draft NICE guidelines are available <https://www.nice.org.uk/guidance/NG43/documents/transition-from-childrens-to-adults-services-full-guideline2>

## 7.1 Inpatient care

The 2014 NHS England CAMHS Tier 4 (inpatient) report was critical of the geographical inequality and the consequent distance between a suitable inpatient provision and individual patients' homes. It made a series of recommendations, including the appointment of Care Managers to improve the patient experience. <https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf>

NHS England subsequently published service specifications for General Adolescent Inpatient Units <https://www.england.nhs.uk/wp-content/uploads/2013/06/c07-tier4-ch-ado-mh-serv.pdf> for specialist inpatient units for young people with autistic spectrum disorders <https://www.england.nhs.uk/wp-content/uploads/2013/06/c07-tier4ch-ado-mh-aut.pdf>

Inpatient care is critically dependent upon good pathways in and out of the inpatient environment to enable a smooth transition into hospital (often enhanced by outreach services jointly provided by community based and inpatient teams) and the implementation of a high quality discharge plan and the appropriate community based services to support the young person once they get home. This could include the provision of 'day services' in the hospital to enable an earlier discharge whilst maintaining close clinical supervision of the young person in transition. The Burrows Unit in Northamptonshire is an example of this. <http://www.nht.nhs.uk/main.cfm?type=THEBURROWSCAMHSHIG>

## 8 OUTCOMES MEASUREMENT AND EVIDENCE BASED PRACTICE

With greater scrutiny of the commissioning and delivery of child and adolescent health services, the emphasis on measuring the outcomes of interventions has emerged as a method for local commissioners to determine the impact and value for money of those interventions.

Alongside this has grown an ‘outcomes industry’ but at the same time a growing interest in the effectiveness and the evidence-base for interventions –evidence-based generally meaning that there is sound research evidence for the delivery of interventions, frequently informed by NICE guidelines.

The CAMHS Outcomes Research Consortium [www.corc.org.uk](http://www.corc.org.uk) is a subscriber based organisation that supports local specialist CAMH providers in developing a systematic approach to outcomes measurement and provides comparisons with statistical neighbours to enable such comparisons.

The Children and Young People’s IAPT programme

The Royal College of Psychiatrists Quality Network for Community CAMHS <http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/communitycamhs.aspx> and its Quality Network for Inpatient CAMHS <http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/qnic1.aspx> are peer-review networks using a standardised format to benchmark quality across a comprehensive range of domains, and enabling comparisons with other providers.

With the development of thinking and standards for routine outcome measurements, CAMHS providers are better positioned to evidence the effectiveness of its intervention and commissioners are better placed to implement evidence-based commissioning as a result. <http://bit.ly/1VAesNY>

## 9 PATIENT AND CONSUMER INVOLVEMENT

Underpinning the Mental Health Strategy 2011 was a clear statement: “*No decision about me, without me*”. There is evidence, six years later, that there is a developing momentum that has seen children and young people experiencing a greater level of involvement in developing, reviewing and advising on local service development.

Children and young people have been actively involved in the CYP IAPT programme across England <http://www.myapt.org.uk/about/myapt-makers/> and developed the CAMHS participation ebook <http://bit.ly/1QyNE8w>

Children, young people and their families should be involved in the development of local CAMHS strategies and Local Transformation Plans for example, Guildford and Waverley have a strong children and young people involvement in their local Transformation Plan <http://bit.ly/1NPQx4X>

Children and young people with mental health problems frequently report their experiences of stigma, and this includes the stigmatising impact of asking for and being the recipients of mental health services. Involving children and young people and their families in developing, providing and reviewing services is one way of reducing that stigma and ensuring that the kind of services that are commissioned are those that children, young people and families will want to use. The Well Centre<sup>26</sup> in Streatham is a good example of 100% involvement of the service

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<sup>26</sup> <http://www.thewellcentre.org>

consumers in how the service itself was developed, including being involved in the building design.

## 10 ONLINE RESOURCES

Local services are often behind the curve in relation to social media and the methods young people use to access information. These online resources illustrate some examples of local and national services/resources and the way that they engage children and young people. It is important to be aware, however, that young people frequently use online resources to access *information* but there is scant evidence that online therapy for children and young people is currently capable of replacing the most critical of components of a therapeutic intervention – that of the relationship between human beings.

That said, we must be aware that young people are media-savvy and get a lot of their information online.

Online resource for families involved in CAMHS <http://minded.e-lfh.org.uk/families/index.html>

Treatment choices <http://mycamhschoices.org>

Royal College of Psychiatrists online resources <http://bit.ly/1SN4c4p>

Online training about CAMHS <https://www.minded.org.uk>

Medication <http://www.headmeds.org.uk>

Online advice 24 hours <http://www.getconnected.org.uk/get-help/>

Young People's Advisory Service <http://www.talktofrank.com/treatment-centre/young-persons-advisory-service-ypas>

Young Minds [www.youngminds.org.uk](http://www.youngminds.org.uk)

Centre for Mental Health [www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)

Rethink Mental Illness [www.rethink.org.uk](http://www.rethink.org.uk)

Norfolk Mental Health <http://whatsthedealwith.co.uk>

ChildLine [www.childline.org.uk](http://www.childline.org.uk)

NSPCC [www.nspcc.org.uk](http://www.nspcc.org.uk)

**APPENDIX 1**

NICE GUIDELINES

1. Eating Disorder in over 8's		2004
2. Social and Emotional Wellbeing Primary Education	2008	
3. Social and Emotional Wellbeing Secondary Education	2009	
4. Psychosis with substance misuse		2011
5. Social and Emotional Wellbeing: Early Years	2012	
6. Psychosis and Schizophrenia in children & young people	2013	
7. Autism in u19s	2014	
8. Anorexia Nervosa		2014
9. Anti-social behaviour	2013	
10. Self-Harm		2013
11. Challenging Behaviour and learning disability	2015	
12. Violence and aggression	2015	
13. Promoting quality of life for looked after children		2015
14. Children's attachment	2015	
15. Attention Deficit Hyperactivity Disorder	2016	
16. Transition from children to adult services		2016
17. Community engagement: improving health and wellbeing And reducing health inequalities		2016

## Appendix D

### **Kirklees Future in Mind Transformation Plan – Children and Young People’s Mental Health and Wellbeing 2015-2020**

#### **Theme 1. Promoting resilience, prevention and early intervention for the mental wellbeing of children and young people**

- Redesign and implement a school nursing service that is more focussed on emotional health and wellbeing and provides an early intervention function across all education settings
- Implement clear joint working arrangements and clear pathways between schools and emotional health and wellbeing provision
- Collaboratively commission emotional health and wellbeing provision with schools
- Collaboratively design young people peer education programmes

#### **Theme 2. Improving access to effective support – a system without tiers**

- Redesign the Tier 2 and Tier 3 specifications to provide a tier free service model based on the “Thrive” approach
- Increase capacity in tier 2 and 3 to reduce waiting times and improve access
- Provide a comprehensive eating disorder service
- Implement tier 2 and 3 link workers to directly liaise with and support schools, primary healthcare and other universal provision
- Implement a joint training programme with universal services, tier 2 and tier 3 staff
- Put in place a single point of access for advice, consultation and assessment and coordination of provision
- Provide a one stop shop for advice and support collaboratively commissioned with the voluntary and community sector
- Provide a local crisis model that responds within 4 hours
- Design and implement all age psychiatric liaison services

#### **Theme 3. Caring for the most vulnerable**

- Invest in and implement a flexible multiagency team to address the emotional health and wellbeing needs of looked after children, children in the youth offending team, children experiencing child sexual exploitation (CSE) and children on child protection plans
- Ensure rapid access to CAMHS interventions for those children who are part of the Stronger Families programme
- To provide cohesive CAMHS provision regionally for looked after children

- To work with KSCB to do a deep dive into the ay children and young people experience the CAMHS service and use the learning to inform our discrete provision for vulnerable children

#### **Theme 4. To be accountable and transparent**

- Implement lead commissioning arrangements
- Use the Transformation plan as the basis for commissioning priorities over 5 years
- Embed responsibility for oversight the commissioning intentions with the Health and Wellbeing Board
- Ensure the Integrated Commissioning Group is overseeing implementation of the detailed operational commissioning plan, ensure commissioned services are evidence based and National Institute for Health and Care Excellence (NICE) guidelines are implemented throughout the service
- Ensure the Integrated Commissioning Group closely monitor the CAMHS minimum data set and waiting time standards whilst developing an outcome based dataset to monitor and improve performance across the system
- Implement clear and transparent outcome monitoring
- Receive quarterly feedback from children, young people and families

#### **Theme 5. Developing the workforce**

- Ensure Tier 2 and 3 providers are fully participating in the children and young people's Improving Access to Psychological Therapies (CYP IAPT) core curriculum in 2016/17
- Ensure Tier 2 and 3 providers are involved in the introduction to CYP IAPT in 2015/16
- Ensure that where required staff and parents receive appropriate training and continuing development opportunities to enable them to deliver relevant evidence based interventions
- Develop a comprehensive workforce development strategy for CAMHS across Kirklees

## Appendix E

### CAMHS Review Case Audit Tool

Auditor:

Service Provider:

Case ID

Gender/sexuality:

Age:

Ethnicity:

Area:

#### **1. Quality of file**

- Chronology up front?
- Clear, accessible and readable
- All basic details included
- Well recorded and well evidenced
- Consent and information sharing dealt with
- Focussed on the views, wishes, feelings and self-knowledge of the CYP
- Telling the story
- Records differences of view, concerns and issues
- Demonstrates reflective practice
- Evidence of practice/clinical oversight and supervision
- Up to date, timely, signed off

#### **2. Initial contact**

- Is it clear who made initial contact with the service and why?
- Is the reason/rationale for making contact clear and well presented
- Are the views of CYP/Adult Family Members about the initial contact, reasons and rationale visible and clear
- Is the CYP's emotional wellbeing, health, social and educational context, family life and daily life experience included in the initial contact/referral details
- What was the response to initial contact
- Was the response timely – if not, why not
- Was consent recorded/dealt with
- Was the history/story well recorded
- Was it clear who was/is involved at the point of contact
- Are any risk of safeguarding issues identified and recorded

#### **3. Identification of need and/or diagnosis**

- Is there a clear assessment of need and or a diagnosis if relevant
- Is the assessed context and lived experience for the CYP clear – can you see the “story”
- Are the views, wishes, feelings and desired outcomes for the CYP clear
- Are the adult and other family members views, wishes, feelings and desired outcomes for the CYP clear
- Is the assessment evidence based and the rationale and analysis clear
- Is there a clear well evidenced plan for intervention/treatment arising out of the assessment
- Does the plan include regular 1:1 with the cyp on their own
- Does the plan assess and mitigate risks including safeguarding risks
- Is the plan strengths-based or deficit focussed
- Does the plan set out
  - A clinical diagnosis or assessment of need with an easy to understand treatment/intervention plan
  - Clarity about the model of intervention and or model of practice being applied and why
  - Clarity about roles, responsibilities and multi-agency/multi-disciplinary involvement
  - Clear outcomes (what needs to change and how will everyone know) and clear milestones and stages
  - Consent to, understanding of and engagement with the CYP/Adult family in the plan

#### **4. Intervention and/or treatment**

- Is the journey through the intervention/treatment/plan/programme well recorded
- Can you see the story and “hear” the voice of the CYP
- Are the views of CYP and adult family members included in each record
- Is progress measured and celebrated
- Are reviews of progress included – formal and informal and recorded
- Is there a rationale for changes to the plan
- Is there a clear relationship between both clinical recording and recording of the context, (social, emotional, educational, familial and health)
- Are crisis points and change of direction points recorded
- Is safeguarding risk regularly reassessed and mitigated
- Is there a plan b (or even a plan c too)
- Does the CYP know what has to happen for the intervention to be deemed successful

**5. Closures and transitions** (where relevant)

- Is there a clear record of the final stages of the plan, progress towards the desired outcomes and degree of success in achieving change
- Is there a view about ending the intervention from the CUP/Adult family members recorded
- Is there a transition plan (step up/step down/direct access to re-referral/self-referral, transition to alternative service etc.)
- Do the CYP/Adult family members know what to do if the problems/needs re-emerge

Do other professionals know about/understand reason for closure and do they know what to do if problems re-emerge

**CAMHS Review Case Audit Tool criteria for judgements**

**A good quality file:**

- Has a clear chronology upfront and up to date
- Includes all basic details including extended family members
- Is clear, accessible and readable, with well evidence and clear recording that is concise and focussed
- Clearly demonstrates consent has been addressed
- Tells the “story” lucidly
- Focusses on the child or young person, their views, wishes and feelings
- Is up to date, timely and signed off regularly
- Evidences analysis and reflective practice
- Evidences professional/clinical and managerial oversight and supervision

**A good file deals with initial contact:**

- Clearly recording not only who made contact and why, but what the story behind that contact was
- Gives a clear rationale for both the contact and the response
- Clearly sets out the views of the CYP and family members
- Demonstrates how the contact was responded to and dealt with
- Clarifies what will happen next
- Identifies both needs and clinical issues and risks and any safeguarding issues

**A good file deals with the identification and assessment of need/diagnosis of illness:**

- Clearly and with resort to appropriate assessment tools
- Is and remains child or young person focussed, and which tells the story of what that CYP’s life is like

- Demonstrates the detail of assessment, analysis and decision making clearly and gives the rationale for decisions
- Results in a clear and well evidenced plan with detailed content
- Is outcome focussed
- Shows how well/often the CYP was seen on their own
- Clearly demonstrates how that CYP has been listened to and what their own wishes, feelings and views are

**A good file demonstrates clearly that during the intervention/treatment:**

- There is a journey through the process which is well recorded
- Shows the CYP's voice throughout
- Measures and celebrates progress
- Shows how often/well the process is reviewed
- Shows clinical and social context
- Is clearly multi-agency developed/owned and communicated
- Regularly reassesses and mitigates risks and ensures safeguarding is clear
- Demonstrates there are alternative plans if progress does not go as planned

**A good file shows what happens next:**

- Where the case is nearly ended or closed the file sets the scene, completes the story and has a clear plan for transition

**An outstanding file** has all the features above and includes clearly recording from the CYP throughout

**An adequate file** demonstrates more than a ¼ and up to at least ½ the characteristics of a good file, is clearly CYP centred and includes the wishes, feelings and experiences of the CYP to a certain degree

**A less than adequate file** does not meet more than a ¼ of the standards above

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<sup>i</sup> Kirklees Overview and Scrutiny Annual Report 2015/16

<sup>ii</sup> Early Years Foundation “stage profiles”

<sup>iii</sup> The Five Year Forward View for Mental Health – The Independent Mental Health Taskforce to the NHS in England February 2016

<sup>iv</sup> National Service Framework for Children, Young People and Maternity Service 2004 HMSO

<sup>v</sup> Future in Mind – protecting, promoting, and improving our children’s mental health and wellbeing. 2015 HMSO

<sup>vi</sup> Lightning Review: Access to Child and Adolescent Mental Health Services, May 2016 Children’s Commissioner for England

<sup>vii</sup> Suicide by children and young people in England National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. May 2016 University of Manchester and Healthcare Quality Improvement Partnership

<sup>viii</sup> NHS Joint Commissioning Panel 2011 Ten key messages in CAMHS services

<sup>ix</sup> Best Start in Life May 2016 Local Government Association

<sup>x</sup> Working together to safeguard children 2015 HMSO

<sup>xi</sup> Our Voice project on children’s health and emotional wellbeing

<sup>xii</sup> Our Voice project CHEWS Client Feedback Report June 2014