

# **Children and young people's mental health Local Transformation Plans - a summary of key themes**

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# Children and young people's mental health Local Transformation Plans - a summary of key themes

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## 1. Introduction

### 1.1 Background

In 2015, NHS England and the Department of Health (DH) published [Future in Mind](#), the report of the Children and Young People's Mental Health Taskforce. This report established a clear direction and set key principles about improving access to high quality mental health care for children and young people. In March 2016, the independent Mental Health Taskforce published the [Five Year Forward View for Mental Health](#) for the NHS in England which endorsed the vision of *Future in Mind*, but extended the focus to include improvements to crisis care, seven-day care and the development of new models to improve outcomes through integrated services. The recommendations of the *Five Year Forward View for Mental Health* have been accepted by the NHS, and in July 2016 NHS England published [Implementing the Five Year Forward View for Mental Health](#). This lays out a blueprint for the delivery of the recommendations over the coming years to 2020/21.

*Future in Mind* set out how local agencies should develop Local Transformation Plans (LTPs) which demonstrate how they would work together to improve the emotional health and well-being of children and young people in their area and support those with mental health problems across the whole care pathway. The area covered by each LTP was decided locally, with some covering multiple CCG areas and others covering just one. The LTPs in their totality cover the whole of England.

By October 2015, all 123 plans had been submitted and included information about how partners would use their allocation from the new funding from the Autumn Statement 2014 and Spring Budget 2015 to improve the mental health and wellbeing of children and young people. The Government has pledged £1.4bn to 2020/21.

### 1.2 This report

LTPs are the richest source of information available to date on the state of children and young people's mental health services across England. NEL Healthcare Consulting, part of North East London Commissioning Support Unit (NEL CSU), worked with NHS England to summarise how themes from *Future in Mind* were reflected in the LTPs. They reviewed the plans and supporting documents from both a quantitative and qualitative perspective. The quantitative analysis provides a regional and national overview of the baseline data presented in the plans such as activity, expenditure and current workforce. It is available on the [NHS England website](#).

The qualitative summary of LTPs is set out in this report. It is based on the evidence provided in the LTPs only, so there may be additional information beyond these plans. For example, many LTPs did not include details of existing programmes or services and focused instead on planned changes. The summary does not assess the quality of individual plans, or of local services. The analysis of the quality of the plans was carried out by NHS England local teams across the country, and assessing the quality of local services is the responsibility of local commissioners.

The summary also includes information about the delivery of evidence-based eating disorder treatments. This was not a key theme of *Future in Mind* but, as extra funds had been provided in the Autumn Statement 2014 (£150m over 5 years), local areas

were asked to identify how they would meet the requirements of the referral to treatment standard published in August 2015 alongside the LTP Guidance.

### **What is it for?**

This report aims to highlight innovations and emerging practice so that local areas can learn from other plans when updating their own LTPs. As set out in *Implementing the Five Year Forward View for Mental Health*, LTPs should be living documents that are reviewed and refreshed at least once a year. Local areas are expected to have expanded, refreshed and republished LTPs by 31 October 2016. Refreshed plans should detail how local areas will use the extra funds committed to support their ambitions across the whole local system. Plans should be accessible and include clear numeric targets for improved access to services in each year to 2020/21. These plans will continue to be refreshed annually in line with business planning cycles.

CCGs will be working through Sustainability and Transformation Plans (STPs) to implement the changes required to modernise mental health services. STPs will include LTPs, and, as data from the Mental Health Services Dataset (MHSDS) becomes more robust, national metrics will be developed to demonstrate improved outcomes for children and young people.

### **What does it cover?**

This report is organised into the following headings:

1. Whole systems approach
2. Participation
3. Resilience, prevention and early identification of need
4. Outcomes monitoring
5. Children and young people with extra vulnerabilities
6. Eating disorders
7. Next steps

## **1.3 Key messages from the LTPs**

The 2015 LTPs are a starting point for delivering the vision set out in *Future in Mind*, endorsed and extended by the *Five Year Forward View for Mental Health*. A joined-up approach to the commissioning and delivery of accessible support for children and young people can only be delivered in partnership with children, young people, and families. It requires a continued emphasis on prevention and early intervention as well as evidence-based treatment when it is required.

The process also highlighted challenges which need to be addressed locally and nationally, in particular around the skills and capability of the workforce, and the need for more responsive IT and data systems. There is also a need to join up community and inpatient pathways and commissioning, reducing the need for inpatient care and improving access to community services

Although there is variation in local approaches, quality and priorities, there is much to celebrate:

- every area submitted a plan, and many areas combined across larger footprints demonstrating a high commitment to partnership working;
- the production of the LTPs raised the profile of children and young people's mental health and the need to improve outcomes locally and nationally;

- the sharing of good practice and creative solutions across localities continues; and,
- all plans offer a foundation on which local areas can build.

The annual refresh offers the opportunity for continuous joint planning, strategic reflection and development, improving partnership and visible accountability. This is the first year of a five-year programme of change that requires continued focus and energy if we are to deliver the goal of improved access, outcomes and experience for children, young people and their families.

## 2. Whole systems approach

### Chapter guide

#### Overview

1. What do we mean by a whole system approach?
2. What did the LTP process tell us about existing partnership across agencies?
3. Whole systems engagement figures at a glance.

#### Making it happen

4. Integrated working and co-location of services
5. Coordinating community and inpatient care
6. Transition

Each of these sections includes examples with links.

### 2.1 What do we mean by a whole system approach?

The key challenge in *Future in Mind* was to deliver change through improved joint working across the NHS, public health, voluntary and community, local authority, education and youth justice sectors to:

- create a system built around the needs of children, young people and their families, rather than one focussed on distinct services from separate agencies;
- deliver a clear, joined-up approach by linking services so care pathways are easier to navigate;
- improve access so that children and young people can get the right support at the right time and as close to home as possible; and,
- improve transparency and accountability across the whole system - being clear about how resources are being used in each area and providing evidence to support collaborative decision making.

### 2.2 What did the LTP process tell us about existing partnership across agencies?

Areas were at different stages in terms of partnership working and the level of detail within plans was variable. For some areas, LTPs built on existing arrangements of joint commissioning and planning. For these, the eight month period between the publication of *Future in Mind* in March 2015 and the submission of their plans

provided opportunities to expand existing strategies. In other areas, partnership working was less well developed and the process of developing LTPs gave them a chance to begin a programme of whole system change.

### 2.3 Whole systems engagement figures at a glance

The graph below presents the percentage of LTP areas that reported they are working with, or have plans to work with, different organisations in the whole system.

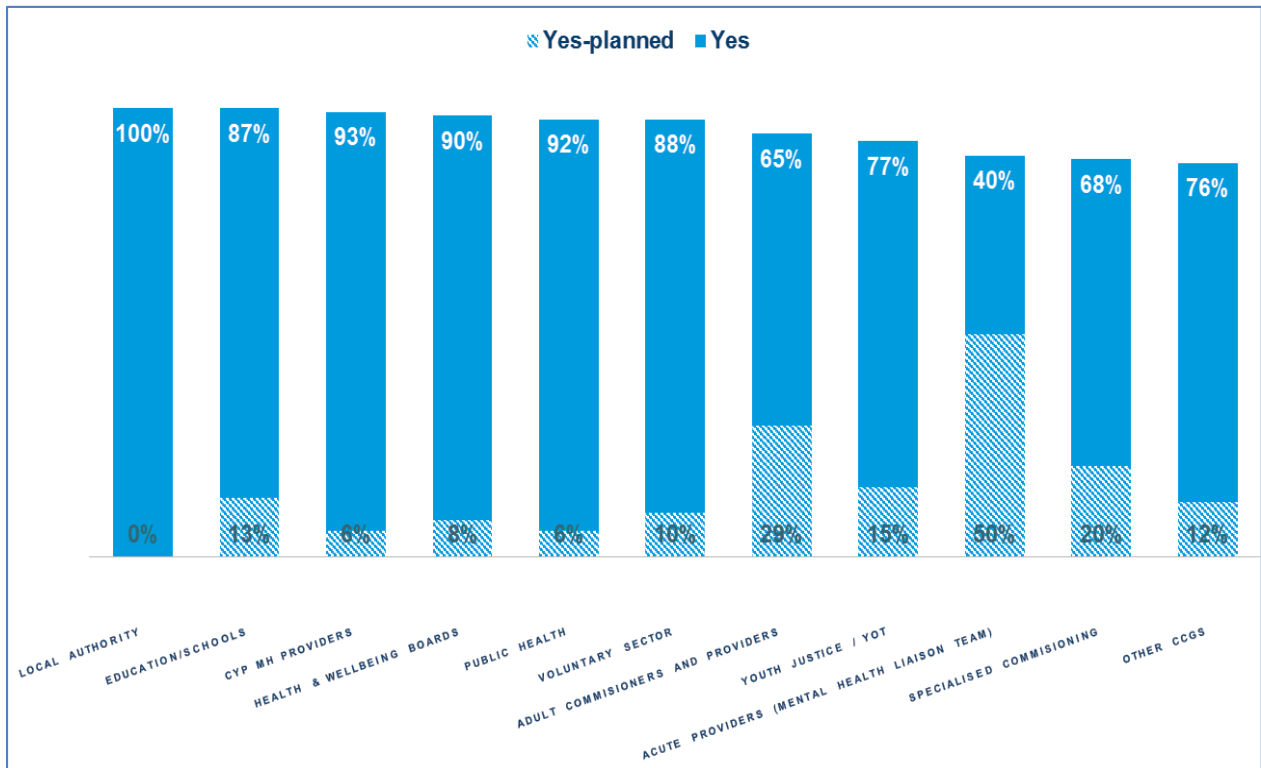


Figure 2: Statistics on LTP plans to work with organisations across the whole system.

Most areas have established multi-agency delivery boards to oversee the implementation of LTPs. Almost all named a lead accountability and decision-making commissioning body for children and young people’s mental health services and most referenced plans to pool local budgets. The majority of LTPs also contain references to integrated local agency planning and commissioning groups, and to expert strategy and steering groups, to advise on local commissioning and service design.

Approximately 50% of LTPs had specific reference to networks or partnerships with other groups or organisations, including:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>GPs and primary care;</li> <li>patient forums;</li> <li>parent forums;</li> <li>youth councils;</li> <li>young ambassadors;</li> <li>young commissioners;</li> <li>Healthwatch;</li> <li>early years’ groups;</li> <li>local safeguarding children boards;</li> </ul> | <ul style="list-style-type: none"> <li>academies and further education;</li> <li>health visitors and school nurses;</li> <li>educational psychologists;</li> <br/> <li>special educational needs and disabilities (SEND) teams;</li> </ul> |
|--|--|



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autism services;  
young carers;  
advocacy services;  
children's centres;  
looked after children (LAC) groups;  
fostering & adoption services;  
social care teams;  
youth support workers;  
police and ambulance;  
substance misuse services.

One example of cross-agency working to provide services built around the child or young person is an interim education programme in [Doncaster](#) that works with children and young people's mental health services (CYPMHS) and local schools. It offers part-time education to Key Stage 3 and Key Stage 4 pupils experiencing severe and enduring mental health difficulties who have difficulty accessing school.

## 2.4 Integrated working and co-location of services

### How are areas integrating services?

All local areas are embedding integrated working into everyday practice. This may involve:

- embedding children and young people's mental health staff in relevant teams;
- developing integrated pathways with defined workforce roles;
- co-locating staff, sometimes through a single point of access; and,
- multidisciplinary teams to ensure each young person sees the most appropriate person the first time. [Leicestershire's](#) LTP, for example, noted an all-ages service that includes a specialist CYPMH consultant, nurse, psychologist, child social worker and a substance misuse worker.

Over half of local areas either have co-located services, or are planning to establish them. Common examples of co-location include:

- CCG and local authority teams;
- specialised children and young people's mental health services and social work;
- youth offending services and children and young people's mental health;
- children and young people's mental health and children's centres;
- psychology and speech and language therapy with youth offending teams; and,
- a handful of local areas also consider co-location with community services including voluntary services. [Tower Hamlets](#), for example, described collaborative working with a voluntary sector Children and Youth Forum Coordinator.

Common methods for co-locating include:

- a single point of access for mental health and wellbeing services, which may offer, for example, Rapid Assessment, Interface & Discharge services (RAID) or out-of-hours GP services;
- co-located services in secondary care settings (e.g. Tiers 2 and 3);
- multidisciplinary teams, such as [East Sussex's](#) multi-professional teams for children and families in receipt of statutory safeguarding services, or [Wiltshire's](#) co-location of mental health practitioners with professionals from children's services who support LAC and those with learning difficulties and autism; and,
- community hubs (primary care and social care), such as [Knowsley's](#) plans for integrated, locality-based services covering mental and physical health, social care, prevention and lifestyle services. After a single assessment of physical and mental health, care and wellbeing needs, a named lead professional is responsible for more specialised treatment and care. There will be extended access to primary care, allowing patients from all practices within each hub area to access general practice services on weekdays and at weekends. Designated pharmacists will be available for minor ailments, medicine reviews, preventative health advice and prescribing.

## 2.5 Coordinating community and inpatient care

The responsibility for commissioning inpatient care for children and young people's mental health moved to NHS England in 2013. The [Health Select Committee and Tier 4 Review](#) highlighted the importance of joint planning and good communication to ensure a continuous care pathway and ensure children and young people were treated as close to home as possible in the most appropriate setting.

As well as specialist commissioner involvement in local transformation boards or delivery groups, some described setting up local collaborative commissioning arrangements and developing integrated pathways from inpatient to community support.

*Implementing the Five Year Forward View for Mental Health* includes a commitment from NHS England to transform the model of commissioning so that general inpatient units are commissioned by localities on a place basis (whether alone, as part of an STP or another group covering a defined geography), to align incentives and ensure that efficiencies delivered are reinvested in communities.

As a first step, all CCGs are expected to develop collaborative commissioning plans with NHS England's specialised commissioning teams by December 2016. These plans will include locally agreed trajectories for aligning in-patient beds to meet local need, and where there are reductions releasing resources to be redeployed in community-based services.

Some LTP areas provided strong evidence of coordination between inpatient and community commissioning, such as:

- maintaining regular contact between young people admitted to inpatient care and local children and young people mental health teams to facilitate effective discharge planning;
  - planned care to include step-down arrangements to move support into the community;
  - standardised processes and information flows regarding referral, admission and discharge to and from inpatient service; and,
  - investment in community crisis care and intensive interventions for children and young people at risk of admission to inpatient care, available 24/7, with the intention of maintaining care at home or in a community setting.
- [Doncaster](#), for example, plans to develop an intensive home treatment service offering twice daily visits to monitor the child or young person at risk of admission, support for parents and carers to manage medications at home and 24/7 on call support. The service will provide direct support to acute paediatric wards and A&E and provide peer support to the CAMHS interface and liaison nurse. [Shropshire and Telford & Wrekin](#), [Solihull](#) and [Hambleton, Richmondshire & Whitby](#) describe similar plans or existing services.

## 2.6 Transition

Transition, whether to adult mental health services or elsewhere, has long been acknowledged as a critical point in a young person's care. Poor transition can lead to a break in the continuity of care, or access to support – whether it needs to be from adult mental health services or from another agency – stopping altogether.

## Did LTPs address transition?

65% of LTPs contained specific references to improving transitions for children and young people. A third of areas evidenced work to improve services, and over half of the remaining areas stated intentions to develop clear transition protocols.

## How did LTPs propose to improve transition?

Common approaches include:

- developing a life-course approach by removing age-based criteria for accessing services, or exploring the feasibility of 0-25 or 16-25 services;
- linking with community eating disorder services;
- providing accessible information and improved signposting;
- employing peer support workers. In [Doncaster](#), for example, peer support workers attend transition meetings, support the young person in meeting personal, social and educational goals, and act as mental health promotion advocates. The process can also help the longer term transition of peer support workers themselves, many of whom have since graduated to gain posts in the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) and training to band 6 practitioner level via university, paramedics and project leads in non-NHS community projects;
- using transition coordinators;
- developing co-designed, individualised transition plans;
- improved communication, including written discharge summaries and follow up appointments after transition; and,
- incorporating minimum standards into Commissioning for Quality and Innovation (CQUIN). [Berkshire East](#), for example, is working to embed core standards that include a transition coordinator, a personal transition plan, written information about the service they are transitioning into and a comprehensive discharge letter.

### 2.6.1 Transition for children and young people with extra vulnerabilities

Children and young people with extra vulnerabilities can find transition particularly challenging. In their LTPs, a number of areas specified those with LD, neurodevelopmental difficulties or Autistic Spectrum Disorder, looked after children and children and young people known to the youth justice system as needing additional planning and support during transition.

Areas noted that many vulnerable children and young people may need mental health support during a range of transitions, for example when moving from pre-birth to pre-school, to starting in primary school and transitioning to secondary school. [Lincolnshire's](#) LTP, for example, details new transition protocols that define the latest date for identification and referral, involvement of the young person in decision-making, and accessibility of information;

Some areas suggested strengthening local approaches by putting care coordinators, champions and one-on-one advisors in place to support young people through the process. [Camden](#), for example, has appointed eight transitions champions across services, whilst [Brighton and Hove](#) runs a teenage to adult personal advisor service built around the young person's preferences;

Other areas proposed extending service eligibility for children and young people with extra vulnerabilities. The [Isle of Wight](#)'s LTP, for example, describes a dedicated transitions team for children with a disability, whilst [Stockport](#) has a dedicated Leaving Care Team.

## 2.7 Workforce planning

The development of a capable and competent workforce is essential to the continued modernisation and expansion of evidence-based services across the whole pathway. However, there was limited information on workforce within the plans. In October 2015 when the LTPs were finalised, most areas were still developing workforce plans and few included evidence of working with Health Education England (HEE) locally through Local Education & Training Boards (LETBs). As part of the CCG Improvement and Assessment Framework, local areas will be required to produce joint agency workforce plans over 2016-17.

References to workforce centred on developing comprehensive workforce strategies with other organisations and sectors by undertaking both a workforce capacity and needs analysis. These cover a number of strategic issues including workforce mix, training needs and skills across providers, recruitment and retention of staff.

Approaches to enabling the workforce include:

- supporting integration and partnership working;
- improving supporting IT, data and infrastructure;
- recruiting and training volunteers and peer support workers to support the workforce; and,
- ensuring estates are child friendly.

Approaches to training include:

- employing specific professionals for liaison and case management particularly for complex cases;
- comprehensive workforce training including CYP IAPT leadership modules, supervision modules and diplomas and employing staff to oversee transformation;
- delivering specific training to meet local skills gaps for particular evidence-based treatments or diagnostic categories;
- Giving staff the digital skills to support children and young people who use online channels to access help and support.
- 

LTPs also looked at training for universal services to encourage prevention and early intervention:

- More than half of plans referenced a need for mental health training for school staff and teachers;
- some local authority health and wellbeing service providers provide tools for professionals and primary mental health workers to help them deal with the emotional health needs of children and young people;
- training for parents and carers to ensure problems are picked up at an early stage and to support their own wellbeing;
- nationally provided training and support for universal service staff, such as Make Every Contact Count and MindEd.

## 3. Participation

### Chapter guide

#### Overview:

1. Background: why is participation important?
2. Summary: participation and engagement rates in LTPs.

#### Involving children, young people, their parents and carers throughout the process:

1. Communicating effectively
2. Designing, commissioning, delivering and evaluating services
3. Shared decision-making about treatment.

(Each topic includes signposts to examples and case studies.)

#### Case studies:

4. Further examples of engagement and participation approaches.

### 3.1 Background: Why is participation important?

Outcomes improve when services combine involving children, young people and their parents/carers in shared decision making with treatment that follows the evidence base.<sup>1</sup> Services that are delivered and designed in a way that is more responsive to meeting the needs of their local population are more likely to be used and to be effective.

*Future in Mind* described a mental health system where children, young people, families and carers are involved in the local transformation of their community services, and in decisions about their own treatment plans. It also stressed the importance of a positive attitude and culture within services that promotes effective participation. *Future in Mind* set out four principles to ensure children and young people, families and carers were engaged in the development of local transformation at all levels. These were:

- children, young people and, where appropriate, families and carers should participate in treatment decisions and plan for engagement with children, young people, and those who care for them;
- children and young people should participate in LTP development, commissioning and service delivery through shared decision making and co-production;
- this participation should be supported by an open and transparent engagement plan which presents options clearly and accessibly with regular updates and/or provides multiple opportunities for feedback from an appropriate sample; and,
- a robust engagement methodology should be used, effective communication of vision and commissioners demonstrating how feedback has influenced proposals.

LTPs were reviewed to identify examples of delivery against these principles.

<sup>1</sup> (Frueh et al, 2012) *Evidence-Based Practice in Adult Mental Health. Handbook of Evidence-Based Practice in Clinical Psychology*. published [online](#).



## How do we describe participation in this review?

Participation can be separated into two broad categories:

1. **Co-production and shared decision making.** This requires a partnership approach, and might include training youth commissioners or co-designing services. Most LTPs acknowledge the importance of participation, and note that co-production with children and young people is likely to achieve better outcomes. Approximately 25% of LTPs identified co-production as a specific objective. Around 35% evidenced some form of co-production with children and young people and another 30% evidenced plans to implement in the future. Most LTP areas acknowledged that co-production is evolving in children and young people’s mental health and continued development in this area is needed.
2. **Consultative and advisory models.** This was more commonly evidenced in LTPs than co-production, and might include engagement events or advisory panels of children, young people, their parents and carers.

Two plans that showed a comprehensive approach and range of mechanisms for engaging with children, young people, their parents and carers, and using feedback appropriately, were [Greenwich](#) and [Lincolnshire](#).

### 3.2 Summary: participation and engagement rates

Figure 3 summarises the evidence local areas submitted on participation.

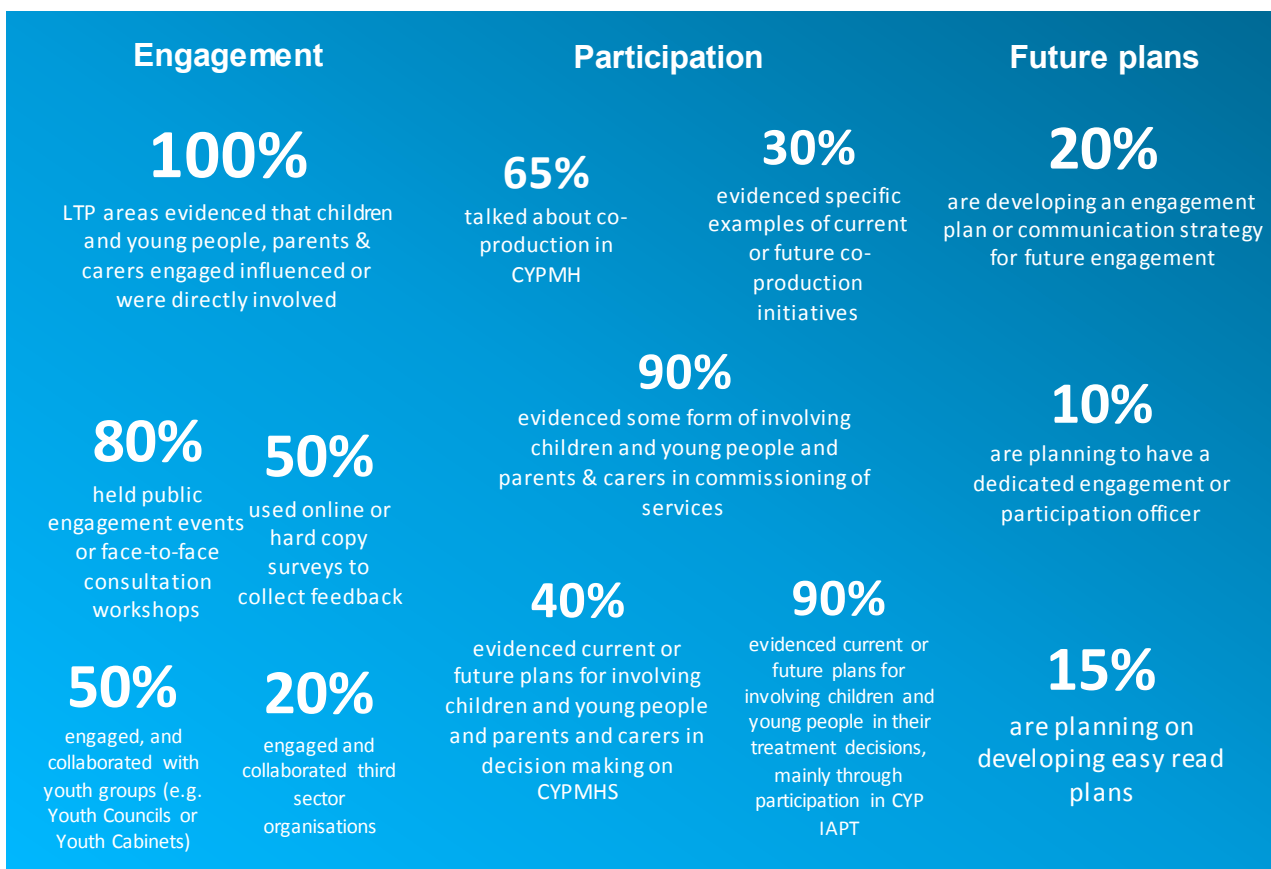


Figure 3: Statistics relating to the evidence of participation from the LTPs.

### **Who was consulted?**

All areas reported consulting with children and young people, their families and carers to inform their plans, and 65% of plans had specific examples of how feedback from children and young people and families and carers had influenced commissioning.

Most areas evidenced engagement with a specific group of children and young people, including those with special educational needs and disabilities, looked after children, specific age groups and black and ethnic minority groups.

### **What was asked?**

Most areas sought general views from children and young people, asking what was working well and what needed to change. Some areas went further, involving children and young people in establishing the vision for local services, or involving children and young people in designing local outcomes frameworks. Methods of engaging with children, young people, their families and carers varied, and evidence of engagement with families and carers was limited. Very few areas specifically included case studies or stories of those with experience of CYPMH services in their work.

### **How did areas engage?**

Most areas held local engagement events, including face-to-face consultations, structured interviews and telephone interviews. Approximately half of all areas held focus groups and workshops or public listening events with larger groups of children and young people. Approximately 50% of LTPs referred to using existing participation forums, stakeholder reference groups and networks to gather feedback, mostly using local authority, patient and charity groups and schools forums.

## **3.3 Communicating effectively**

Besides laying out principles for engaging children, young people, families and carers, *Future in Mind* also emphasised the importance of transparency and highlighted a lack of clear information, despite the repeated calls for this to be available made in previous reports into CYPMHS.<sup>2</sup> LTPs offer an opportunity to communicate the vision for service change in a way that is relevant for children and young people and those who care for them.

### **How many LTPs have communication plans?**

One third of LTP areas have specific plans to communicate why and how local mental health services are being transformed. These include developing a communication strategy and using media and events. There was also widespread activity to boost awareness on what current and future services there will be. These communication projects were almost always co-produced with children and young people.

### **What methods are being used to communicate effectively?**

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<sup>2</sup> Such as the [National Advisory Council's \*New Horizons: Towards a Shared Vision for Mental Health\*](#) (2009).



## Public engagement

Two thirds of LTP areas specified communication initiatives with children and young people and parents and carers:

- 15% of LTP areas are making children and young people-friendly versions of plans;
- 20% of LTP areas are developing engagement or participation plans to test and support LTPs with children and young people and families;
- some areas ran roadshow events to signpost to local services and mental health awareness campaigns;
- some held communication events or workshops with children and young people and parents and carers before developing their LTP;
- some committed to publishing and signposting further information on websites and updating this as transformation progresses. Most LTPs contained evidence of current or planned use of media and social media, including Facebook, Twitter, apps and online blogs and interactive websites. For example, [Essex](#)'s LTP planned a launch in partnership with youth councils that included press, radio, TV, social media and direct messages to schools and other stakeholders.

## Co-production

Most of the 65% of LTPs that evidenced current or future plans for some form of co-production focused on involving children and young people in raising awareness.

Approaches included:

- involving children and young people in the design and delivery of local mental health awareness events (e.g. festivals, roadshows, exhibitions and school events);
- involving children and young people in developing anti-stigma campaigns;
- co-designing digital tools and channels for children and young people's mental health.

## Consultations and surveys

Examples include:

- [Bedfordshire](#) used focus groups, surveys and regular review.
- [East and South Cheshire](#) ran a school-focused survey reaching 2,800 children and young people, as well as face-to-face consultations reaching 800 children and young people.
- [Bromley](#) produced an online survey of social norms.
- [Northumberland](#) produced an online questionnaire on children and young people experience of health services.

## Reference groups and cross-agency collaboration

Examples include:

- [Halton](#) runs a voluntary sector expert group to advise commissioners.
- [Northamptonshire](#) runs a children and young people group with champions across the area to evaluate schools, create toolkits, and raise awareness in schools.
- [East Sussex](#) runs a CYPMH user group which brings mental health pledges to commissioners, decision-makers and local MPs.

- [Essex](#) runs focus groups on health and social care, in partnership with local clubs.
- [Salford](#) has externally commissioned peer researchers to focus on young black male access and representation.

### 3.4 Designing, commissioning, and evaluating services

Almost all LTPs recognised the need to involve CYP and their families in this area and could demonstrate that their views had influenced commissioning decisions.

Half reported taking feedback from children and young people for service development, while 20% noted current or future projects for more direct participation in service delivery, and another 20% had it as a generic objective. A quarter of LTPs had evidence of children, young people and families being directly involved in decisions about service design and commissioning; and a further 15% had specific plans to do this in the future.

#### How do local areas involve children, young people, their parents and carers in decisions about service design and commissioning?

##### Consultative and advisory models

Involving children, young people, parents and carers in commissioning decisions was primarily an indirect process, where views and feedback were gathered and then used by commissioners. These included:

- engagement events (such as 'Takeover Days', as used in [Liverpool](#)), initiatives and surveys of children and young people, parents' and carers' emotional and wellbeing needs and opinions;
- consulting regularly with the local youth parliament and youth council, or setting up user forums (for example, [Leicestershire](#) has established a forum for ex-service users of the specialist CYPMH service);
- third party research, local reports and feedback from partners;
- working with children and young people through CYP IAPT, using routine outcomes monitoring (ROM) and feedback to guide service design; and,
- developing outcomes-based commissioning models designed through engagement with children and young people.

##### Co-production

A third of those LTP areas detailing participation in commissioning provided additional evidence on directly involving children, young people, parents and carers in the commissioning process.

Some areas recruited children and young people directly into existing governance structures:

- setting up groups of children and young people service users or parents and carers to be part of commissioning panels, staff recruitment panels and in the procurement process for services. [Tameside and Glossop](#), for example, is setting up a service user group for children and young people, which has a presence on the programme board;

- including children and young people in the co-development/production of new specifications, outcomes frameworks, and re-designing of services, through workshops or longer term programmes;
- recruiting service user champions or parents and carers to management boards.

Though less common, some plans included youth-led initiatives:

- co-produced mental health charters;
- online self-help service tools;
- co-designing the transformation objectives in the LTPs;
- co-designing peer education, mentoring and buddy systems;
- youth-led commissioning frameworks, such as the [Lewisham Young Mayor and advisors](#) programme;
- training young commissioners or youth commissioning panels to work directly with the local authority and CCG to develop services, as in [North West London's](#) Mental Health in Co-production (MiC) project and Sheffield's three-year [Chilypep Young Commissioners](#) programme. [South Devon and Torbay](#) has commissioned Young Devon (a voluntary organisation) to bring children and young people into Passport to Participation training to evaluate services, work with commissioners, take part in staff interviews, train staff and train Cognitive Behavioural Therapy (CBT) students at university. Young Devon's engagement group has also run a 'mystery shop' for Torbay CYPMHS.

Some plans gave examples of making children and young people key agents in designing, commissioning and evaluating services:

- children and young people being trained to inspect and formulate improvements to services, such as in [Northamptonshire Young Healthwatch Group](#) where they act as mystery shoppers, promote Healthwatch Northamptonshire events in schools and communities, and provide peer support;
- "community consultants" or "young advisers", where children and young people are formally trained as consultants, specialising in health and wellbeing, to advise commissioners on service improvements they want;
- "young trainers" delivering training to staff on what it is like to be 'on the other side'; and,
- 'young champions' taking part in CCG reference groups as part of the improvement and re-commissioning of services, trained by organisations such as Healthwatch, Barnardos or Young Minds.

### 3.5 Shared decision-making about treatment

Shared decision-making means working in partnership with children, young people, their families and carers to make decisions about their care, giving them agency over their own recovery and treatment. Shared decision-making, combined with clinical expertise and following the evidence base, has been shown to improve outcomes.<sup>3</sup>

#### How much did LTPs evidence participation in decisions about treatment?

90% of areas reported evidence for children and young people participation in treatment decisions. For the majority of areas, participation of children and young people in treatment decisions follows the embedding of this practice through the CYP

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<sup>3</sup> Frueh et al, 2012, ibid.

IAPT programme.<sup>4</sup> This involved using specific measures agreed with the child or young person, particularly goal-based outcomes, to inform interventions.

### How did local areas involve children, young people, parents and carers in treatment decisions?

Approaches included:

- using personalised health budgets and care packages that people can use according to their needs; and,
- developing infrastructure for self-help, treatment choice, outcomes monitoring and access to patient records, including digital tools such as apps and online facilities. [Oldham](#)'s Personalised Health and Care 2020 plan proposes digital real-time records joined up across health care, with standards around data and ensuring public access to view and add to records. [Enfield](#) is developing 'CAMHS web' with the Anna Freud Centre, which supports joined-up IT across organisations to enable mobile working, data collection and real time understanding of activity and outcomes.

## 4. Resilience, prevention and early identification of need

### Chapter guide

Overview:

1. Why is this important?
2. Overview: where did LTPs focus?

Specific approaches at different stages:

3. Maternal and perinatal health
4. Parenting and early years
5. Working through schools

General approaches:

6. Reducing stigma
7. Digital tools.

(Each approach section includes signposts to examples and case studies.)

### 4.1 Why is this important?

*Future in Mind* highlights the importance of recognising and promoting good mental health and wellbeing in all people, not just focusing on mental illness and diagnosis.

It also notes evidence that supporting families and carers, building resilience through to adulthood, and supporting self-care reduces the burden of mental and physical ill

<sup>4</sup> References and resources include: <http://www.england.nhs.uk/mentalhealth/cyp> ; <http://www.myapt.org.uk/> ; <http://www.youngminds.org.uk/psaytoolkit> ; <https://www.minded.org.uk/>

health over the whole life course, reducing the cost of future interventions, improving economic growth and reducing health inequalities.

This theme is further developed in the *Five Year Forward View for Mental Health*. Defining a whole-system local offer that uses an integrated, partnership approach to prevention is essential. It requires input from children, young people and their families (see chapter 2) and from a wide range of professionals across universal, targeted and specialist services.

The priorities are:

- promoting good mental wellbeing and resilience, by supporting children and young people and their families to adopt and maintain behaviours that support good mental health such as self-management;
- preventing mental health problems from arising, by taking early action with children, young people and parents who may be at greater risk; and,
- early identification of need, so that children and young people are supported as soon as problems arise to prevent more serious problems developing.

## 4.2 Overview: where did LTPs focus?

### Resilience

Around 50% of LTPs referenced using evidence-based approaches to improve resilience and a further third referenced developing future commissioning plans. Around 30% had plans to build resilience in communities.

Where areas set out a specific approach as to how they would be addressing resilience, they generally did so by referencing the following:

- multi-agency community resilience plans, such as [Sunderland's](#) Community Resilience Plan;
- accessible resilience services, such as [Richmond's](#) Mindkit Youth Wellbeing Project, where young people aged 14-25 years can access free wellbeing and resilience sessions delivered by volunteers with lived experience; and,
- Young Health Champions projects.

### Early identification and intervention

60% of areas referenced the importance of early identification and intervention, and 10% of areas had plans to commission a new service or review their current offering.

The most common services, schemes and initiatives were:

- Early Help Services;
- Early Intervention Service;
- Early Intervention in Psychosis Service (the most common distinct service referenced, featuring in around 25% of LTPs); and,
- 0-2 year old early intervention pilots.

Some areas also noted the role of the Family Nurse Partnership to address early intervention in new, young mothers and infants. In other plans, liaison and diversion services, such as in [Gloucestershire](#), were cited as a strong example of early intervention through cross-agency working.

### 4.3 Maternal and perinatal mental health

Approximately 75% of the LTPs referenced perinatal mental health care and pathways in some way and 10% of LTPs outlined plans to review, improve and develop perinatal services. Where LTPs refer to maternal and perinatal services, the following services or initiatives were commonly used:

- Family Nurse Partnership;
- Healthy Child Programme;
- perinatal community health team;
- perinatal mental health pathway; and,
- children's centres.

Midwives are the healthcare professional that spends the most time with expectant mothers, and LTPs identified them as being best placed to offer temporary support, identify the early symptoms of mental health conditions and help the person access the right care. Some areas set out targets to make sure that a higher proportion of midwives receive mental health training.

Other areas prioritised perinatal mental health pathways, noting that they needed to include:

- prevention and promotion across universal and primary care services;
- improved identification; and,
- targeted and specialist services.

Specific examples of LTP approaches include:

- [Richmond](#)'s Welcome Baby programme, where a volunteer listens to concerns, supports women in attending medical appointments, links with healthcare support and helps with worries and anxieties through a weekly visit to the family;
- [Southampton](#)'s Mums Matter programme assesses all prospective mothers on a range of vulnerability factors and then at the 6-8 week health visitor check on signs of postnatal depression. They offer 4-6 listening sessions where there are concerns identified and also refer to Steps to Wellbeing when appropriate.

### 4.4 Enhancing parenting and early years programmes

There is a strong evidence base for the benefits of particular parenting programmes.<sup>5</sup> Almost 90% of LTPs referenced having early years programmes in place, and these services primarily focused on two areas: improvement of parenting skills and support for the healthy development of children. Examples include:

- Family awareness programmes;
- early help practitioners, and early help hubs;
- Healthy Child programmes;
- Home-Start;
- children's centres; and,
- therapeutic offers including systemic family therapy, parenting therapy, cognitive behavioural therapy and functional family therapy.

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<sup>5</sup> Chief Medical Officer Annual Report 2012: [Our children deserve better: prevention pays](#) (October 2013).



The early help offer usually includes improved access for parents to evidence-based programmes of intervention and support focusing on:

- strengthening the attachment between parent and child;
- building resilience;
- improving behaviour;
- dealing with stress; and,
- fostering positive mental health and emotional wellbeing in their children.

Specific examples include:

- [Haringey](#)'s Open Door Parent Teenagers Project supports parents of young people aged 12-21
- [Staffordshire](#)'s SPURGEON's charity offers children, young people and families evidence-based parenting programmes focusing on training, support and skills enhancement. The programme is typically eight sessions with a group of up to 10 in a community venue.
- [Newcastle](#)'s Incredible Years programme for parents of children aged 5-13 years spans 14 weeks and focuses on specific parenting skills like praise, setting limits, and using 'time outs'. It is delivered by practitioners from social care, education, health and the voluntary sector;
- [Nottingham](#)'s Small Steps, Big Changes programme offers family mentors and a peer workforce of parents or grandparents who deliver activities in family homes and co-deliver group sessions and activities in the community.

## 4.5 Schools and colleges

Plans recognise the importance of schools, colleges, and other educational settings in the prevention and early identification of mental health issues, as well as in building resilience.

### **How many LTPs detailed schools-based approaches, and where was their focus?**

Approximately 75% of LTPs mentioned whole-schools approaches, albeit in varying detail. Approximately 40% of LTPs referred to school counselling, but just 3% of areas have plans to commission it. Just under half of LTPs are planning for an increased role for school nurses.

### **How did LTPs propose to work jointly with schools and colleges?**

Some models to build resilience in schools include:

- emotional resilience, health and wellbeing support, especially for young children. [Haringey](#)'s Time2Talk programme uses drama, film making, teaching and peer support to address mental health and emotional wellbeing and the barriers which can stop children and young people accessing support;
- empowering children and young people by educating them on their own health, how their decisions affect wellbeing, and how to articulate issues to medical professionals – such as [Gloucestershire](#)'s Facts4Life pilot, which encouraged debate about illness through discussions and games in 10 primary schools;
- peer support models;
- mental health first aid training for professionals;
- public health programmes focused on health promotion; and,

- whole school approaches, which may use existing successful programmes such as the Healthy Schools programme, provide counselling in schools (online and face to face), and enhance the role of school nurses through initiatives like a Public Health Nursing Service. [Medway's](#) Risk Avert programme, for example, uses a survey to identify vulnerability to multiple risk-taking amongst school years 7 and 8. Results are fed back to teachers who deliver targeted interventions. Of the 37 schools taking part, 94% of children reported feeling more confident about managing risk.

## 4.6 Reducing stigma

The stigma associated with mental illness remains a significant barrier to seeking help. Although a number of areas referenced the importance of tackling this issue, the level of detail provided on how they would do this was very variable.

Approaches include:

- anti-stigma campaigns, awareness raising and education for the general public;
- using existing bodies, particularly ones led by children and young people. [Newcastle and Gateshead's](#) mental health youth board for the North East includes over 100 members and can offer guidance and representation of young people;
- providing advisory services that children and young people feel comfortable accessing; and,
- peer support and youth led services. [Surrey's](#) CYPMH Youth Advisors networks challenge stigma in mental health, offer peer support, recruitment, staff training and support service development.

## 4.7 Digital tools

Our children and young people are digital natives, and digital technology plays a key role in their lives. Using digital tools presents an opportunity to make information and services more accessible and engage children and young people in new ways.

### How many LTPs included digital tools – and where did they focus?

Around 70% of areas mentioned plans to develop online and digital tools and technology.

Within these plans, the focus was on building resilience, promotion and prevention:

- 30% indicated intentions to enhance and develop their local websites, looking at online portals, more early help online resource kits, better accessibility and signposting;
- 30% also mentioned plans to increase accessibility with, for example, interactive communication with professionals (video or live online and SMS), access to records, self-referral tools and monitoring appointments online;
- 25% have developed or are developing apps providing information on wellbeing and self-care, monitoring treatment outcomes and local CYPMHS;
- 20% of areas have or are extending online emotional support and counselling services which include video platforms and online chat functions. [Brighton and Hove's](#) E-Motion website, for example, offers online counselling in an effort to reach more young men and BME groups;



- 20% of areas are using or have plans to harness social media (especially Twitter and YouTube) for anti-stigma work, promotion and provision of support to children and young people;
- just under 10% looked at using mobile technology (such as tablets and smartphones) for staff and touchscreens for service users;

Examples of digital innovations include:

- [Croydon's SkyCasts programme](#) delivers interactive psycho-educational online groups for 14-25 year olds using webinars. Groups are facilitated by a counsellor and offer practical information, coping strategies and options for further support. Mental health outcomes measures and feedback are used to assess levels of need and to ensure high-risk young people are directly involved in the sessions through 'live chat', surveys and Q&A. Feedback since its launch in 2015 indicates that young people would recommend SkyLine because of its flexibility and accessibility, but it is being independently evaluated.
- The [Isle of Wight's Check it Out](#) website and app, developed by a group of young people, focuses on accessibility and signposting, and includes a 'Live Chat' facility (6pm-9pm daily) with instant responses from a trained responsible adult.
- In [Leeds](#), young people have led the design and content for the interactive [MindMate](#) website that allows users to explore mental health issues and find out where they can get help. Children and young people also lead work at the Leeds Digital Innovation Lab to review digital tools and develop ideas for new ones such as online access to therapy.

## 5. Outcomes monitoring

### Chapter guide

#### Overview

1. Why is outcomes monitoring important?

#### Making it happen

2. How are outcomes being measured?
3. What steps are being taken to improve outcomes monitoring?
4. Using outcomes monitoring in commissioning and service design.
5. Where do areas need more support?

Each of these sections includes examples with links.

### 5.1 Why is outcomes monitoring important?

Routine outcomes monitoring and feedback is essential to guide professionals, young people and, where appropriate, parents and carers, in understanding how treatment is progressing and moderating the approach where necessary. Outcomes monitoring is used by supervisors and services managers to ensure treatment is

effective and on track. Commissioners will use outcomes monitoring for service design and to benchmark.

*Future in Mind* is clear that services should focus on the outcomes of the support they offer. This builds on the principles established by the CYP IAPT transformation programme – to improve access to collaborative, evidence-based and outcomes focused care between the therapist, child, young person and their family or carer.

Improved transparency and accountability across the whole system should drive further improvements in outcomes, and promoting outcomes-based commissioning is a focus for NHS England. All providers of NHS-funded mental health care are mandated to record and submit data as part of the Mental Health Services Dataset (MHSDS). The MHSDS incorporates the measures that were developed for the CYP IAPT programme. Providers and commissioners should monitor outcomes to ensure the needs of children and young people and their families/carers are being met, whether this is through the national dataset or their own locally designed outcomes frameworks.

## 5.2 How are outcomes being measured?

The CYP IAPT programme includes training and support to enable services to monitor outcomes. Most areas already use routine outcomes monitoring are part of the CYP IAPT programme. Only four areas did not have plans to join the programme.

Common measures referenced in LTPs include:

- parent/child rated Strengths and Difficulties Questionnaire (SDQ);
- Goal Based Outcomes (GBO);
- Children's Outcomes Rating Scale ((C)ORS);
- Evaluation of Services Questionnaire (ESQ) and clinician rated Health of the Nation Outcomes Scale (HONOSCA);
- Children's Global Assessment Scale (CGAS); and,
- Revised Child Anxiety and Depression Scale (RCADS).

## 5.3 What steps are being taken to improve outcomes monitoring?

Examples of action to improve routine outcomes monitoring include:

- improving and standardising the frequency and quality of outcomes recording;
- commissioners performance managing providers through levers such as Commissioning for Quality and Innovation (CQUIN), and embedding measures into CYPMH service specifications;
- extending ROM training to across staff and developing outcomes-based key performance indicators;
- joining CYP IAPT learning collaboratives;<sup>6</sup>
- extending the coverage of ROM and promoting its use beyond CCG commissioned services, such as in voluntary services, statutory services and local authority commissioned services;
- increasing transparency by integrating outcomes in patient records systems;

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<sup>6</sup> CYP IAPT learning collaboratives are made up of universities and training providers working with local area partnerships of children and young people's mental health commissioners and providers, including those in the NHS, Local Authorities and the third sector.

- involvement in a cross-sector outcomes and data linkage project, led by [CORC](#);
- implementation groups within trusts to ensure embedding of ROM;
- engaging with children, young people and their families to gather feedback on using outcomes information; and,
- using funding to make sure that providers are inputting to the MHSDS, such as appropriate equipment and secure connections.

Having IT systems that can record outcomes and bring real time feedback is one of the greatest challenges faced by services.

A quarter of areas identified a need to invest in improved IT to support outcomes measurement. Approaches included:

- consistent IT systems for recording, collating and sharing outcomes data to stakeholders locally and as part of the MHSDS;
- outcomes analysis systems that create dashboards and reports and can analyse implications of different measures;
- mobile technology such as tablets or online portals for staff and service users to input and monitor outcomes increasing visibility and transparency of outcomes, for example an online assessment and action planning tool which charts progress and measures outcomes; and,
- investing transformation funding in developing feasibility studies of available hardware and software options .

## 5.4 Using outcomes monitoring in commissioning and service design

Along with outcomes monitoring for treatment, many CCGs and LAs are collaborating to develop and commission outcomes based service specifications and service models:

- 75% of LTP areas stated outcomes monitoring will not just inform treatment but will also be used to guide commissioning and service improvement, delivery and development.
- Many CCGs and LAs are working together to redesign services and embed outcomes in contractual service specifications (i.e. using scorecards and dashboards of collected data). [West Sussex](#), for example, is already incorporating its local outcomes framework into contracts for counselling and advocacy services, whilst [Northumberland](#) is commissioning all services through outcomes-based contracting.
- 10% of areas have already re-procured services based on information from outcomes monitoring.
- Some areas are going further and developing local outcomes frameworks through engagement with local stakeholders, such as [Tower Hamlets](#).
- Clinicians, children and young people and their families as well as other stakeholders are consulted in the design of the frameworks to ensure they are relevant to all. In most cases, this process is commissioner-led and monitored by providers, in turn informing service improvement and design for commissioners
- A third of areas have indicated they have plans to move to an outcomes-based commissioning model, with some areas indicating they are going use payment systems as an incentive for achieving local outcomes.

In [Camden](#), a comprehensive quarterly monitoring framework comprises a standard local dataset of anonymised, patient-level demographic and referral data, information on presenting problems and waiting and response times. As the monitoring dataset has become more complete, it has informed discussions between commissioners and service managers about service improvement opportunities, demand management, the appropriateness of referrals, through-put and case closure. This information feeds into annual commissioning intentions to ensure appropriate decisions are made about the use of resources to meet the identified need of children and young people in Camden, which in turn feeds into annual budget setting cycles.

## 6. Children and young people with extra vulnerabilities

### Chapter guide

#### Overview:

1. Why is it important to consider children and young people who have extra vulnerability to mental health problems ?
2. References to groups with extra vulnerability in LTPs and common approaches.

#### Adjusting approaches for particular vulnerabilities::

3. Child sexual exploitation and child sexual abuse
4. Looked after children
5. Youth justice
6. Complex needs
7. Urgent and emergency care in a crisis.

Each of these sections includes examples with links.

### 6.1 Why is it important to consider children and young people who have extra vulnerability to mental health problems?

Any child or young person with a mental health problem is vulnerable. However, there are some specific groups who have a greater likelihood of difficulties requiring extra support. There is evidence from services which suggests there is increasing demand for support from children and young people in these groups, but the same groups often find it more difficult to access help. *Future in Mind* detailed how they are less likely to attend appointments, and so less likely to have mental health issues identified, diagnosed and treated. They are also likely to have a range of complex needs involving a number of services and organisations. These factors combine to create an overall health inequality for many vulnerable groups of children and young people.

LTPs present an opportunity for joint working to consider the needs of these groups and how services and outreach can be adjusted to reduce that inequality. As *Future*

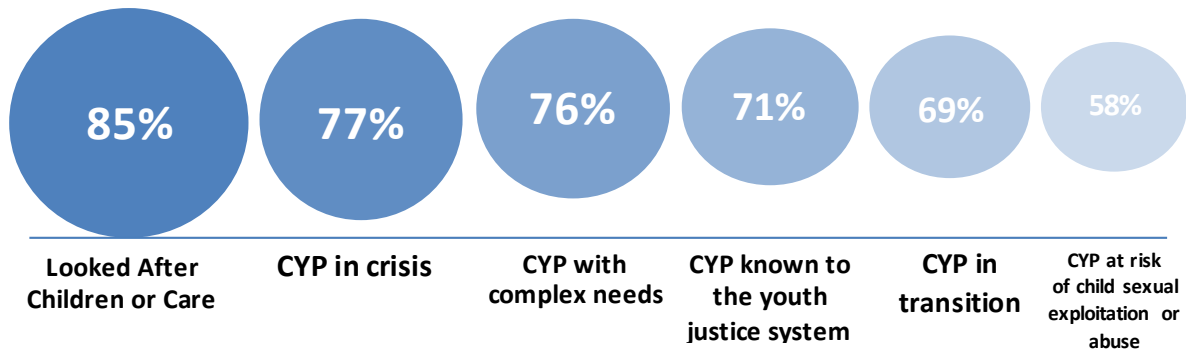
*in Mind* pointed out, “if we can get it right for the most vulnerable...then it is more likely we will get it right for all those in need.”<sup>7</sup>

Specific groups of children and young people identified in LTPs who may have extra vulnerability to mental health problems include but are not limited to:

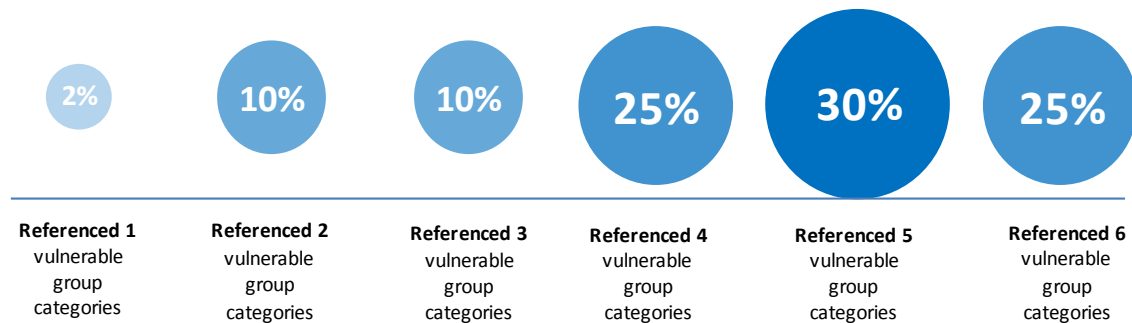
- looked after and adopted children and care leavers
- those who have experienced trauma such as child sexual abuse
- children and young people in contact with the youth justice system; and
- children and young people living with issues such as learning disability or neurodevelopmental problems.

## 6.2 References to groups with extra vulnerabilities in LTPs and common approaches

The first chart below shows the proportion of LTPs that contained activity in relation to specific groups.



The second chart shows that most LTPs referenced four or more specific groups, illustrating awareness of the complexity present in their community.



Common approaches to improving care and access for those with extra vulnerabilities include:

- creating bespoke pathways, such as for those with neurodevelopmental issues or ASD, or victims or child sexual exploitation;
- community outreach programmes, such as in [Camden](#), where a community outreach team, many of whom are young people, is trained to work with those who are excluded and hard to reach with mental health needs;
- joint working, co-location, shared strategic oversight groups and shared management structures across organisations (as in [East Sussex](#)), and embedding mental health professionals in various teams from those working

<sup>7</sup> [Future in Mind](#).

with the homeless to social services. In [Camden](#), for example, the Child and Family Refugee Team is provided with an integrated multidisciplinary team that includes child psychology, psychiatry, psychotherapy and family therapy. The [Stockport](#) Family team, meanwhile, works with vulnerable families and includes social workers, midwives, health visitors, school nurses and staff from children's centres;

- multi-agency safeguarding hubs (MASH), a single point of contact for professionals to report safeguarding concerns, as used in [Southampton](#);
- coordinated mental and physical health care, such as with offers of supervision from mental health professionals;
- lead professional approach in which a professional is responsible for ensuring a child or young person's plan is properly managed and implemented;
- redesigning 'did not attend' (DNA) policies with active follow-up, outreach into homes, GP surgeries, children's centres and schools (as in [Islington's](#) DNA schools approach), or greater choice of appointment – as with Barnardo's Buddies in [Buckinghamshire](#);
- improved training, such as in [Birmingham's](#) virtual schools programme.

Some areas detailed preventative programmes aimed at children and young people at risk of exclusion. [Haringey](#) runs a 12-week programme targeted at vulnerable groups delivered in partnership between the adolescent outreach team and the Tottenham Hotspur Foundation. The programme is aimed at working with children and young people at risk of exclusion from secondary school and works with five cohorts over a five-year period. It is centred on playing football and receiving structured, motivational talks focused on using a therapeutic model informed by Cognitive Analytic Therapy (CAT). Sessions are delivered away from school with school staff and mentors to help students learn transferable skills to take back to the classroom. SDQs showed a significant shift in average behavioural/conduct difficulties (30% reduction) and an improvement in 'kind and helpful behaviour' (20% improvement). Of the 60 students at risk of exclusion who took part, 56 remained in school after a six-month follow up.

### 6.3 Child sexual exploitation and child sexual abuse

A significant number of LTPs referenced child sexual exploitation (CSE) and child sexual abuse (CSA) as a priority. Areas were at varying stages in terms of developing models and approaches, which include:

- developing CSE/CSA pathways to ensure there is age appropriate provision at all stages of the pathway;
- management by a CSE coordinator;
- a preventative and early intervention approach;
- increasing awareness amongst professionals and the public, as with [Bury's](#) 'It's Not Okay' campaign;
- whole school approaches, providing advice and support to schools or holding forums where schools can discuss concerns and seek advice;
- a small number of areas highlighted the 'Think Family' approach that seeks to improve joint working between services from the police to ambulance services, to youth workers, voluntary organisations, and schools;
- sensitive enquiry into neglect, abuse and violence, with some areas investing in CSE/CSA training for staff;
- using outreach and non-conventional settings rather than clinics or offices, such as CSE/CSA hubs or child houses;



- one-to-one relationships with an individual worker or single point of access; and
- robust, evidence-based specialist therapeutic interventions.

In addition to ensuring that early identification is in place, some areas are using or developing indicators and risk-assessment tools to assist in the identification of CSE/CSA. There are also regional responses supported by NHS England, such as the pan-London establishment of CSA hubs and child houses, which will act as integrated centres of support to deal with CSA, CSE and female genital mutation (FGM).

## 6.4 Looked after children and care leavers

85% of LTPs identified LAC and care leavers as a priority group. Many areas have a dedicated joint LAC service between health and social care. Other areas have an integrated offer with social workers and MH workers providing support.

Some areas are considering whether specific digital tools and resources can be developed to provide information, online support and self-care resources. Evidence-based models of delivery or treatments include multi-systemic therapy and dialectical behaviour therapy.

### What approaches did local areas take to provide a service for LAC?

A range of approaches were identified, including:

- training and assessment for local authority teams in areas such as attachment and other mental health issues that looked after children are more likely to experience;
- fast-track access for assessment and treatment for those in need;
- training for foster carers, adoptive parents, those working with care leavers and residential care staff. [Coventry and Warwickshire's](#) LTP describes a parenting training programme that has improved the resilience and health outcomes of children and young people and their carers. [Haringey](#) also details a programme to train teachers in emotionally-friendly classrooms and foster carers in dealing with trauma;
- assistance with placement stability, including behavioural management strategies to help prevent breakdown of placements;
- coordination and liaison between inpatient and specialist outreach services to provide a consistent approach;
- monthly 'reflective practice' to support foster parents and adoptive parents;
- peer support;
- quick response to crisis;
- flexibility in terms of location and setting of services;
- effective and supported transitions between children and young people's and adult services and leaving care;
- working with schools to build resilience;
- effective implementation of multi-agency tools and protocols; and
- ensuring treatment takes into account the impact of potential attachment and identity issues, fragmented families, impact of maltreatment including trauma, loss and separation. [North Lincolnshire's](#) LAC model, for example, does not require a mental health diagnosis as it is based around psychosocial thinking, including the development of attachment relationships and resilience, rather than a focus on one-to-one interventions. This model has enabled

approximately 65% of LAC to receive support from CYPMHS – in keeping with the anticipated percentage of LAC with mental health concerns.

## 6.5 Youth justice

Children and young people in or on the edge of the youth justice system are also particularly vulnerable to mental health difficulties, and many find it difficult to access services.

Plans with a focus on youth justice highlight a number of areas that can improve the effectiveness of services, including:

- mental health practitioners and speech and language therapists embedded within youth offending services;
- multidisciplinary teams, as in [Oldham](#)'s integrated centre for youth offending services which hosts the police, children and young people's mental health services, a generalist nurse and assistant practitioner team, counselling services, housing advocacy and mediation services, the after-care team from children's social care, and a range of holistic family services, including early help support and multi-systemic therapy;
- training on relevant mental health issues for those who work in the youth justice sector;
- support with resettlement and continuity of care following a period in custody;
- a whole-family approach as well as the inclusion of parents in interventions;
- youth-friendly delivery of services, as with [Trafford's](#) 'health drop-in' service and volunteer mentors for young offenders;
- youth justice pathways to focus on both the mental health and physical health needs of young offenders, and a specific pathway for young offenders with learning disabilities to ensure specialist support can be provided to this group;
- multi-systemic therapy within the youth offending setting;
- links to crisis support services and to liaison and diversion services. In [Gloucestershire](#), liaison and diversion staff are co-located with young offender services, whilst [Barnsley](#) has an enhanced liaison and diversion service for children and young people with a learning disability within the youth justice system; and
- workforce development and training.

## 6.6 Children and young people with complex needs

Children and young people with complex needs, such as those with learning disabilities, those requiring neurodevelopmental support, those with co-morbidities and those with physical health issues often have mental health problems and find it difficult to access services that fully understand the complexity of their presentation.

Most plans focused on children and young people with learning disabilities and those who require neurodevelopmental support. Some LTPs referenced plans around co-morbidities and/or physical health needs. In many cases this is being dealt with via the existing team or an enhanced paediatric liaison service.

Common approaches include:



- creating pathways focusing specifically on learning disabilities, neurodevelopmental issues, ASD or Attention Deficit Hyperactivity Disorder (ADHD);
- creating a co-ordinated multi-agency response; and,
- creating an all-age pathway for learning disabilities and joint pathways between mental health and learning disabilities services.

Approaches and evidence-based treatments include:

- positive behaviour support service;
- a “team around the family” approach with specific work to support families. [Oldham](#), for example, has an established forum for the families of for parents and carers of children and young people aged 0-25 with additional needs, which has over 850 members. [Bristol](#) offers families training programmes on basic care (feeding, sleep, social development and play) and on positive parenting, as well as offering support through ‘circle of security’ parenting groups;
- stepped model of care that seeks the most effective care for the least resource necessary, stepping up to clinical intervention when required;
- a life course approach adopted across services to ensure smooth transitions between services. [Barnsley](#), for example, provides short term tenancies in an enabling/training flat environment for those young people with a learning disability, mental health issue and/or autistic spectrum disorder in transition;
- specialist assessment tools used by specialist staff in some areas to identify need and risk in the learning disability cohort;
- flexibility in how care is delivered for example offering home interventions
- early assessment and intervention for the neurodevelopmental pathway investment to reduce waiting times;
- a consultancy offer to support staff working with children and young people with learning disabilities;
- offering school clinics for children and young people with learning disabilities, such as [Shropshire, Telford and Wrekin](#)’s ‘Think Good, Feel Good’ programme which runs scouts and guides groups, youth clubs and sports clubs;
- shared, person-centred interventions and care plans, with lead professionals to coordinate and streamline multi-agency work; and
- using a single point of access to deliver more integrated services.

## 6.7 Urgent and emergency mental health care in a crisis

Mental health crises are not only experienced by children and young people in vulnerable groups, but certain vulnerable groups may be more likely to experience a crisis. Many areas are planning to improve integrated working across different services and professions and provide alternatives to A&E and in-patient services. Local action was frequently aligned with national priorities relevant to crisis care.

Approaches include:

- using new investment to increase the capacity of crisis teams to offer better out-of-hours provision;
- developing an agreed, local multi agency response to crisis aligned with the [Crisis Care Concordat](#), often involving the voluntary sector;

- developing intensive home treatment teams to offer alternatives to in-patient admission, as used in [Northamptonshire](#), or intensive community-based interventions, as used in [South Gloucestershire and Bristol's](#) partnership outreach support programme;
- implementing street triage to reduce the demand on A&E and other acute services;
- improving liaison services within A&E and acute services, training of 'first responders' for hospital staff and others who respond to children and young people in crisis;
- ensuring that local 'places of safety' are appropriate and able to accept children and young people;
- developing a single local point of access; and
- focusing on those who self-harm in an effort to prevent crises.

In addition, some areas identified online provision as a possible access route to self-help, and peer and professional support in and out of hours. Some areas are developing KPIs in relation to crisis care, for example, four-hour emergency waiting times and 24-hour urgent waiting time.

## 7. Eating Disorders (ED)

### Chapter guide

#### Overview:

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### 7.1 Why is this important?

Eating disorders are serious, often persistent, mental health disorders. They include anorexia nervosa, bulimia nervosa, binge eating and 'atypical' eating disorders that do not fall within the other categories. They can be life threatening conditions with some of the highest mortality rates of any psychiatric disorder. They are associated with high levels of impairment to everyday functioning and development, and a high burden on families and carers.

### 7.2 Background

In Autumn 2014, the Government announced an additional £30m recurrent funding over the five years to 2020 (totalling £150m) to improve the support for children and young people living with eating disorders. A particular focus was to provide better

community based support, reducing the need for inpatient admissions, often at long distances from where young people live.

In August 2015, NHS England published a [Commissioning Guide for the Access and Waiting Time Standards for Children and Young People with an Eating Disorder](#). This included a new referral to treatment standard that states:

By 2020, National Institute for Health and Care Excellence (NICE) concordant treatment should start within a maximum of weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.

The Commissioning Guide also outlined the care ‘pathway’ professionals should follow when providing care to children and young people with eating disorders and models for delivering dedicated Community Eating Disorder (CED) services for children, young people, families and carers. The requirements for CEDS-Children and Young People’s Services include:

- to receive a minimum of 50 new ED referrals a year
- to cover a minimum general population of 500,000 (all ages)
- the use of up-to-date evidence-based interventions to treat the most common types of co-existing mental health problems (for example, depression and anxiety disorders) alongside the ED
- enable direct access to community ED treatment through self-referral or from primary care (for example, GPs, schools, colleges and voluntary sector services)
- both medical and non-medical staff with significant ED experience

The £150m additional funding is being allocated to Clinical Commissioning Groups in order to build on current investment to create the multidisciplinary teams that would provide the community based eating disorder services, and by 2020, meet the standard. This should reduce the numbers of young people transitioning to adult eating disorder services and the use of inpatient beds.

### **7.3 Projections to 2020: will local areas be compliant with ED standards?**

Local areas were asked to set out within their LTPs how they intend to invest new funding and build capacity and capability to meet the standard by 2020. Of all LTP areas:

- **100%** state they will be compliant with the ED standard and guidance by 2020.
- **84%** are not currently compliant, but are making plans to be so by 2020.
- **16%** report they are already compliant with the ED guidance.
- **18%** of LTP areas are meeting four-week waiting times for routine cases.
- **14%** are meeting one-week waiting times for urgent cases

### **7.4 Plans for areas that are not currently compliant**

Most areas are not currently compliant with the guidance, but are planning to be by 2020. LTPs include a variety of approaches to improving community ED services, but the majority outlined intentions for family-based approaches and Cognitive Behavioural Therapy (CBT). Most areas will structure community ED services as ‘hub and spoke’ or a single service in a central location supported by single point of

access. Areas are planning in line with the 2015 commissioning guidance, in particular:

- seven-day access with appropriate out of hours and crisis support;
- responsive and intensive home and community treatment;
- access to effective treatment, with teams of sufficient numbers and capability to deliver age-appropriate, evidence-based interventions and approaches such as multi-family therapy;
- routine monitoring of outcomes that are meaningful to children, young people and their families or carers;
- investment in prevention, early detection and early intervention;
- a person-centred approach that enables direct access to ED services through self-referrals and primary care services (including schools, colleges and voluntary services);
- ensuring children and young people, and where appropriate families and carers, are involved in decisions about treatment and in the design of services themselves;
- ensuring strong integration and liaison with other services including voluntary providers; and,
- improving wider support and advice for those affected including effective use of guided self-help, peer support, GP awareness training, skills for carers and liaison with schools, colleges and other settings.

Areas are also considering how to ensure robust systems are in place to support delivery, such as improved IT and data collection capabilities, strengthened needs assessment and admission protocols, the adoption of named co-ordinators or health leads, and multidisciplinary support for discharge.

## **7.5 Plans for areas that report compliance**

16% of areas state they are already compliant with the eating disorder guidance. In these cases, areas were asked to set out in LTPs how they would use the extra funding to improve self-harm and crisis services. For those areas focusing on crisis and self-harm, common priorities included:

- Supporting the local response for children and young people who present in crisis in A&E;
- supporting other vulnerable groups at risk of crisis and those that are harder to reach;
- increasing capacity to support A&E and outreach to schools and GPs;
- increasing capacity in outreach/home treatment;
- funding the development of places of safety to prevent placing children and young people in police cells in emergencies;
- improving early intervention services for crisis and self-harm;
- establishing self-harm and risk management care pathways;
- developing local consultation and liaison service for self-harm and crisis; and,
- investing in improved peer supervision for professionals working with children, young people and their families/carers.

Some areas plan to use the additional funding to deliver an eating disorder service that goes further than what they already deliver, offering an 'enhanced' service. Key features of an enhanced service include:

- improving the opportunity for children, young people and families/carers to self-refer (such as with [Northamptonshire](#)'s Referral Management Centre, which encourages self-referral);
- developing online resources;
- developing support services and training for parents and carers;
- investing in outreach into schools;
- improving collaboration with crisis services and other children and young people's mental health services;
- developing public health programmes around eating and healthy lifestyles in educational settings;
- improving the range of therapies available, such as Multi Family Therapy;
- increasing provision of home and day care; and,
- improving the pathway from referral and initial appointment through to intervention.

## 8. Next steps

As set out in [Implementing the Five Year Forward View for Mental Health](#), local areas should have expanded, refreshed and republished LTPs by 31 October 2016. LTPs should be living documents that are reviewed and refreshed at least once a year. Children, young people, families and carers should be involved in this process. CCGs have been advised of their share of the new funds for the next five years, allowing them to plan with partners with confidence.

The publication of the *Five Year Forward View for Mental Health* in 2016 reiterated the commitment to implementing the vision in *Future in Mind*, but extended further to include development of further evidence-based care pathways, a seven-day service and new models of care. CCGs will be working through Sustainability and Transformation Plans (STPs) to implement the changes required to modernise mental health services. STPs will include LTPs, and, as data from the Mental Health Services Minimum Dataset becomes more robust, national metrics will be developed to demonstrate improved outcomes for children and young people.

A whole system approach will be supported by the Clinical Networks and assurance process, using the CCG Improvement and Assessment Framework to identify further areas of interesting practice and where improvements are needed. The development of joint area workforce plans is one of the CCG IAF indicators for 2016-17, highlighting the importance of the creation of a workforce with the right skills and capabilities. These joint workforce plans will need to be shared with commissioners of training across health and social care, including Local Education and Training Boards. Health Education England's national audit of workforce will help local agencies to develop strategies to extend the capacity and capability of a complex workforce.

New and existing ED teams will be able to apply for whole team training in 2016. Alongside this, NHS England worked with the Royal College of Psychiatrists Centre for Quality Improvement and stakeholders to develop service standards in line with the ED guidance and establish a quality improvement and accreditation network for community eating disorder services. The new eating disorder network ([QNCC-ED](#)) was launched in March 2016 and the service standards are due to be published in summer 2016, with a service directory for Community Eating Disorder Services for Children, Young People and their Families and Carers. Community eating disorder

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services are being invited to join the network to support shared learning amongst peers, demonstrate compliance with delivering a quality ED service in line with the guidance (through an annual cycle of self- and peer-review), and supporting service improvements with peers.

In 2016, NHS England will also establish a new care model for specialist mental health to test the impact of secondary providers of mental health services (such as eating disorders) managing the budgets for tertiary, or specialist, services.

## 9. Appendix: Clinical Network Regions

