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Health and Justice CAMHS Transformation Workstream Report

Final report
19 April 2016

Glossary of terms

ACCT	Assessment, Care in Custody,Teamwork
CCG	Clinical Commissioning Group
CJS	Criminal Justice System
CJB	Criminal Justice Board
CSE	Child Sexual Exploitation
CYP	Children and Young People
DH	Department of Health
HWB	Health and Wellbeing Board
H&J	Health and Justice
IRC	Immigration Removal Centre
LA	Local Authority
L&D	Liaison and Diversion
LTP	Local Transformation Plan
MASH	Multi Agency Safeguarding Hub
MoJ	Ministry of Justice
PCC	Police and Crime Commissioner
PCH	Police Custody Healthcare
RRB	Reducing Re-offending Board
SARC	Sexual Assault Referral Centre
SCN	Strategic Clinical Network
SM	Substance Misuse
YJB	Youth Justice Board
YOT	Youth Offending Team (also see YOS)
YOS	Youth Offending Service (also see YOT)
VCS	Voluntary and Community Sector

Contents

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Background and scope of our work

National CAMHS services and provision

It is estimated that 898,000 5-16 year olds have a diagnosable MH condition in England (Data Source: LTP Review 2015, NHS England).

Future in Mind

— The *Future in Mind* report issued by the Department of Health and NHS England in March 2015 was a summary of the issues giving rise to the frequently variable quality of mental health services provided to children and young people. The report arose out of the widely growing recognition that children and young people's (CYP) mental health is a key determinant of adult life expectancy, well being and future economic activity. Early identification and effective management of childhood mental health conditions was judged to have a fundamental impact on our adult lives, as many mental health conditions in adulthood stem from childhood issues – Both health- and non-health related – That go unnoticed and/or untreated.

— The report describes how over half of mental health problems in adult life (excluding dementia) start by the age of 14 and 75% by age 18. One in ten children needs support or treatment for mental health problems, and a similar proportion of CYP have a diagnosable mental health problem.

— The report also sets out some key gaps in terms of access to services. Many mental health providers are reporting increased complexity and severity of presenting problems, in both adults and children. Specific issues were reported to be facing highly vulnerable groups of children and young people and their families, who frequently find it particularly difficult to access appropriate services. Access to crisis, out of hours and liaison psychiatry services are variable. In some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s.

CAMHS and services for children and young people in secure settings

— The report describes a strong need for multidisciplinary action to tackle the wide-ranging issues affecting CAMHS services. The national ambition is to adopt a comprehensive approach to improving the model of delivery for CYP's mental health services.

— The issues affecting the relatively small but highly complex group of CYP in secure settings are particularly difficult. In addition to the issues affecting mental health provision, this group of people requires a joined up service involving health, criminal justice and local authority provision. Improvements have been made with the advent of Liaison and Diversion services, among others, but the commissioning arrangements and the data to track patient progress are fragmented.

East and West Midlands - Area characteristics

Our scope of work is outlined on page 7.

CAMHS services in the Midlands region

In the context described on the previous page, NHS England has asked its ten regions to undertake a study of the provision and effectiveness of mental health provision and commissioning for CYP in secure settings. This report covers the East Midlands and West Midlands.

The East and West Midlands are geographically and ethnically diverse regions with a total population of over 10 million people with approximately 21.3% of the population aged 0-17 years. In the West Midlands there are 15.73 per 1000 0-17 years olds referred for MH services and 11.66 per 1000 in East Midlands, compared with 18 per 1000 on average in England. The approximate spend in the West Midlands on CYP MH was £84.9m, and £67.9m in the East Midlands in 2014/15. (Data source: ONS 2013, LTP review 2015, NHS England).

The issues facing CAMHS services nationally are also facing CAMHS services in the Midlands region. In particular:

— Increase in **demand** for CAMHS services, accompanied by a rise in **complexity of cases.**

— Addressing **gaps in services** – Need for improvements in mental health provision for the most vulnerable CYP, including those in secure settings and SARCs, as well as improving access to crisis care (including inpatient beds).

— **Workforce** development, placing emphasis on building capabilities and capacity.

— Fragmentation of **commissioning arrangements**, there is a lack of a unified clear governance structure for the commissioning of CAMHS services.

East and West Midlands - Area characteristics (cont.)

National issues also facing CAMHS in the Midlands:

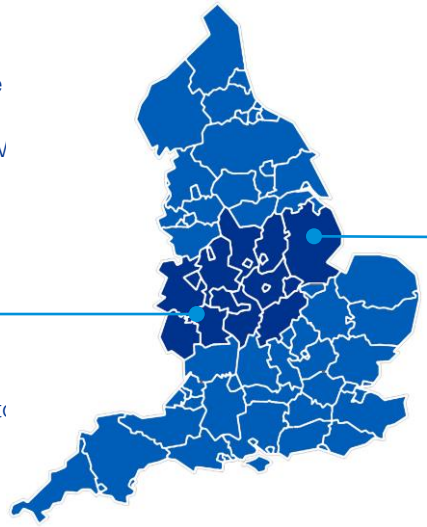
- Increase in demand and complexity of cases.
- Addressing gaps in service provision.
- Workforce development.
- Fragmented commissioning.

West Midlands

Stoke-on-Trent
Staffordshire
Warwickshire
Telford and W
Birmingham
Coventry
Dudley
Wolverhampt
Walsall
Solihull
Sandwell
Worcestershire
Herefordshire
Shropshire

East Midlands

Derby
Derbyshire
Nottingham
Nottinghamshire
Leicester
Leicestershire
Milton Keynes
Northampton
Rutland
Lincolnshire



West Midlands
23 CCGs

21.3%
Population 0-17 years

9.8%
Estimated 5-16 years with MH condition

East Midlands
21 CCGs

21.4%
Population 0-17 years

10.1%
Estimated 5-16 years with MH condition

Scope of our work

The findings and recommendations, as outlined in the Executive Summary, have been set out under each of these four areas of scope.

The following paragraphs have been extracted from our letter of engagement and form the scope of work for this report.

1. Map existing arrangements with the Strategic Clinical Network for maternity, children and young people's mental health services within secure settings (YOI, secure training centres, secure children's homes, Sexual assault referral centres, Liaison and diversion services) across the Midlands region of NHS England (i.e. North Midlands, West Midlands and East Midlands).
2. Understand the Mental Health Collaborative Commissioning arrangements between CCGs and NHS England and whether current commissioning and provision aligns with the regional and local SCNs that are supporting 'Future in Mind' and support Transformation Plans. Ensure the existence of robust pathways to and from the Children and Young People's Secure Estates for CYP so that the development of pathways/actions are sustainable and impact on outcomes that we will measure.
3. Develop a clearer narrative on the needs of children in receipt of directly commissioned Health and Justice provision; this will include consideration of Sexual Assault Referral Centres (SARCs) and Liaison and Diversion. This narrative, or understanding of evidence of needs, will also need to incorporate description of current arrangements for communication and information sharing.
4. There is already a known gap in service provision for both these groups in terms of their access to services. This will mean working closely with existing Strategic Clinical Networks and Collaborative Commissioning Networks that are already set up between Specialised Commissioning and CCGs, using well defined knowledge of needs to inform plans and consideration of future financial arrangements such as pooled budgets.

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Executive summary

Headline issues and recommendations (1 of 2)

The following two pages provide a high level summary of our recommendations which are explored more fully on pages 11-20.

Headline issue	Recommendation
Collaborative Commissioning Commissioning landscape is fragmented; H&J not been formally involved with most LTP development; lack of visibility of funding arrangements for CAMHS in secure settings.	— Formal representation of H&J NHS England on collaborative commissioning groups. — Formal/structured involvement of all key stakeholders in LTPs, including H&J NHS England. — SCNs to oversee end to end pathway for CAMHS (including into, during and leaving secure settings) at regional level. — HWBs or YOBs or RRBs to have responsibility for end to end pathway at local level. — Commissioners/providers identify level of spend/provision on CAMHS in secure settings to improve visibility of spend.
Pathways and Provision No single organisation has overview of pathway, with gaps in provision at transition points, variations in provision across the region	— Overarching governance board that oversees end to end pathway (SCN at regional level, HWB/YOB/RRB at local level). — Map pathways from end to end ensure awareness of full pathway across agencies. — All secure settings and SARCs to have clearly defined CAMHS pathways with clear and consistent referral processes. — Commissioners to consider offering same service across localities (e.g. consistent out of hours services, consistency in provision for different age groups). — Undertake regional needs assessment to ascertain where there are gaps in provision and use evidence based findings to inform changes to services across region. — Reduce/eliminate delays in handovers/provision from one agency to another. — Create formal mechanisms that allow for timely and secure delivery of information across stakeholders. — Improved management of CAMHS cases to prevent escalation to acute/crisis that warrant in-patient admission. — Agree transition arrangements from CAMHS to adult MH services, and establish stronger links with L&D and other local VCS service providers. — Intensify efforts on prevention/building resilient families, with clear links to local authorities, L&D, and VCS provider organisations.

Headline issues and recommendations (2 of 2)

Headline issue	Recommendation
Data collection and data sharing Data collected inconsistent; data sharing is limited/not timely.	— Commissioners to agree on common minimum data to be collected by providers and reported. — Agree common relevant performance indicators. — Develop approach to data sharing where presumption is to share unless by exception. — Enhance IT systems to support secure and timely transfer of data. — Develop electronic information sharing hubs to cover multiple agencies. — Set formal communication platforms between community CAMHS and secure setting CAMHS teams.
Workforce Complexity of cases requires early intervention and increased awareness/capabilities.	— Continually improve staff awareness and capabilities across all agencies involved with CAMHS. — Regular workforce planning to maximise the opportunity to meet workforce needs.

Health and Justice CAMHS transformation workstream

Details on pages 24, 37.

The executive summary is focussed around the four areas of scope of this project.

1. Map existing arrangements with the Strategic Clinical Network (SCN) for maternity, children and young people's mental health services within secure settings across the Midlands region of NHS England (i.e. North Midlands, West Midlands and East Midlands). Understand the Mental Health Collaborative Commissioning arrangements between CCGs and NHS England and whether current commissioning and provision aligns with the regional and local Strategic Clinical Networks that are supporting 'Future in Mind' and support Transformation Plans.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Collaborations: — Collaborative commissioning arrangements are not clearly defined. — There are various relevant networks in the region but not necessarily linking with each other or the SCN. — Mental Health Commissioning group is not fully engaged with Youth and Justice teams.	— Formal representation on collaborative commissioning groups e.g. CCG Collaborative Network for CAMHS and Commissioning Champions Group for CAMHS to ensure CYP MH issues in relation to H&J are reflected.	— NHS England to consider CAMHS/H&J representation on HWBs (HWBs have a good overview of CYP needs in the locality).
SCNs: — East Midlands SCN has dedicated full time resources to support the SCN, which includes a Senior Quality Improvement Lead for CAMHs and Clinical Lead for Transition. They have made progress in bringing the key stakeholders together/strengthening existing arrangements. West Midlands SCN does not have similar resources. This resource limitation is impeding integration and collaborative commissioning.	— The East Midlands SCN to ensure needs of CYP in relation to MH in secure settings H&J are reflected in plans (and the cohort is not forgotten/missed). — The West Midlands SCN appoint a full time resource(s) to develop network and engage key stakeholders across future in mind agenda. — The West Midlands SCN to ensure needs of CYP in relation to MH in secure settings H&J are reflected in plans (and the cohort is not forgotten/missed). — East Of England to also consider progress made in East Midlands and look to establish in similar way.	

Health and Justice CAMHS transformation workstream (cont.)

Details on pages 24, 27, 30, 33.

1. (cont.) Map existing arrangements with the Strategic Clinical Network for maternity, children and young people's mental health services within secure settings across the Midlands region of NHS England (i.e. North Midlands, West Midlands and East Midlands). Understand the Mental Health Collaborative Commissioning arrangements between CCGs and NHS England and whether current commissioning and provision aligns with the regional and local Strategic Clinical Networks that are supporting 'Future in Mind' and support Transformation Plans.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Commissioning arrangements: — Highly complex and fragmented commissioning arrangements across a typical CAMHS pathway (LAs, CCGs, NHS England, schools, public health, PCCs). No clarity on which organisations commission which services along the pathway. The current siloed commissioning perpetuates gaps in the pathways. — No single organisation has a complete overview of the pathway. — Lack of visibility on funding arrangements (provision and spend) across organisations for CAMHS spend in secure settings. Current spend on this population is part of larger block funding/contracts for CAMHS or for the secure setting.	— One organisation to have responsibility for provision of services across the entire clinical pathway. Recommendation that SCN would be the appropriate organisation/body to provide regional overview of pathway. HWBs could provide overview of pathways in localities. — Commissioners/providers identify the level of provision/spend on CYP for mental health across secure settings to improve visibility of demand and supply of services.	— Consider a person-centred approach to commissioning, i.e. the 'commissioning a pathway' approach'.

Health and Justice CAMHS transformation workstream (cont.)

Details on pages 24 and 37. Proposed checklist for commissioners preparing LTPs is set out on page 46.

2. Work with CCGs via the above networks or developing H&J networks to ensure that local CAMHS Transformation Plans include the needs of children and young people ('CYP') who are at risk of or are in contact with the justice or welfare system. This should then ensure the existence of robust pathways to and from the Children and Young People's Secure Estates for CYP so that the development of pathways/actions are sustainable and impact on outcomes that we will measure.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Local transformation plans (LTPs): — Not all clearly demonstrate linkages with justice agencies. — No clear description on how CYP in secure settings and SARC will be catered for. — Lack of a joint strategic approach in their development. It appears there was minimal collaboration from all key agencies, as well as service users. — Variability in maturity and robustness of LTPs. — Resource limitation and challenging timecales for development /submission of LTPs. — Only a limited no of LTP clusters responded to the data request for this project citing that 'secure settings' do not relate to them and they do not commission the MH services.	— The LTPs are part of a five year evolutionary process, therefore ensure that the next updates clearly articulate the links with justice agencies. — Formal and structured involvement of all key stakeholders in the development of LTPs- including LAs, CCGs, NHS England H&J Commissioners and NHS England Specialist Commissioners. This could be brokered through the Future in Mind Steering group for SCN. — Provide proposed checklist to commissioners preparing LTPs to ensure populations in secure setting are not overlooked (see page 46). — Ensure clearer understanding of end to end pathways and where different commissioners interact/service provision could be provided seamlessly.	

Health and Justice CAMHS transformation workstream (cont.)

Details on pages 25-34, 36.

2. (cont.) Work with CCGs via the above networks or developing H&J networks to ensure that local CAMHS Transformation Plans include the needs of children and young people ('CYP') who are at risk of or are in contact with the justice or welfare system. This should then ensure the existence of robust pathways to and from the Children and Young People's Secure Estates for CYP so that the development of pathways/actions are sustainable and impact on outcomes that we will measure.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Pathways: — CAMHS end to end pathways are not understood/apparent to key stakeholders. As such, there is no one organisation responsible for the full pathway/outcome for the young person.	— To have an overarching governance board that ties the pathway together and ensures accountability along the course. Ideally SCN (at regional level) and HWB or YOB or RRBs (at locality level) to have an oversight/responsibility for the end to end pathway. — Map pathways from end to end and ensure an awareness of the full pathway is shared/understood across all key agencies.	
Lack of standardisation in service provided: — Variation in service provision across the region and in the times they are offered e.g. some L&D services are offered 24 hours a day whilst in some localities they are only offered in the daytime. — Eligibility criteria to accessing certain services, e.g. age limitations, and worsened condition severity thresholds due to budget cuts which mean individuals cannot access appropriate services until their issues have escalated or worsened.	— Commissioners to consider offering the same service across localities and considering the cost implication of this. — Use of evidence based findings to inform homogenous changes to CAMHS services regionally. — Regular monitoring and evaluation of services.	— Use of evidence based findings to inform homogenous changes to CAMHS services nationally.

Health and Justice CAMHS transformation workstream (cont.)

Details on pages 25, 38.

3. Develop a clearer narrative on the needs of children in receipt of directly commissioned Health and Justice provision; this will include consideration of Sexual Assault Referral Centres (SARCs) and Liaison and Diversion. This narrative, or understanding of evidence of needs, will also need to incorporate description of current arrangements for communication and information sharing.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Data — There is paucity and inconsistency of CAMHS related data that is collected and reported by commissioners and providers. — There is no consistency in the performance indicators that are measured/reported.	— Commissioners to agree on common minimum data to be collected by providers and reported to commissioners. — Agree common performance indicators.	— Develop electronic information sharing hubs to cover multiple agencies across the nation.
Data sharing — Data sharing arrangements very limited, especially when sharing outside localities. The infrastructure to support this is already in place within organisations but at the interface between agencies the data sharing (and communications) is often poor. — Data sharing protocols cited as sometimes resulting in organisations not sharing data.	— Develop an approach to data sharing where the presumption is that data is shared unless by exception. — Enhance IT systems to support secure and timely data mobility.	— Develop an approach to data sharing where the presumption is that data is shared unless there is an exception.

Health and Justice CAMHS transformation workstream (cont.)

Details on pages 25-34, 38.

3. (cont.) Develop a clearer narrative on the needs of children in receipt of directly commissioned Health and Justice provision; this will include consideration of Sexual Assault Referral Centres (SARCs) and Liaison and Diversion. This narrative, or understanding of evidence of needs, will also need to incorporate description of current arrangements for communication and information sharing.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Provision — Previous history/records often not passed on to secure setting in timely manner. May delay medication and intervention. — Once in secure settings the needs of CYP are met in a timely manner (e.g. if referred to CAMHS from health screening will be seen within 24 Hours). — CAMHS issues more likely to be picked up due to regular MASH meetings/ACCT reports/regular observation. — No structured commissioning arrangements for CYP convicted of sexual harming offence. Currently the service is commissioned on an adhoc basis – No formal contract. As such, some children in this group don't get their needs met.	— Create formal mechanisms that allow for timely and secure delivery of information across different stakeholders. — Enhance IT systems and other necessary infrastructure to allow for effective data sharing. — Undertake a regional needs assessment to ascertain where there are gaps in provision. — Use evidence based outcomes to prioritise the needs for local population.	— Create formal mechanisms that allow for timely and safe delivery of information across different stakeholders. — Enhance IT systems and other necessary infrastructure to allow for effective data sharing.

Health and Justice CAMHS transformation workstream (cont.)

Details on pages 25-34.

3. (cont.) Develop a clearer narrative on the needs of children in receipt of directly commissioned Health and Justice provision; this will include consideration of Sexual Assault Referral Centres (SARCs) and Liaison and Diversion. This narrative, or understanding of evidence of needs, will also need to incorporate description of current arrangements for communication and information sharing.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Inpatient beds: — There is a widely recognised psychiatric bed crisis, however the situation is particularly dire for children in secure units as they cannot be admitted to acute NHS settings due to security challenges. Instead, they require specialist centres which are sparse across the country.	— Need for improved management of CAMHS cases, especially in secure settings, to prevent escalation of conditions to acute/crisis episodes that warrant inpatient admission.	
Pathways: — CAMHS pathways or referral pathways in some secure settings and SARCs are either non existent or imprecise.	— All secure settings and SARCs to have clearly defined CAMHS pathways which also address referral processes for CAMHS services inside a secure setting or in the community. — To have an overarching governance board that ties the pathway together and ensures accountability along the course. Ideally SCN (at regional level) and HWB or YOB (at locality level) to have an oversight/responsibility for the end to end pathway. — Map pathways from end to end and ensure an awareness of the full pathway is shared across all key agencies.	

Health and Justice CAMHS transformation workstream (cont.)

Details on pages 25-34.

3. (cont.) Develop a clearer narrative on the needs of children in receipt of directly commissioned Health and Justice provision; this will include consideration of Sexual Assault Referral Centres (SARCs) and Liaison and Diversion. This narrative, or understanding of evidence of needs, will also need to incorporate description of current arrangements for communication and information sharing.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Handovers: — Delays in accessing victims/offenders' medical notes as they move between agencies. This causes delays in commencing appropriate care. — IT/data systems in secure settings are not usually the same systems as those used by community CAMHS teams/other agencies. This makes it more difficult to provide timely intervention upon entering or leaving the secure setting.	— Create formal mechanisms/links that allow for timely and secure delivery of information across different agencies.	Invest in IT platforms that can share data in a timely manner.
Communication: — Communication arrangements between agencies is suboptimal, hence information sharing affected in most cases.	— Set formal communication platforms between community CAMHS teams and secure setting CAMHS.	
Role modelling or peer mentoring schemes: — Limited support available in secure settings and in the community (e.g. pilot project in Walsall).	— Encourage the establishment of role modelling or peer mentoring schemes in secure settings and in the community. Peer support is deemed very valuable due to its ethos on driving equality and the therapeutic value of 'lived experience' amongst peers.	

Health and Justice CAMHS transformation workstream (cont.)

Details on pages 25, 36.

4. There is already a known gap in service provision for both these groups in terms of their access to services. This will mean working closely with existing Strategic Clinical Networks and Collaborative Commissioning Networks that are already set up between Specialised Commissioning and CCGs, using well defined knowledge of needs to inform plans and consideration of future financial arrangements such as pooled budgets.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Transition from child to adult mental health services: — Arrangements are variable across the region. They can be obscure and complex in most cases – resulting in delay in transition or some cases being missed. — The criteria for support for adults is different to criteria for CAMHS and some 18 year olds no longer qualify for support.	— Agree transition arrangements from CAMHS to adult MH provision and identify budgets to cover this. — Ensure a clear link to Liaison and Diversion services to address this gap in provision/support with approved three year funding.	— Develop nationally recognised criteria and clear process for referring CYP to adult mental health services.
Disproportionate increase in demand for CAMHS versus provision: — Recognised increase in demand for services potentially due to day to day stresses in this population group or an improvement in diagnostic capabilities.	— Early projections on service need should be made – To allow for sufficient and timely provision.	

Health and Justice CAMHS transformation workstream (cont.)

Details on page 38

4. (cont.) There is already a known gap in service provision for both these groups in terms of their access to services. This will mean working closely with existing Strategic Clinical Networks and Collaborative Commissioning Networks that are already set up between Specialised Commissioning and CCGs, using well defined knowledge of needs to inform plans and consideration of future financial arrangements such as pooled budgets.

Key issues	Recommendations to H&J NHS England	Recommendations to NHS England
Reduced funding for children's services within local authorities: — This will particularly affect tier 1 and 2 services (in some cases), which negatively impacts on the preventative care and early intervention aspects of the service.	— Intensify efforts to support families (building their resilience) with CAMHS cases. This will improve family members resilience in supporting the affected individual. — Strengthen links with L&D to improve understanding of the nature of underlying need, and consider joint commissioning of appropriate community-based earlier intervention and prevention services with CCGs and local authorities	— Preventative care needs strengthening so to minimise avoidable escalation of mental health problems. — Clear link with L&D services.
Workforce: — The increase in service demand and complexity of some cases requires a workforce that can effectively meet the needs in a timely manner.	— Continually improve staff awareness and capabilities across all agencies involved with CAMHS, including health, education and local authorities. — Workforce planning to be undertaken regularly so to maximise the opportunity of meeting workforce needs.	

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Engagement methods

Health and Justice CAMHS transformation workstream

The Key Stakeholders involved in interviews, site visits, the workshop, or where the data request was sent to them are listed in the Appendices.

Engagement methods

Stakeholder interviews

- Key stakeholders were identified in the project initiation stages.
- A total of 21 face to face and telephone interviews were conducted.
- The key stakeholders interviewed included CAMHS commissioners, providers and secure setting and SARC managers across West Midlands and East Midlands.

Site visits

- Three different sites were visited:
  - HMYOI Werrington (Stoke on Trent).
  - Serenity SARC (Northampton).
  - Clayfields Secure Children's Home (Nottingham).
- The purpose of the site visits was to:
  - Tour the site and gain the context.
  - Interview staff members on current service provision.
  - Discuss current pathways.

Workshop

- A workshop to discuss current CAMHS service provision and future ambitions was held on the 2 of March 2016.
- 37 key stakeholders were invited to attend.
- Networks that are concerned with children's health and/or mental health and the commissioning of those services in East, West or North Midlands were identified.
- Using example pathways, current challenges and gaps in CAMHS services were discussed.

Data request

- Qualitative data requests were sent to CCG cluster leads in East and West Midlands region. 19 CCG cluster leads were contacted.
  - 10 did not respond.
  - Five responded to state that they were not well positioned to respond.
  - Four responded.
- Both qualitative and quantitative data requests were sent out to NHS England H&J commissioners – Most of whom signposted us to providers.
  - 9 out of 12 commissioners responded.
  - 3 out of the 11 providers contacted responded.
- Most of the responses were incomplete.

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Current state

Health and Justice CAMHS transformation workstream

This page sets out the current state and the range of networks currently operating.

Examples of current pathways are explored from pages 27-35.

Current state

We engaged with a wide range of stakeholders, as outlined in our engagement methods, to establish the current state of mental health services for CPY in secure settings. We considered appropriate networks across the region and developed example pathways to demonstrate different commissioners and services provided for CYP going into/in/leaving secure settings.

The Secure Estate in the Midlands

There are currently two Secure Children's Homes (Clayfields and Kesteven House) which are national resources, one Secure Training Centre at Rainsbrook, one YOI at Werrington, and eight SARCS.

It is difficult to estimate the spend on CAMHS in secure settings as the spend is either part of a wider secure settings budget, or part of a wider CAMHS spend.

Networks

We found a range of networks are operating in the region, at national, regional and local level (see Appendices for networks identified at the workshop). Different stakeholders are linked into different networks, depending on nature of work, service being commissioned and personal contacts/relationships. We found that there was no single organisation with an overview of end-to-end pathways and no existing network that currently has all relevant key stakeholders involved in the provision of CYP MH services in secure settings across the Midlands region.

In East Midlands the Maternity and Children's services SCN has responsibility for CAMHS. In the West Midlands the MH, Dementia and Neurological Conditions SCN has responsibility for CAMHS. Currently neither SCN has specific responsibility or oversight of MH services for CYP in secure settings. At a regional level the welfare of CYP in secure settings is overseen by the Health and Justice Boards.

At a local level there are a plethora of networks and Boards meeting to discuss elements of CAMHS. There are a range of multi-agency groups operating such as MASH Boards (Safeguarding Boards), Youth Offending Boards, Health and Wellbeing Boards.

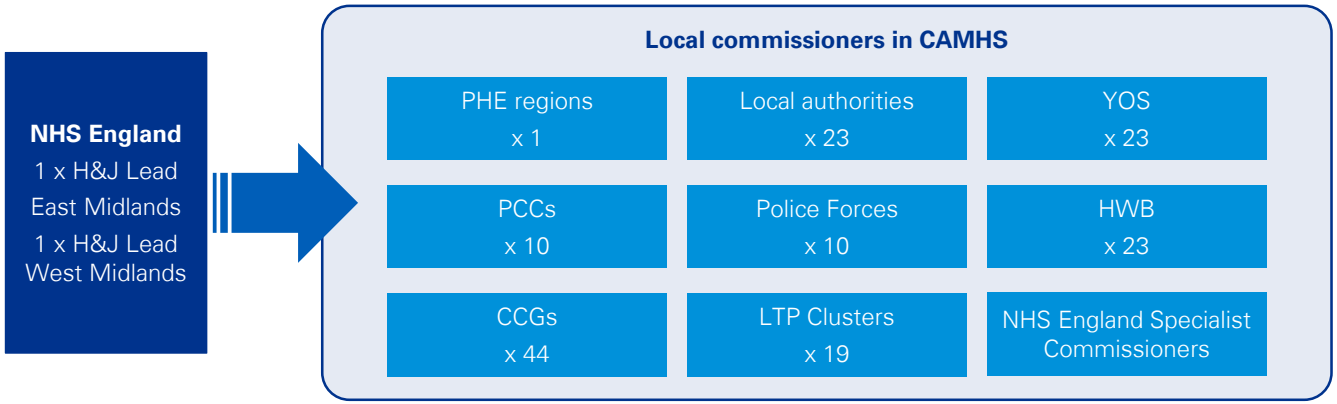
Health and Justice CAMHS transformation workstream (cont.)

This page sets out current arrangements for collaborative commissioning.

Examples of current pathways are explored from pages 27-35.

Collaborative commissioning and local transformation plans

Collaborative commissioning groups exist to consider community CAMHS but these often do not consider the needs of the population in secure settings as these as commissioned differently. Current commissioning arrangements are complex and fragmented making it difficult to achieve focus, shared solutions and shared priorities. Current commissioners of CAMHS in the Midlands include:



The average annual CYP MH spend by funding source as a percentage across England is 46% CCGs, 38% NHS England, 16% LAs. The approximate average spend per child 0-17 years was £78 in 2014/15. (Data source: 2015 LTPs, NHS England).

The LTPs set out the priorities of Future in Mind in the local area. The degree to which the needs of CYP in secure settings have been taken into account varies from some reference to CAMHS in secure settings, or support for CYP in the justice system or those vulnerable to CSE, or no reference at all. LTP clusters are CCG-led and we have had a limited response in engaging with CCGs/LTP clusters as many feel this is not their area of responsibility or a priority for them. There is a danger that the needs of the secure setting population will be missed if LTP clusters do not include NHS England commissioners/specialist commissioners when developing/further developing the LTPs. Only one LTP cluster has directly involved and NHS England commissioner to discuss the needs of CYP in secure settings/SARCs and this was facilitated by individual relationships/informal networks.

Health and Justice CAMHS transformation workstream (cont.)

This page sets out current arrangements for data collection, data sharing, pathways and inconsistencies in provision.

Examples of current pathways are explored from pages 27-35.

Data collection and data sharing

There is variability in service provision and outcomes across the Midlands and a lack of consistent and accurate data on activity and outcomes. There is no agreed common data set, the returns received to inform this project were incomplete and a high number were not returned despite a number of follow-ups. There is no clear picture of performance measurement across the region as KPIs are inconsistent, making accurate evaluation of performance across the region difficult.

Key stakeholders are using different systems and IT platforms which do not 'speak' to each other, and this does not promote data sharing. For example in Leicester the three key providers all use different systems making electronic data sharing very difficult. Some providers are not using IT systems (e.g. Chesterfield) and have paper-based reporting systems.

Pathways

We worked with key stakeholders to develop example pathways for CYP, giving examples of interventions from L&D, SARC, SCH and YOI. The example pathways for Tom, Alex and Carla are shown as illustrations but are based on real examples of the needs of young people in the Midlands region as identified from stakeholder interviews, meetings, and the stakeholder workshop.

Inconsistency of provision

There is a lack of consistency in the services provided across the region. For example, Out of Hours L&D services are provided in Nottinghamshire but not in Derbyshire. 24/7 crisis care services for CYP are often not provided and CYP will see an adult Psychiatrist or could be admitted temporarily onto an adult ward. There is opportunity to improve access to L&D services for those in contact with the criminal justice system, particularly those whose needs have not been identified by services elsewhere; and to improve the quality and consistency of L&D services provided across the patch.

Service provision differs between SARCs. Some centres, such as Serenity, Northants, offer rape and sexual assault counselling to CYP aged 15 and over. In other SARCs this is not available until 16 years of age.

Services for children and young people and their families and carers, are inconsistent, misaligned and disrupted by transition points. This can be at transition points between providers/commissioners, or as CYP reach the age of 18 and may no longer meet the criteria for adult MH services.

1) Tom's story* - The journey

Tom

Tom's Profile:

- 15 years old.
- Substance misuse.
- Mood swings and anger problems.
- Behavioural issues.
- Known to CAMHS.
- Known to his local community policing team and has a YOT worker.

Tom's family:

- Mother and father unemployed.
- Older brother living at home and frequently in trouble with police.

Meet Tom

Tom has been suspended again from school due to disruptive behaviour. He is known to his local CAMHS community team. He suffers from mood swings and severe episodes of anger. He has been seeing a community CAMHS specialist every three months.

He also has a YOT worker supporting him.

Home and social

Tom spends minimal time at home. He goes out regularly with his friends to drink at a local park.

On a particular evening, Tom and his friends, after drinking, steal one of his friends' parent's car. Tom, whilst driving, runs over a pedestrian and causes serious injuries. The victim later dies in hospital.

Police

Tom arrives at the police station after the incident at around 01:00 – No L&D officers are available at this time. The on-call medical officer undertakes a physical and mental examination, however does not pick up on Tom's mental health history, neither does Tom share the information. Tom spends the night in a police cell. The following day Tom gets moved to a secure unit where he spends the rest of his time; pre and post court hearing.

YOI

On arrival at the YOI, Tom has to repeat his medical history again and still does not make staff aware that he is known to CAMHS. The YOI staff do not receive awareness on Tom's CAMHS history until this information is shared by his YOT worker, three days later. The Community CAMHS team is then contacted for access to Tom's full medical notes, whilst a referral is also made to the YOI CAMHS team. In the meantime, Tom gets really upset and anxious over the loss of his personal property from his cell. As time goes on, his mood is made worse by the fact that he gets convicted for manslaughter.

Crisis

Tom refuses to eat for a couple of days and he also starts developing regular episodes of extreme panic attacks. He complains of difficulty in breathing and feeling faint. The YOI CAMHS team intervene and a Psychiatrist is called in as the situation is deemed critical. (The team still has no access to Tom's records with his previous mental health history). An inpatient admission is advised, however there are no beds in PICU – Tom is put on the waiting list.

Specialist care

Tom's receives his specialist CAMHS care in the YOI. However there are limitations around the timings of his sessions and sometimes getting an appropriate room to conduct the sessions.

After one week, Tom gets an inpatient bed outside his locality – A long distance for his family to regularly visit. He spends two months there before returning to YOI.

He continues with CAMHS input until the time of his release from the secure unit. The YOI CAMHS team find out at a MASH meeting that Tom's release date is the following day. Confirmation of Tom's release is immediately sent out to the Community CAMHS team – Within 24 hours of his release.

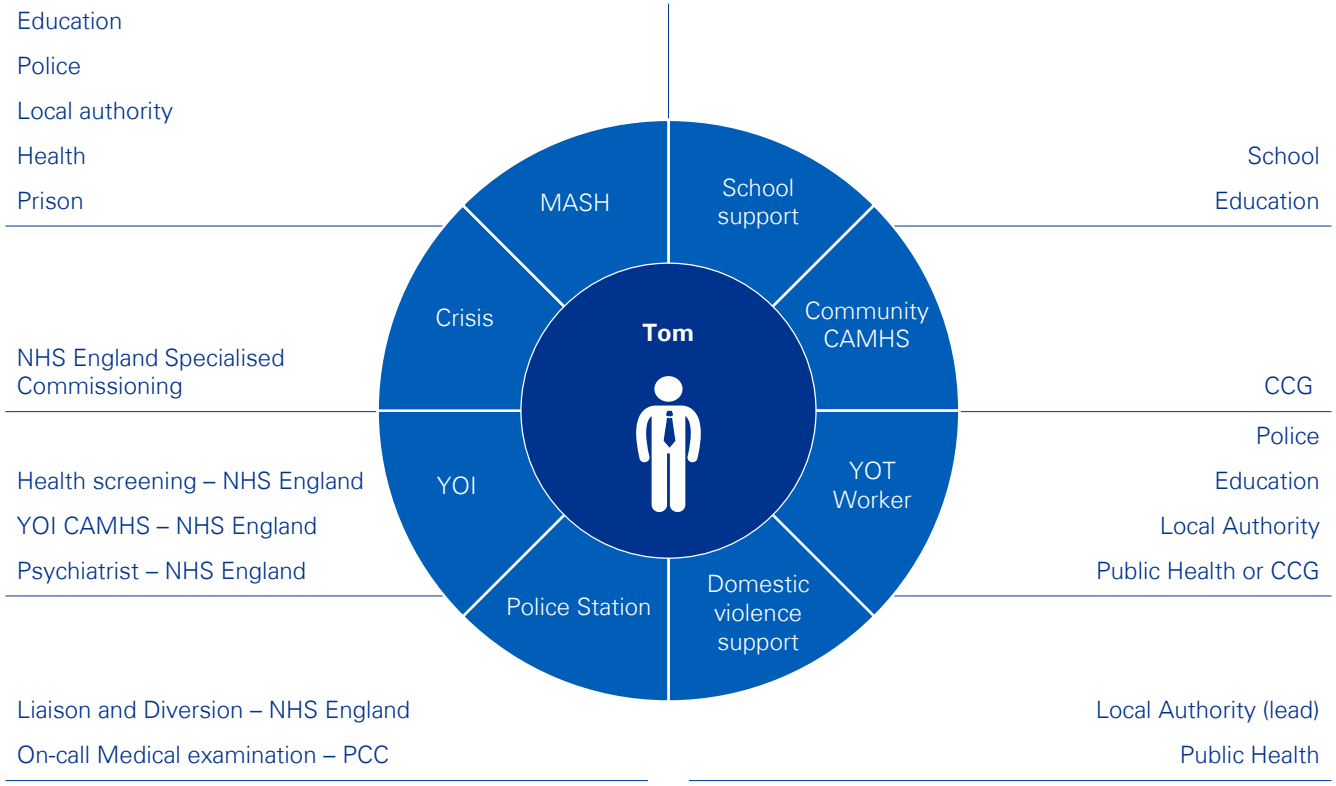
Tom back at home

Tom is then booked for his first appointment with the Community CAMHS team six weeks after release. Whilst waiting for this appointment, Tom fell back into his previous routine and he's hanging out with his friends again and drinking at the park. He was heard saying he felt down again because of witnessing domestic violence between his parents, however Tom did not share this with the YOT worker.

*Hypothetical example based on current pathway challenges identified within stakeholder interviews/workshop discussions.

1) Tom's story* - The commissioners across the journey

Tom's story demonstrates the complex commissioning landscape and the high number of handovers experienced during Tom's journey.



*Hypothetical example based on current pathway challenges identified within stakeholder interviews/workshop discussions.

1)Tom's Story*- The issues

Tom (YOI)	
What works well	— Once Tom was admitted to YOI his needs were met in a timely manner.
What doesn't work well	— Preventative care and family/peer support. — To minimise the chance of Tom offending in the first place. — To avert the risk of his mental health problems escalating to a crisis. — Lack of information sharing capabilities. — Infrastructure is present in majority of the organisations. — Tom has to repeat his medical and social history as he manoeuvres across agencies. — Poor communication between and within agencies. — Limited of collaboration amongst various organisations such as; education, Youth Offending teams and CAMHS in order to develop appropriate packages of care. — No support for Tom's parents whilst he is detained and upon his release. — Resilience building is necessary for them. — Need for role modelling or peer mentoring schemes being offered in the school/community. — No substance misuse support in the community.
Gaps	— Support to Tom's family. — Liaison and Diversion service not available 24 hours a day in some localities across the Midlands region. — Delay in court records/medical records. — Delayed interaction between YOT worker and YOI/CAMHS.
Key concerns	— Release day notification was issued less than 24 hours – Making it difficult to arrange community CAMHS support in a timely manner. Particularly an issue if the offender is on psychiatric medication. — Delay in accessing Tom's full medical records. — The delivery of crisis care support is not always appropriate in a secure setting due to time and space constraints. This could cause delays in the recovery process and also affect the quality of outcomes.

* Hypothetical example based on current pathway challenges identified within stakeholder interviews/workshop discussions.

2) Alex's story* - The journey

Alex

Alex's Profile:

- 15 years old.
- Undiagnosed Depression (low in mood).
- Family known to social services on the Troubled Families register.

Alex's family:

- Mother and father unemployed
- Known to social services – Troubled Families register
- Younger brother (11) regularly not attending school.

SARC

On arrival to SARC, Alex goes through a health screening process and forensic medical examination. Again, she is asked for the same information that the police previously requested. The verdict was that Alex had experienced serious sexual assault.

CAMHS input is warranted and therefore a referral is made to her local Community CAMHS team.

Whilst in SARC, Alex also receives counselling specifically related to rape and sexual assault.

Community CAMHS

Four week after discharge from SARC, Alex has her first community CAMHS appointment. During the four weeks of waiting, Alex was worried and spoke to her ISVA a few times about the length of wait for her CAMHS appointment.

Eventually, a package of CAMHS treatment is started for Alex. And she does not miss any appointments. However, Alex shares that she wishes her CAMHS treatment package also included a counselling service similar to the one she got in the SARC – She was told that it could not be offered.

School

Alex finds it hard to concentrate at school. She also finds it difficult to follow instructions which often makes her frustrated and quite disruptive in class. The school has made several attempts to speak with her parents but have not been successful due their failure to meet set appointments.

One day, Alex opens up to her school nurse and tells her she has been sexual assaulted at home, by her uncle who occasionally visits them. Alex also shares that she would rather not inform her parents as they will not believe her.

Police

A case is open with the police who:

- Immediately refer Alex to SARC.
- Liaise with the social worker and Alex regarding informing her parents.
- Investigate Alex's uncle for sexual assault.

Alex shares that she is threatening to self harm because she feels vulnerable and also cannot live with the memories of what has been happening to her.

Alex back at home

Alex is eventually discharged home from SARC five hours from admission. She is given contact details for her Independent Sexual Violence Advocate (ISVA) whose role is to provide ongoing support whilst awaiting further reviews and investigations.

Her social worker is involved throughout the process and ensures safeguarding measures are in place for Alex.

On the other hand, Alex's mental health is not addressed for a while until she gets her community CAMHS appointment. During the wait, she continues to be low in mood, filled with fear that the assault may happen again, although her uncle had been held under investigation by the police.

Inspite of a great family and friends support network, Alex does not want to talk to them about her feelings. She occasionally fights suicidal thoughts. By herself.

Home and social

Alex lives with her parents who are both unemployed and drink excessively. She repeatedly experiences inappropriate behaviour from her uncle, however no one else seems to notice it. Her low mood is worsening and she prefers to be either out at a friend's house or in her bedroom by herself most of the time.

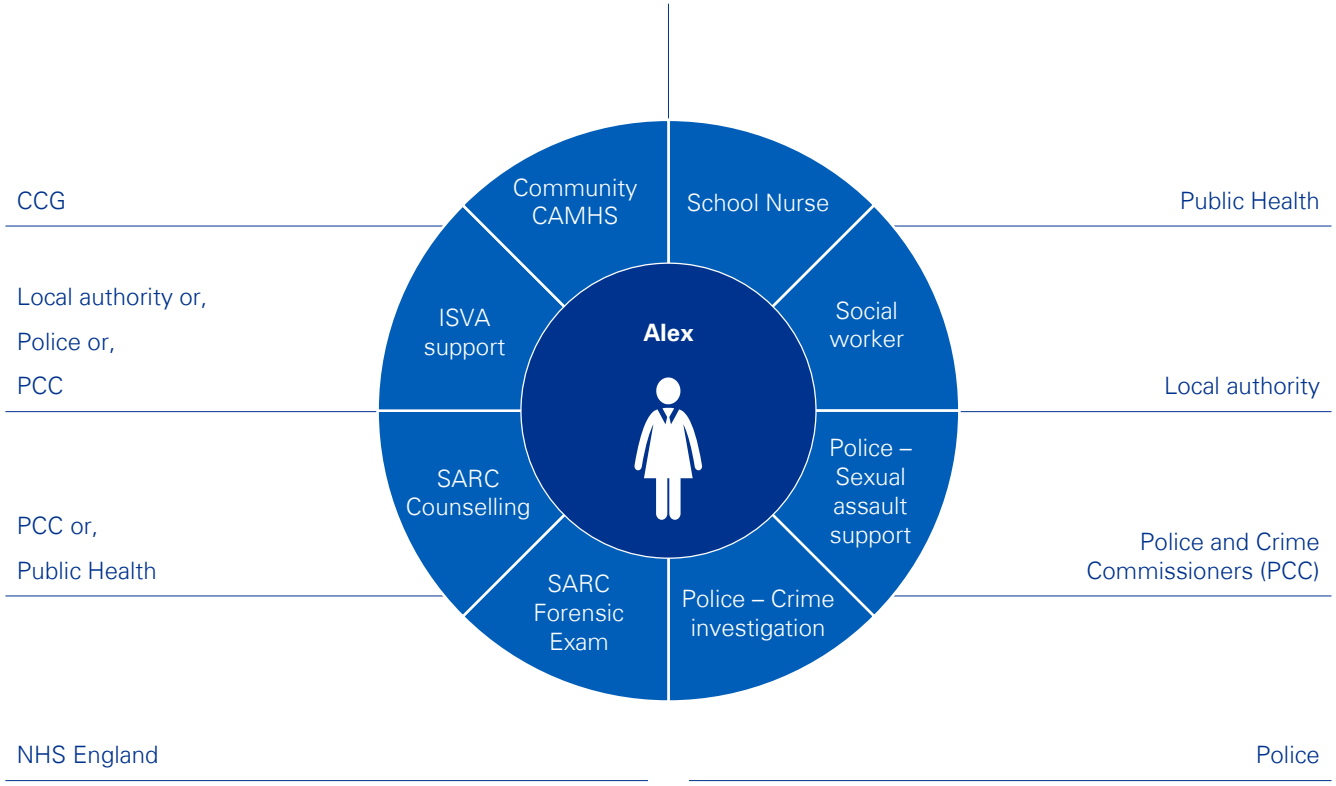
Social services

Alex's school nurse informs her social worker of the sexual assault experiences. They all agree (including Alex) that the police need to be informed and that Alex will need to be medically examined.

* Hypothetical example based on current pathway challenges identified within stakeholder interviews/workshop discussions.

2) Alex's story* - The commissioners across the journey

Alex's story demonstrates the complex commissioning landscape and the high number of handovers experienced during Alex's journey.



*Hypothetical example based on current pathway challenges identified within stakeholder interviews/workshop discussions.

2) Alex's story*- The issues

Alex (SARC)	
What works well	— The benefit of having a school nurse is shown here – Alex's situation is brought to light during a discussion with the school nurse and intervention starts. — Alex's story is believed and appropriate support is given.
What doesn't work well	— Information sharing. — Alex keeps having to repeat her story across different organisations and people. — Communication between agencies sub-optimal. — Alex either gets the SARC counselling service [she is 15 and some areas would not be able to access this support as an under 16] and has to wait for about one month before receiving CAMHS input to address her identified mental health need. — During the wait, Alex fights suicidal thoughts.
Gaps	— Clear pathway to explain the transition from child (CAMHS) to adult mental health services. — Adult addiction services to support Alex's parents. — CAMHS team not offering a package to incorporate rape and sexual assault counselling service. — Clarity on safeguarding support offered to Alex. — Lack of a specialist or tailored package of service to cover victim's needs.
Key concerns	— Some SARC victims are still not getting CAMHS input despite evidenced need, because SARC counselling is seen as sufficient by some organisations. — Some SARC units do not have referral pathway to a community CAMHS team. They refer to GPs who then have to review the case and forward to the CAMHS team if deemed necessary. This causes severe delays before a victim's mental health needs are met. — There are various SARC counselling agencies – Referrals can be duplicated at times.

*Hypothetical example based on current pathway challenges identified within stakeholder interviews/workshop discussions.

3) Carla's story* - The journey

Carla

Carla's Profile:

- 14 years old.
- Has a boyfriend, Ben, who is known to his local community policing team and has a YOT worker.
- ADHD – Known to CAMHS.
- History of self harming.
- Recently suspended from school.

Carla's family:

- Lives with her mother who's unemployed.
- Has a younger brother.

Meet Carla

Carla was diagnosed with ADHD three years ago, after her school recommended a medical review (by her GP) due to her frequently displaying signs of inattentiveness, associated with symptoms of anxiety.

At that point she got referred to a local CAMHS team for ongoing support. Weeks after diagnosis, Carla expressed that she also felt low and eventually began to self harm – She was then put on psychiatric medication.

SCH

On arrival to the SCH, Carla has a healthcare screen by the CAMHS team. Although it has been pointed out that Carla needs CAMHS input, her data sheet is incomplete. Missing are the; next of kin details, name of the drug Carla is on (and Carla does not remember this) and the details of the community CAMHS team she is known to. At this stage, Carla is very anxious and extremely fidgety – she has not had her medication in two days and therefore she is not cooperative. A Psychiatrist is called in to intervene and prescribe suitable medication.

Her YOT worker was immediately contacted to seek this information, as well as her full medical history.

Police

Carla gets arrested and spends two days in the police cell before attending court. In the two days, she had a medical screening and was also assessed by a Liaison and Diversion officer who noted that Carla was vulnerable, had a history of self harming and therefore would require CAMHS support where ever she ends up.

Carla attends court and she's found guilty of theft and grievous bodily harm. She' then sent to a Secure Children's Home (SCH), 80 miles from her home.

Mother and baby unit

Carla's profile and medical history are transferred electronically via a shred 'clinical spine' system. The unit receives information about Carla just prior to her arrival.

A referral to a CAMHS team that support that particular unit is made, emphasis is put on the fact that Carla is on medication and as such would require prompt assessment.

SCH (cont.)

Eventually Carla's symptoms are managed well and she gets settled. Her medical notes arrive two days after admission to the SCH via her YOT worker. Carla is also referred to Midwifery team in light of her pregnancy.

Although Carla settles in to the SCH well, she dislikes the fact that the room she has CAMHS therapy in, is the same room she was in for her initial assessment and the police interviews – this evokes bad memories. She mentions this all the time during her therapy sessions, however gets reminded that there are space constraints in the home and they have to work with what is available.

Nearer the time of delivery, Carla gets moved to a secure mother and baby unit in the same locality.

Home and social

Carla has always had a good relationship with her mother, they do a lot together. However since the diagnosis, Carla's mother has reduced the amount of activities they do together, not wanting to 'disturb' her ADHD therapy routine. Carla ends up spending majority of her time with Ben, her boyfriend, who has a strong influence on Carla' behaviour.

School

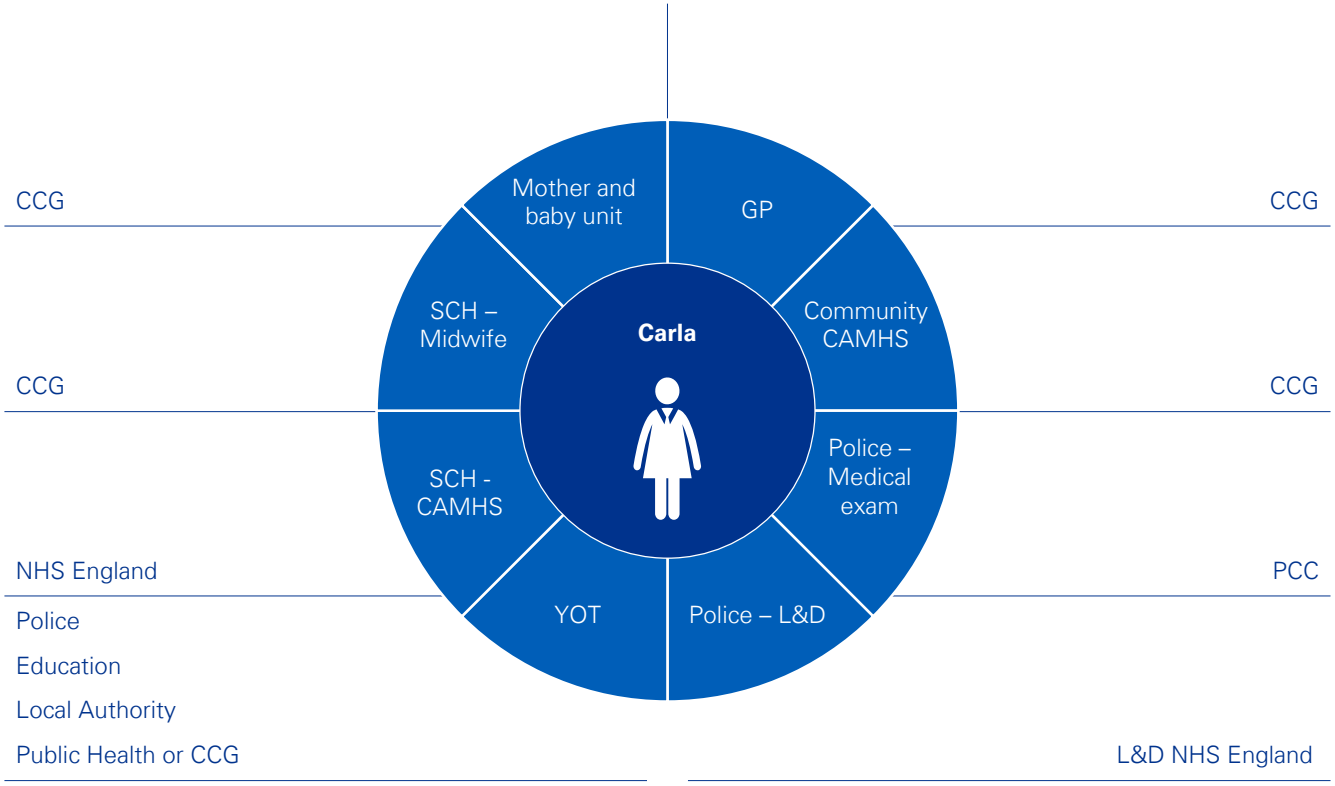
Ben's influences grow on Carla, she starts taking risks in behaviour which leads to her falling pregnant. She also become rebellious at school and eventually gets suspended.

Further, Carla finds herself in trouble with the police for seriously harming an elderly lady before stealing some jewellery and money from her. She was caught by a neighbour as she tried to escape and the police were called in.

*Hypothetical example based on current pathway challenges identified within stakeholder interviews/workshop discussions.

3) Carla's story* - The commissioners across the journey

Carla's story demonstrates the complex commissioning landscape and the high number of handovers experienced during Carla's journey.



*Hypothetical example based on current pathway challenges identified within stakeholder interviews/workshop discussions.

3) Carla's story*- The issues

Carla (SCH)	
What works well	— Carla's needs are met in the SCH in a timely manner.
What doesn't work well	— Information sharing. — Health records incomplete when passed on to SCH and Carla can't remember the name of her medication. — Communication between agencies sub-optimal.
Gaps	— Mother doesn't know how to support her daughter and is not getting help to on how best to support. — Delay in court records/medical records. Resulted in delay in treatment/meds. Emergency Psychiatrist input required which could have been avoided if information had transferred in timely manner. — Liaison and Diversion service not available 24 hours a day in some localities across the Midlands region. — Delayed interaction between YOT worker and SCH/CAMHS.
Key concerns	— Delay in accessing Carla's full medical records caused delay and avoidable specialist intervention. — Secure Children's Homes are national facilities and cater for CYP from any area of England. This results in CYP often being placed a long way from family and friends and there are reports that treatment takes longer without help and encouragement from family and friends.

*Hypothetical example based on current pathway challenges identified within stakeholder interviews/workshop discussions.

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Future state

Health and Justice CAMHS transformation workstream

Key stakeholders/ workshop attendees have suggested the future state will need:

- **Improved data gathering and sharing**
- **Collaborative Commissioning**
- **Early intervention/Clear links with L&D**
- **Clear governance of Pathways**
- **A strong evidence base**
- **Workforce development**

The future state – Areas for improvement

Feedback from key stakeholders/workshop attendees on the future state falls into six main areas as outlined in the diagram below:

— Development of electronic information sharing hubs to cover multiple agencies.

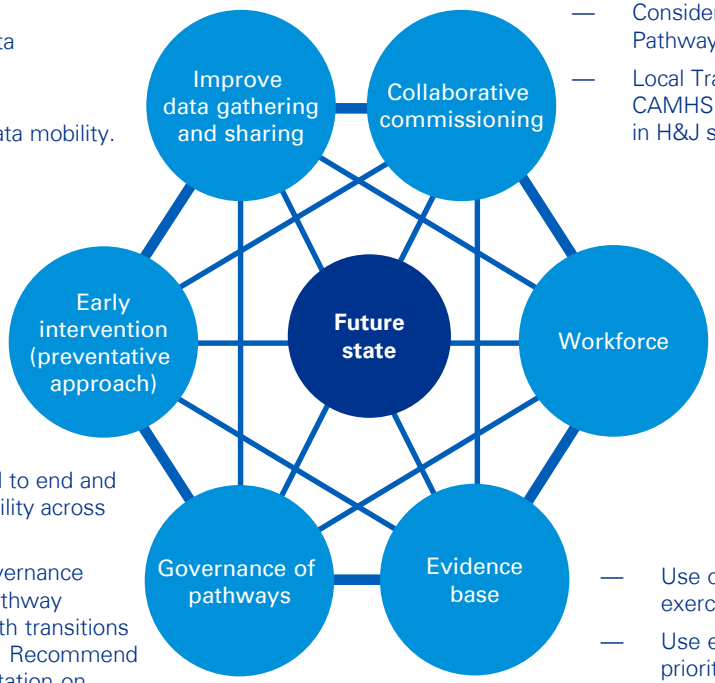
— Improve and enforce data gathering mechanisms.

— Enhance I.T. systems to accommodate secure data mobility.

— Development of networks to support collaborative commissioning.

— Consider the 'Commissioning a Pathway' approach.

— Local Transformation Plans on CAMHS to be inclusive of CYP needs in H&J setting.



— Improve preventative care to minimise unnecessary escalation of health problems.

— Clear links with L&D services and defined pathways for identified needs.

— Continually improve staff capabilities across all agencies, including health, education and local authority.

— Workforce planning to be undertaken regularly in order to maximise the chance of meeting establishments needs.

— Map pathways from end to end and ensure widespread visibility across all agencies.

— Have an overarching governance board that 'holds' the pathway together, ensures smooth transitions and holds accountability. Recommend SCN with H&J representation on Steering Group and/or task and finish groups. Stronger links with LTPs and needs of CYP in H&J setting. At local level HWB, YOB and RRBs to ensure oversight of complete pathway.

— Use outcomes from benchmarking exercises to inform change.

— Use evidence based findings to prioritise the needs for local population.

— Monitor and evaluate existing pathways for effectiveness e.g. the L&D youth pathway.

Health and Justice CAMHS transformation workstream (cont.)

The future state requires a collaborative commissioning approach where LTPs adequately take account of H&J issues.

Proposed checklist for commissioners preparing LTPs is set out on page 46.

Collaborative commissioning and LTPs

The current commissioning landscape is complex and fragmented. In the future state Collaborative Commissioning will ensure that the needs of all CYP are met in a holistic way. Commissioning will centred on the Pathway/individual needs rather than sections of the pathway. Handovers in provision, where sections of the pathway are currently commissioned will therefore be reduced or eliminated. Populations in secure settings will be considered as an integral part of the pathway. LTPs will cover all aspects of the CYP MH pathway, including the population in secure settings or using SARCs. The governance of this pathway will be overseen by the SCNs (for East and West Midlands) with a clear remit for overseeing the complete pathway, including H&J elements.

Commissioners will also offer the same service across localities and considering the cost implication of this. Commissioners will use evidence based findings to inform changes to CAMHS services across the region.

The EM SCN Future in Mind Steering Group is a platform that could be used to raise awareness of the MH needs of the H&J population in secure settings. The Steering Group will have overview of the LTPs. To ensure that the needs of the population of CYP with MH issues in secure settings are not overlooked we set out a proposed checklist for commissioners preparing LTPs in the Appendix.

Case Study: The East Midlands (EM) SCN maternity and children's

The EM SCN has received additional funding from NHS England to support the development of a local 'hub', to augment SCN funding and local quality improvement staffing. They have established a dedicated implementation team to establish sound governance, engagement and commitment to joint working arrangements in relation to CYP MH. Their objectives are to:

— Develop a community of practice by establishing a virtual network to share emerging and best practice and identify emerging issues.

— Identify gaps and common themes for supporting the implementation of LTPs across EM.

They have identified clear governance levels for the project and have established a CYP MH Steering Group that sits under the SCN with links to the Commissioning Champions Group and the CAMHS Collaborative Commissioning Working Group. The Steering Group will have overview of the LTPs (and the LTP Implementation Groups) and will set up task and finish working groups as required. An NHS specialist commissioner has been invited to join the SG.

The priorities of the EM SCN are to:

- Establish EM CYP MH Improvement Team CN through a local "spoke"
- Establish governance and delivery arrangements for Future in Mind Steering Group
- Establish and develop local CYP MH Learning Communities
- Making use of the Future in Mind Self-Assessment Tool
- Support the establishment of new/expand on current CYP-IAPT Learning Collaboratives.
- Support improvements in local commissioning arrangements and with the implementation of the LTPs across East Midlands
- Support the development of an effective, skilled local CYP MH workforce across the East Midlands SCN Network
- Support the development of a standard approach to data collection and outcomes monitoring

The first cross-sector workshop was held in March 2016 to share emerging and best practice. A further event is planned later in the year.

Health and Justice CAMHS transformation workstream (cont.)

The future state requires improved data collection and data sharing, early intervention and a workforce that has a greater awareness of MH issues facing CYP.

Data collection and data sharing

There is a lack of consistent and accurate data on activity and outcomes across localities. There is no agreed common data set currently being collected and reported, and no clear picture of performance measurement across the region. Key stakeholders are using different systems and IT platforms causing a significant barrier to data sharing. Investment is required in the future state to ensure commissioners and providers across the pathway collect and report common data. Handovers between the different commissioned elements of the pathway are not timely, resulting in delays to the transfer of medical records and the treatment received. These barriers should be reduced/eliminated by investing in a common IT platform that allows for the timely and secure exchange of data/medical records.

Early intervention

Funding for services in the public sector is being reduced in many areas in the current state. Cuts to LA budgets have resulted in some cuts to early intervention services, which can have a knock-on effect on provision further down the pathway. We need to take a whole system approach to tackling CYP MH and ensure that cuts by one funder are not causing an increased workload/funding expectation by other funders/commissioners.

In the future state, clear links between L&D and local authorities – particularly early intervention services and complex dependency programmes - should be established. A clear understanding of high risk or known individuals and their characteristics could prevent run-ins with the criminal justice system by through targeted upstream (earlier) interventions. In addition, other services that can meet lower level / sub-threshold needs identified by L&D services are required to afford individuals suitable help as needs arise, and prevent further escalation of issues. This may require definition of alternative pathways, including much better understanding and utilisation of the breadth of services provided of the VCS sector, and joint commissioning of lower threshold services where there is significant and/or growing demand.

Workforce

The NHS England baselining report (LTP review 2015) identified an average total CYPMH workforce of 0.9 WTE per 1000 CYP aged 0-17. In the East Midlands this was 0.82 WTE per 1000 CYP aged 0-17. The lowest WTE was in the West Midlands at 0.64 WTE (Data source: 2015 LTPs). Workforce planning is required in the future state to ensure there are sufficient numbers of trained practitioners to meet increasing demand.

In the future state we must ensure that all staff working with CYP who may have a MH condition have a greater awareness of MH issues and referral pathways.

Disclaimer

This report is provided pursuant to the terms of our engagement letter dated 25 January 2016. We have not verified the reliability or accuracy of any information obtained in the course of our work, other than in the limited circumstances set out in our engagement letter. This report is for the sole benefit of NHS England.

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Appendices

Networks

Stakeholder engagement

Current networks identified by stakeholders

Local networks		
Healthy Care Partnership, Corporate Parenting (LAC) network.	Offender Health Improvement Group.	Sexual Harming networks.
Social Care networks.	CAMHS in HMYOI.	Cognitive Behavioural Therapy (CBT) networks.
Strategic partnership Board between LSU and Clayfields.	Domestic and Sexual Violence executive Strategic Group.	Secure Units Case Management Groups (Education, Secure unit staff, Healthcare, CAMHS and Social Services).
Paediatrics networks.	Joint domestic and sexual violence commissioning group (includes CCGs, local authority, PCC, public health, CRC and NHS England).	Substance Misuse Services – Prisons.
CAMHS Transformation Group and plan development.	Quality and Performance contract group.	Primary Mental Health Nurses groups.
Staffordshire Prison Partnership Board.	Young Persons Drug and Alcohol group.	Health and Social care Public Health commissioners network.
YOS/YOT Management Board.	Health and Well being Board.	Safeguarding Board.
Learning Disabilities networks.	Families Partnership Executive Board.	CAMHS Service – NHS Trusts.
SARC Groups.	Joint commissioning and other workstreams group.	CAMHS Commissioning Groups.
Resilient Families Groups.	Primary Healthcare MASH.	L&D Board.

Current networks identified by stakeholders (cont.)

Regional networks		
West Midlands SARC Board.	CAHMS Service Improvement Group (CCGs and CAMHS providers).	Mental Health Concordat meetings.
Prison Partnerships Board (incorporating YOI).	East Midlands Criminal Justice Board.	Maternity and children's Commissioning Champion Group.
SARC Regional Forum.	West Midlands Criminal Justice Board.	CCG Collaborative Network for CAMHS.
Quality Assurance Groups.	Black Country L&D Partnership Board.	Mental health Commission groups.
Mental Health, Dementia and Neurological Conditions. West Midlands Strategic Clinical Network (SCN) and Senate.	Police Custody Healthcare Regional Board (Includes W. Midlands Police, Warwickshire and West Mercia Police, Staffs Police, PCC office and NHS England).	West Midlands Safeguarding Board.
East Midlands Maternity and Children's Strategic Clinical Network (SCN).	CAMHS Local Transformation and Plan development (x19 across the Region).	

National networks		
NHS England Commissioning Board.	Liaison and Diversion national group.	Multi Agency Public Protection Arrangements (MAPPA) safeguarding Groups.

Stakeholder engagement

Name, role and organisation	Midlands region	Interview/ workshop/site visit attendance
Anthony Nichols Head of Health and Justice (East Midlands) NHS England North Midlands.	East Midlands	✓
Lynda Parkes Health and Justice Commissioner (West Midlands).	West Midlands	✓
Cheryl Sherratt Deputy Director of Nursing NHS England – North Midlands.	East Midlands	✓
Simon Hardcastle Senior Quality Improvement Lead for CAMHs and Clinical Lead for Transition. Maternity and Children's Network.	East Midlands	✓
Bernie County Acting Network Manager – Mental Health, Dementia and Neurological Conditions. West Midlands Strategic Clinical Network and Senate.	West Midlands	✓
Tina Nock Deputy Mental Health, POC and High Secure Lead. Specialised Commissioning (East Midlands Hub.	East Midlands	✓
Sheila Crosbie Commissioning Lead Children/Non-acute. North Staffordshire Clinical Commissioning Group.	West Midlands	✓
Ellen Martin Lead commissioner for health and justice in the Midlands and East northern office.	East Midlands	✓
Helen Turner STC Rainsbrook - Commissioning lead.	West Midlands	✓

Name, role and organisation	Midlands region	Interview/ workshop/site visit attendance
Hannah Robertson HMP Glen Parva YOI, Leicestershire - Commissioning lead.	East Midlands	✓
Paul Brewer SCHs (Clayfields and Kesteven House, Nottingham) commissioning lead.	East Midlands	✓
Jade Poyser SCHs (Clayfields and Kesteven House)commissioning lead.	East Midlands	✓
Stephanie Johnson Public Health commissioning manager - SARCS – Birmingham (Horizons).	West Midlands	✓
Howard Thompson Public Health commissioning manager -West Mercia (The Glade SARC).	West Midlands	✓
Samantha Hewitt Public Health commissioning manager - Warwickshire (Blue Sky SARC).	West Midlands	X
Stephanie Cook Public Health Commissioning Manager - Staffordshire (Cobridge) SARC.	West Midlands	✓
Jenny Watson Programme Lead Liaison and Diversion- Coventry and the Black Country Early Adopter Healthcare into Custody- Warwickshire and West Mercia.	West Midlands	✓
Kevin Heffernan Programme Lead. Early Adopter Healthcare Custody Programme with Staffordshire and West Midland Police. Liaison and Diversion Project for Staffordshire and Birmingham.	West Midlands	X

Stakeholder engagement (cont.)

Name, role and organisation	Midlands region	Interview/ workshop/site visit attendance
Stacy Woodward Mental Health Supplier Manager Specialised Commissioning (East Midlands Hub).	East Midlands	✓
Allan Kitt Lead - CCG Collaborative Network for CAMHS.	East Midlands	X
Frank McGhee Lead - Commissioning Champions Group for CAMHS.	East Midlands	✓
Sue Sylvester NHS England: Adviser - Children and Young People's Mental Health Improvement Team.	-	✓
Nicola Wade PCC representative: Commissioning manager Nottinghamshire Office of the Police and Crime Commissioner.	East Midlands	✓
Michelle Collins Local authority representative, Derbyshire CC.	East Midlands	X
Phillipa Sharpe PCC Representative: Project Manager Derbyshire Criminal Justice Board.	East Midlands	X
Peter Gormley Governor: HMYOI Werrington.	West Midlands	✓
Claire Clemson YOI Manager: The Healthcare Manager for HMYOI – Werrington.	West Midlands	✓
Rebecca Wheeldon The Healthcare Deputy Manager for HMYOI – Werrington.	West Midlands	✓

Name, role and organisation	Midlands region	Interview/ workshop/site visit attendance
Joanne Heaney Lead for CAMHS - HMYOI Werrington.	West Midlands	✓
Caroline Scol Younger Mind Team Manager. North Staffordshire.	West Midlands	X
Hannah Taylor SARC Manager: Worcestershire.	West Midlands	X
Mandy Orton SARC Manager: Serenity SARC. SARC in Northants.	East Midlands	✓
Samantha Sykes Clinical Nurse Specialist and Service Lead. The CAMHS Head Two Head Team, Nottinghamshire Young People's Substance Misuse Service, WAM (What About Me) and the Health aspects of the CAMHS Children Looked After Provision - Clayfields SCH.	East Midlands	✓
Dr Jeanette Bowlay-Williams Consultant Clinical Psychologist Team Leader- Young People's Team/Head of Clinical Psychology- CAMHS.	East Midlands	X
Praful Solanki CAMHS team: Leicestershire Partnership NHS Trust.	East Midlands	X
Ruth Stothard CAMHS team: Leicestershire Partnership NHS Trust.	East Midlands	X
Sally Savage Local authority representative: Lincolnshire CC.	East Midlands	X

Checklist for commissioners preparing LTPs

Provision

1. Have you included provision for CYP with MH issues as they transition into and out of secure settings?

2. Have you made provision for CYP with MH issues who have been referred to a SARC?

3. Have you made specific reference to these vulnerable cohorts in your LTP? Are you aware of their needs?

4. Have you identified how you will ensure a timely transition into and out of secure settings with seamless treatment/interventions? Does this cohort receive timely support post release? If not how can this be improved? Can you/ do you need to simplify the referral process?

5. Do you have arrangements in place to meet crisis care demand in secure settings?

6. Do you commission specific services that can help to reduce the chances of CYP escalating into a mental health crisis, thus needing in patient admission, whilst in a secure unit?

7. Have you reviewed transition arrangements from CAMHS to adult MH provision to ensure the needs of the CYP population are adequately met and identified budgets to cover this where required?

Collaboration

8. Are you in contact with the NHS England CAMHS commissioners responsible for provision in secure settings?

9. Are you aware of the secure settings for CYP in your locality? (ie Secure Training Centres, Secure Children's Homes, Youth Prisons/ YOI) within your locality? Have you made reference to them in your plan?

10. Are you aware of the SARCs for CYP in your area?

12. Have you asked NHS England commissioners to provide an input or review of your plan and provided a reasonable timescale for their input/response? Do you need to change your collaborative approach to make this happen?

13. Are there existing commissioning groups where the needs of this population are being taken into account/could be taken into account?

14. Do you have formal communications platforms in place between community and specialist/ secure settings CAMHS providers?

Data Collection and Sharing

15. Do you have data sharing arrangements in place with other commissioners and providers regarding CAMHS provision in secure settings / SARCs?

16. Have you agreed common minimum data to be collected and reported in your locality?

17. Have you agreed common performance indicators in your locality?

18. Do you request/have access to feedback data from patients and carers?

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